

# Understanding mechanisms of change in a family-based preventive mental health intervention for refugees by refugees in New England

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## Abstract

Transnational migration of refugees is associated with poor mental health, particularly among children. We conducted a pilot trial of the Family Strengthening Intervention for Refugees (FSI-R), using a community-based participatory research (CBPR) approach to deliver a home-based intervention “for refugees by refugees” to improve family functioning and child mental health.  $N = 80$  refugee families in the Greater Boston area participated in the study ( $n = 40$  Somali Bantu families;  $n = 40$  Bhutanese families) with  $n = 41$  families randomized to care-as-usual. Of the 39 families who received FSI-R,  $n = 36$  caregivers and children completed qualitative exit interviews. We present findings from these interviews to identify the mechanisms through which a family-strengthening intervention for refugees can be acceptable, feasible, and effective at improving family functioning and children’s mental health outcomes. Authors applied Grounded Theory to code interview transcripts and detailed field notes and used an iterative process to arrive at final codes, themes, and a theoretical framework. The greatest contributors to acceptability and feasibility included flexibility in scheduling intervention sessions, the interventionist being a community member, and improvements to family communication and time spent together. All of these factors were made possible by the CBPR approach. Our findings suggest that given the socio-political context within the U.S. and the economic challenges faced by refugee families, the successful implementation of such interventions hinges on culturally-grounding the intervention design process, drawing heavily on community input, and prioritizing community members as interventionists.

## Keywords

adolescent health, child health, community-based participatory research, intervention, mental health, refugee

## Introduction

The number of individuals displaced by conflict is at an unprecedented high (United Nations High Commissioner for Refugees [UNHCR], 2018). As of 2018, 68.5 million people have been forcibly displaced from their homes, 25.4 million of them living internationally as refugees (UNHCR, 2018). This number is anticipated to rise as global conflicts continue (Hugo et al., 2018).

Refugees, or “people who have fled war, violence, conflict or persecution and have crossed an international border to find safety in another country” (UNHCR, 2019, p. 1) are at heightened risk for mental disorders (Bogic et al., 2015).

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Specifically, refugees in Western countries have a 14 times higher risk of depression and 15 times higher risk of post-traumatic stress disorder (PTSD) than the general population (Bogic et al., 2015). Studies on refugee children indicate they are also at risk of poor mental health, having higher rates of depression (10–33%) and PTSD (19–53%) than non-refugee children (6–9% and 2–9%, respectively) (Bronstein & Montgomery, 2011; Kien et al., 2018).

Pre-migration trauma and post-migration stressors strongly predict mental health problems among refugees (Bogic et al., 2015). These include socioeconomic disadvantages, such as poverty, high exposure to crime, overcrowded or inadequate public housing, low performing schools, and acculturation stressors, such as racism, xenophobia, language barriers, and cultural differences (Betancourt, Frounfelker, et al., 2015). Many refugee children bear an additional set of family-level stressors. For example, some children must assume atypical roles, such as being responsible for interpreting or playing cultural mediator for their caregivers. Further, refugee caregivers find themselves in a new culture in which parenting practices and expectations are often different from their native cultures; parents may also face individual-level risks for poor mental health, violence perpetration or victimization, or substance use. As a result of this constellation of risk factors, refugee children face a confusing and contradictory landscape of pressures and expectations (Betancourt, Abdi, et al., 2015).

Additional stressors were present for refugees living in the United States during the 2016–2020 Trump administration. Well known for its anti-immigration and nationalist rhetoric, the administration advocated for the lowest refugee resettlement in U.S. history. An annual ceiling of 18,000 refugees was set for 2020 in the United States, compared to a typical annual resettlement number of 85,000 refugees (Migration Policy Institute, 2020). This public stance against refugees created a socio-political environment with documented harmful mental health effects for refugees (Betancourt et al., 2020; Jorgenson & Nilsson, 2021).

### *Mental health interventions for refugee youth and families*

Multiple mental health interventions for refugee youth exist, including models implemented in schools and with peers, interventions that address services access and contextual factors, and some that focus on parenting (Fazel & Betancourt, 2018; Frounfelker et al., 2020). However, many interventions have not been tested using rigorous methods and do not necessarily employ evidence-based principles (Pfeiffer et al., 2018). An overwhelming number focus on past trauma, neglecting to address other determinants of mental health, including family relationships (Hynie, 2018). Few evidence-based interventions operate at the family level to address family functioning and dynamics (Silove et al., 2017). UNHCR and UNICEF

have called for programs to address parenting skills as a critical way to improve mental health of refugee caregivers and youth (Williams, 2012). As such, there is a need to develop flexible, preventive interventions that engage both youth and caregivers to address family relationships, roles, and their impact on mental health. Given concerns about cultural humility and linguistic abilities of mental health providers, such interventions would be best implemented *for refugees by refugees*, with refugees' own community members designing and delivering the interventions (Murray et al., 2010). Further, developing countries have set a promising precedent for well-trained and supervised lay-workers delivering mental health interventions, helping to close the treatment gap for vulnerable populations (Kohrt et al., 2018).

### *Family Strengthening Intervention for Refugees (FSI-R)*

The Family Strengthening Intervention for Refugees (FSI-R) is a home-visiting program adapted from the evidence-based Family Based Preventive Intervention (FBPI) using a mixed-methods community-based participatory research (CBPR) approach to address the heightened mental health risks facing refugee families (Beardslee, 1998; Beardslee et al., 2003). The FBPI, was listed in the former National Registry of Effective Programs and Practices, was developed to prevent depression in children of depressed caregivers. It has since been adapted for various contexts, yet not for refugees (Beardslee & Gladstone, 2001; D'Angelo et al., 2009). Working closely with local Somali Bantu and Bhutanese refugee communities in the New England region of the northeastern United States, extensive qualitative work was performed to adapt the intervention (Betancourt, Frounfelker, et al., 2015).

FSI-R was developed with a strengths-based orientation, positing that understanding the family narrative, or story, and protective factors that helped the family navigate difficult experiences in the past can serve as resources to support present functioning. FSI-R employs ecological systems theory, which posits that an individual's development is influenced by factors from their immediate environment, the microsystem (i.e., family, peers, caregivers), to the exosystem (i.e., politics, social services, community) (Bronfenbrenner, 1979). This theory suggests that reinforcing resilience across all levels of one's ecological system will further enhance prevention efforts (Fazel et al., 2012). Prevention science also suggests that for children, it is particularly important to target family dynamics (Haggerty & Mrazek, 1994; Williams & Berry, 1991). Therefore, by harnessing indigenous protective processes within the family, interventions that engage the child's microsystem (family) may be able to provide unprecedented support for young people at risk of developing mental health issues.

FSI-R works with parents to develop parent–child communication, positive parenting skills, and alternatives to harsh and conflictual interactions, based on the literature and the FBPI conceptual model whereby negative parent–child dynamics can result in poor mental health of children. As in the FBPI, a core component of FSI-R includes a strengths-focused family narrative that outlines the family’s story from the beginning, through stages of the refugee journey, to current parent–child interactions and family hopes for the future of all members. The FSI-R family narrative was designed based on our formative research among Somali Bantu and Bhutanese refugee families to emphasize strengths and resources unique to each family while honoring difficult times that families overcame to impart feelings of agency and hope.

In accordance with CBPR best practices, Somali Bantu and Bhutanese community members were involved at every stage of the research from intervention design to dissemination of findings (Israel et al., 1998). Community members were trained and supervised to deliver the intervention, collect data, and serve on community advisory boards (CABS) to guide the research project and liaise between the research team and community.

### Somali Bantu and Bhutanese refugees

FSI-R was piloted with two refugee sub-populations resettled in New England, the Somali Bantu and Bhutanese. Somali Bantu is an identity shared largely by ethnic minority peoples either indigenous to Somalia or brought to Somalia as slaves from across Africa centuries ago, who settled in farming communities along the Jubba and Shabelle rivers (Besteman, 2013). Following the collapse of the Somali government in 1991, much of the Somali Bantu population fled to refugee camps in Dadaab and Kakuma, Kenya. After the U.S. government identified Somali Bantu peoples as a persecuted minority group, roughly 10,000 Somali Bantu refugees were resettled in the United States between 2004 and 2006 (Besteman, 2016). Youth within the Somali Bantu refugee community are challenged with negotiating their complex identities as U.S. residents, descendants from enslaved populations in Africa, Somali minorities, and Muslims in the United States. They face risks for mental health problems including depression (*takoor*), anxiety (*wel-wel*), anger (*dherif*), and conduct disorders (*aasiwaalidin*) (Betancourt, Frounfelker, et al., 2015).<sup>1</sup> Often, Somali Bantu parents speak a native, largely unwritten language, Maay Maay, while their children independently learn and speak English.

The Bhutanese refugee community comprises Lhotshampa or Nepalese ethnic origin peoples who have lived as a minority group in Bhutan since the 1600s. At the end of the 20th century, the Bhutanese government forced these Nepali-speaking Bhutanese out of Bhutan, forcing them into refugee camps in Nepal (Rizal, 2004).

Since their resettlement in the United States, this refugee sub-population has been characterized by tremendous mental health needs including a suicide rate of 24.4 per 100,000 among resettled Bhutanese refugees in the United States, which is nearly double the U.S. national average (Centers for Disease Control and Prevention [CDC], 2013). Research attributes the high suicide rate to experiences of family separation, difficulties integrating into U.S. culture, high unemployment, and perceived lack of care, resettlement services, and social support (Hagaman et al., 2016). Qualitative inquiry has indicated that Bhutanese youth experience depression (*dookhit*), anxiety (*chintet*), and behavior problems (*badmaas*), yet little is known about the effects of poor mental health on Bhutanese youth (Betancourt, Frounfelker, et al., 2015).

### Present analysis

A quantitative analysis of this pilot intervention found FSI-R to be acceptable, feasible, and demonstrating an impact on child mental health (Betancourt et al., 2020). The present analysis uses in-depth semi-structured exit interviews with a sample of FSI-R participants to understand family processes and experiences of the intervention to illuminate potential mechanisms of change. Our research questions are:

1. What factors shape the acceptability and feasibility of the family strengthening intervention for refugees at the individual, family, and community levels?
2. What kinds of changes, if any, do caregivers and children experience in themselves and their families after participating in a family strengthening intervention for refugees?
3. What perspectives, if any, do intervention participants offer to improve future impact, acceptability, and feasibility of the intervention?

### Methods

Criteria for enrollment and the study’s definition of “family” was a household with at least one adult caregiver and one child aged 7–17. Participants were recruited to FSI-R via phone and community events, guided by CABS. Participants needed to have formal U.S. government refugee status, have at least one school-aged child aged 7–17 years, and have resided in the United States for at least three months. Exclusion criteria included the family experiencing a severe crisis at the time of enrollment, including recent death or divorce, severe illness, hospitalization, or intimate partner violence. Crises were examined on a case-by-case basis with community research assistants (RAs) working with the family to determine appropriateness of participation. All families in crisis, regardless of participation, were referred to a higher level of treatment.

Following a quantitative baseline assessment, families were randomized to either FSI-R ( $N=39$ ;  $n=19$  Somali Bantu and  $n=20$  Bhutanese) or a care-as-usual condition ( $N=41$ ;  $n=21$  Somali Bantu and  $n=20$  Bhutanese). Most caregivers enrolled were female (79% of Somali Bantu, 52% of Bhutanese) and the biological parent of the child enrolled. In some cases, the primary caregiver enrolled was a grandparent, aunt, or uncle of the child, and all family members were encouraged to attend intervention sessions. We did not differentiate between biological parents and other types of caregivers in our analyses. Bhutanese families, for example, often live in multi-generational homes where the oldest male is head of the household. Care-as-usual families did not receive the intervention but were able to access all services provided by agencies and other support services. All families, regardless of randomization group, received \$50 at two time-points when quantitative pre- and post-test assessments were administered.

The intervention contained 10 modules which were delivered in 10 home-visiting sessions by one of four trained community interventionists. All interventionists were male. Recruitment for these positions was posted at community centers frequented by resettled Bhutanese and Somali Bantu communities in New England and shared by word of mouth. There were no education or licensing requirements; however, the research required interventionists to speak their native languages and English fluently. These requirements made identifying female interventionists more challenging, which has been addressed in subsequent iterations of the intervention. The interventionists selected for the study were well-known, highly respected individuals known within the community. All were affiliated with trusted social service organizations and considered people whom community members turned to for help and support. Licensed clinical social workers at partner service agencies supervised the interventionists who delivered each 90-minute session with the families. Twice monthly “super-supervision” allowed interventionists to discuss challenges as a group and receive guidance and feedback from program developers.

Twenty families from the intervention group were selected to participate in exit interviews using a random-

digits table. One child and one caregiver from each selected family were asked to complete an exit interview following intervention completion. Thirty-six exit interviews were conducted with  $n=18$  Somali Bantu participants ( $n=8$  children,  $n=10$  caregivers) and  $n=18$  Bhutanese participants ( $n=9$  children,  $n=9$  caregivers) (Table 1). Of the 20 families enrolled in the intervention from each community, 11 Bhutanese families and 10 Somali Bantu families completed exit interviews.

### Data collection

Adults provided consent, while minors provided assent with their caregivers granting consent. Caregivers were primarily parents. Institutional Review Board approval was granted through the Harvard T.H. Chan School of Public Health (Protocol #15860) and Boston College (#19.135.01).

Exit interviews were conducted between January and March 2019 using a semi-structured interview guide by RAs who were native speakers of the refugee communities’ mother tongue. Interview data were collected in English, mother tongue, or a mix of both, depending on the comfort of the interviewee. RAs audio-recorded the interviews ( $n=13$ ), or if the participant refused permission for audio recording, took detailed notes ( $n=23$ ). Audio recordings and handwritten notes were translated to English, where necessary, and transcribed. Only the RA and interviewee were present for the interview.

### Data analysis and trustworthiness

Our study follows Tracy’s (2010) criteria for excellent qualitative research, particularly regarding choosing a worthy topic and ensuring sincerity and credibility throughout our analysis (Tracy, 2010). The Introduction details the relevance, timeliness, and significance of improving refugee mental health (i.e., *worthy topic*) (Guba & Lincoln, 1989; Tracy, 2010). Our approach to data collection, analysis, and reporting of results involved constant self-reflexivity and transparency of methodology and challenges (i.e., *sincerity*). We strove for trustworthiness (i.e., *credibility*) by prioritizing the triangulation of findings (Denzin, 1978). All authors were involved in either reading transcripts, creating codes, consolidating codebooks, generating themes, and/or negotiating the meaning of our findings. We grounded all findings in participants’ cultural context by including member checks of all results with authors who are also community members (Lindlof & Taylor, 2002).

We employed Grounded Theory to analyze the interview transcripts and detailed field notes (Strauss & Corbin, 1997). A highly iterative and team-based process was followed to ensure rigorous findings (Polit & Beck, 2008; Tracy, 2010). The first and second authors served as

**Table 1.** Demographics of exit interview sample ( $N=36$ ).

	Somali Bantu ( $n=18$ )		Bhutanese ( $n=18$ )	
	Children	Caregivers	Children	Caregivers
Individuals, $n$	8	10	9	9
Female, $n$ (%)	4 (50%)	9 (90%)	3 (33%)	4 (44%)
Age, $M$ (range)	14.5 (11–17)	40.1 (32–52)	15.7 (12–18)	46.1 (34–60)
Years in U.S., $M$ (range)	12.7 (11–15)	13.3 (12–15)	4.7 (1–8)	4.6 (1–7)

primary coders and began by conducting deep readings of each transcript. They then discussed impressions with the third author, who was the Program Manager for FSI-R, as Grounded Theory suggests that involving someone who intimately understands the context surrounding the data in the coding process offers “the ability to respond to the subtle nuances of ... meanings in data” (Strauss & Corbin, 1998). Then, the primary coders conducted open coding. After developing independent codebooks, they met to negotiate meaning across sets of codes and consolidated them into a final codebook. The coders then recoded a subset of interviews and discussed coding crossover until consensus was met. The greater authorship team then utilized axial coding to draw connections within the data to develop a set of core themes. A critical part of this step, drawing on both CBPR and Grounded Theory best practices, was receiving feedback on themes and theory development from members of both refugee communities to ensure trustworthiness. Finally, the first three authors engaged in advanced coding, specifically using the storyline technique, “a strategy for facilitating integration, construction, formulation, and presentation of research findings through the production of a coherent grounded theory” (Birks & Mills, 2015). The authors discussed the results from each research question, iteratively building a storyline that connected the relevant findings into one cohesive, novel argument (Chun Tie et al., 2019). All analyses were carried out using MAXQDA Analytics Pro (VERBI Software, 2016).

## Results

Several themes were identified, organized in the following sections by how they address each of our three research questions. Figure 1 illustrates the interconnections between several major themes and places them in the intervention’s wider context, that is, of being grounded in CBPR and existing within the U.S. socio-political environment. When noted, additional text and quotes to support themes can be found in the Supplemental Material.

### *Acceptability and feasibility*

Our analysis found that acceptability and feasibility were closely intertwined; in fact, the factors that made FSI-R feasible (e.g., scheduling, timing, convenience, and interventionist language) also made it acceptable to participants (Figure 1).

*Scheduling and timing.* Most participants discussed issues around scheduling and intervention timing. However, due to reasons including frequent contact with and flexibility of the interventionist—and the intervention taking place in participants’ homes—few reported that scheduling was problematic in completing the intervention. Children

discussed the intervention as conflicting with extracurricular activities, while caregivers and children alike noted the challenge of scheduling sessions around caregivers’ work schedules. Other barriers to scheduling included commitments within the community, medical appointments, time needed to care for family members, and extended travel to visit family.

Ultimately, however, scheduling issues were a barrier that most families were able to overcome to participate in the intervention, assisted by the flexibility of home-visiting. Sessions could occur during the day, evenings, or weekends. Often, participants shared that the interventionist played an important role in ensuring that scheduling did not ultimately affect the ability of families to participate. See Supplemental Material for supporting quotes.

*Discussing the past.* Discussing past experiences related to their refugee experience influenced FSI-R’s acceptability for children in both communities. For many children, the intervention’s focus on creating a family narrative provided them an unprecedented opportunity to learn about their family history. When asked what she enjoyed most about the intervention, one 12-year-old Somali girl replied, “when we talk about my grandparents and stuff... My mom never talk[ed] about them before [and I] like to know about them.” A 16-year-old Bhutanese boy remarked that the interventionist

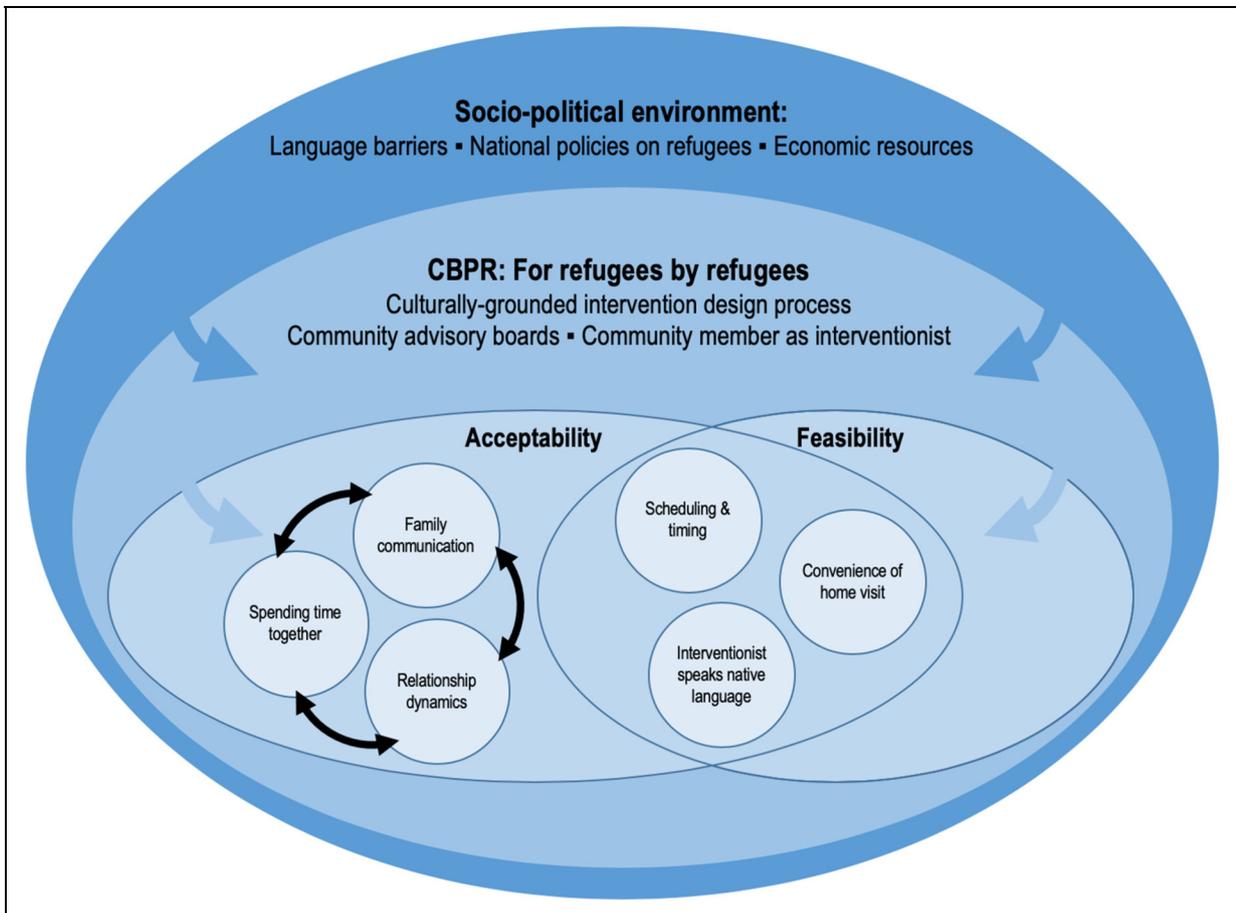
asked us about family, what had happened in the past... All of that I felt good about... He asked from my birthplace to everything after that. I had forgot a lot of things. I knew about things I didn’t know, because of him.

For children participating in the intervention, the family narrative sparked a new dialogue regarding life before the United States. Several parents recognized the importance of sharing these stories, noticing that this discussion was meaningful for children. One Somali mother said, “My child say[s] he liked when he heard me talk about my life back in Africa, when we talk about family relations.” One Bhutanese mother shared, “the most important [part of the intervention] was... sharing things from inside like how hard things had been in the past. These things aren’t bad.”

However, the process of retelling past histories was not easy for all caregivers, particularly for mothers within the Somali Bantu community where trauma experiences had been high. One Somali mother said,

Most of [the intervention] was fine but the only thing I would say I didn’t feel comfortable is talking about [what] happened in the past... in Somali[a] and in the refugee camp too, life wasn’t easy for me and my family.

Another Somali mother echoed this feeling, saying that she also did not like discussing the past since it “reminded [her



**Figure 1.** Multi-level environment supporting the acceptability, feasibility, and outcomes of community-based mental health intervention for refugees by refugees: results of advanced qualitative coding and theory development.

of her] history of trauma” even though home visitors were trained to not probe on traumatic content and to keep the focus on protective factors that made it possible for families to navigate and overcome challenges. Another Somali mother said, “I didn’t like the part where I have to talk about my past,” suggesting a barrier to the acceptability of the family narrative focus of the intervention for some female caregivers struggling with a trauma history.

*The interventionist as a fellow community member.* Participants spoke highly of their interventionists, describing them as respectful, patient, understanding, and competent. Participants conveyed the importance of the interventionist speaking their language. When asked about their experiences with the interventionists, members of both communities explained that their interventionist was a part of their community, which contributed immensely to acceptability. A Somali Bantu mother said,

I don’t see anyone else in the community that will be able to do that job... It was very helpful to see someone from the community... We understand each other.

Another Somali mother echoed this, saying, “[The interventionist] is... someone who understand[s] the dynamic and the function of the intervention and the Somali Bantu culture.”

Participants mentioned knowing their interventionist from before resettling in the United States as a friend, neighbor, or teacher in the refugee camps. Others recalled meeting their interventionist in other contexts in the United States, either as a caseworker or a translator. Although this raised concerns for the project team, discussions with CABs indicated that in these tightly knit communities, it would be impossible to prevent such overlap, and the pre-existing relationships may even foster trust. Our results supported this, as participants reported that interventionists understood their way of living, spoke their language, and understood their needs. Two exceptions are discussed in the Supplemental Material.

### *Effects on participants*

Participants recognized that FSI-R led to positive changes in their families. The intervention effects uncovered by

this analysis—family communication, spending time together, and relationship dynamics—were closely intertwined and mutually reinforcing (Figure 1). Furthermore, participants' awareness of these positive outcomes increased intervention acceptability.

*Family communication.* Both Bhutanese and Somali Bantu families spoke about how the intervention affected communication within their families. Participants often spoke of increased family communication in tandem with increased time spent together as a family, indicating a reinforcing relationship between these themes.

Bhutanese families indicated that the intervention led children to share more with their caregivers and vice versa. A 16-year-old boy remarked about his uncle and primary caregiver: "I used to get scared of communicating with my elder father [uncle]... I just used to communicate with my elder mother [aunt] about needs but after [the] intervention ended, I feel like talking to my elder father more."

Children explained how they were able to share more with their caregivers after the intervention concluded. A 12-year-old Bhutanese girl explained:

Before this intervention, I wouldn't tell anything that happened at school to my parents because I got really worried, 'cause I used to get bullied. Now, I tell my parents and they help me a lot.

This dynamic also pertained to caregivers sharing with children. A Bhutanese mother stated, "[The interventionist] shared about sharing things from inside, like how hard things had been in the past. These things aren't bad [to talk about]. I liked that they talked about it."

Caregivers also took the initiative to ask their children about their lives. An 18-year-old Bhutanese male commented that his parents asked him more about school due to the intervention, saying, "I am glad because they always ask me about my grade... After talking about those things with [the interventionist]... my dad... ask me about the school more often because we talked about importance of school in [the] United States."

Several Bhutanese caregivers also mentioned this dynamic. One mother explained,

I also learned that we should not avoid children... We used to do things in certain ways because we didn't understand. But now we understand that we should talk to each other... We now know things happening in each other's lives.

A Bhutanese father stated, "In this program, things we had talked about like how children are doing, going and talking to teachers how they are doing... If no one reminded us of that, we probably would not have done that on our own."

Overall, Bhutanese children and caregivers enjoyed increased communication and sharing feelings. As one 16-year-old boy explained, "Before we never like sat together and like expressed our feelings and how we felt to each other... I actually know what my parents felt about me and what I feel about them." A Bhutanese father describes his changing dynamic with his children:

Before, we didn't get along really well, we didn't talk. We used to do our own work in the family ... We discuss and do now. That is the difference. I think that has improved a little bit from before. ... Children also ask before they do something. They did on their own before. They ask and discuss now... I have felt good about that.

Somali Bantu families spoke about having an opportunity to discuss life before coming to the United States, having more unstructured communication, and speaking more politely to one another. A Somali Bantu mother shared, "My child say[s] he liked when he heard me talk about my life back in Africa." Somali children echoed an appreciation of learning more about their families through increased communication. A 12-year-old girl stated, "My mom never talk about [my grandparents] before. I like to know about them." This finding directly relates to the above discussion of acceptability.

For some caregivers, family communication meant learning to listen to their children in a different way, to appreciate their children's thoughts. One Somali Bantu father remarked: "It was good: we never talk priority for my kids. [We are] always working... but it give me [a] small lesson that I also need to listen to them about their thought[s]."

Several participants remarked that they enjoyed increased unstructured discussions with their family. As a 17-year-old Somali girl stated, "Just to talk with my family was the best. I never talk with my parent like that." One 12-year-old girl said: "My sister sometimes ask[s] us to talk to each other, sitting around, no TV, no phone, just talk face and face. Nothing else."

Somali caregivers also described increased communication amongst the family and stronger relationships between siblings. One mother said, "I really like talking with my kids in groups, I normally talk to them individually. [We] never sit down with them and talk in general." Another mother explained, "[Before the intervention,] children were not coming out from their room—[but] recently they sat in the living room to share how school was and share daily living activities." Finally, another mother commented, "The only things that I see change after the intervention [is] my kids getting along now a lot [more] than before, because a few times [the interventionist] told them to come together and talk."

Many Somali Bantu caregivers and children also mentioned that family members have learned to "speak politely"

and “respectfully” to one another after the intervention. One mother stated, “We have [a] good understanding now, [and] stopped yelling [at] each other.” However, different parenting expectations can also present a challenge to Somali Bantu caregivers. This Somali mother explained that although it was important to learn about these differences — “[the] most important [topic learned] was parenting strategies. Because I was punished before by my parent with a stick; here in the U.S., [it is] not allowed to punish with stick or belt, only talking to them politely”—it was an unfamiliar adaptation. She continued, “[there is] still no proper way of disciplining the children. Talking to children politely, saying please to your child—I didn’t like that.” Regardless, this parent still adapted her behavior. “I used to yell at my kids all the time; now [we have] better communication. I talk to them as an adult now in [a] respectful way.”

For many Somali Bantu families, language barriers made communication with their children difficult. For Somali Bantu caregivers—many of whom speak Maay Maay, while their children speak predominantly English—the intervention presented an opportunity to overcome this. As the same Somali Bantu mother explained:

My own children, [I] can’t communicate with them... now we had agreed to spend more time as a family, communicate in Maay Maay as a family, we will be accomplishing goals by having family meetings... My children are following the rules I set... We have [a] good understanding now, stopped yelling [at] each other. We provide support to each other. Now my children start helping me learn English.

*Spending time together as family.* Just as families enjoyed increased communication, they also enjoyed spending more time together. This was especially evident in Bhutanese families. One mother explained:

I didn’t know well to give time to my children—what to do and what not to do with kids... We didn’t know how to give time to children at home. I liked [learning] that a lot too... We got to give them time. I learnt that this should have been like this since generations.

Bhutanese children also remarked on the increased family time. A 12-year-old girl explained,

I think the thing that is really helpful for our family is... we go to ... a park... like Saturday and Sunday where we have a day off...that is really nice for our family cause we get closer together... Also good is that my mom and dad have worked at different times. So in the morning, my dad’s at home and in the afternoon my mom’s home. So at that time we both get to get to know our mom and dad better and we get closer to them... Before... my mom

and dad had a really busy schedule. But when the time went on... they made more time for us.

Similarly, a 17-year-old Bhutanese girl said:

We realized our roles in our family... like what we should do. And like how should we spend time with each other... My dad participated in the intervention, so he mainly focus[ed] on spending time among family members... I feel more than me, my father is affected positively with those information, and he mentions about spending time again and again.

Bhutanese families also explained that they spend time together by adopting the practice of family meetings. Family meetings, a cornerstone of FSI-R, served as an opportunity for caregivers to “keep in the loop with school,” for the family to “plan for things together” and “set goals,” and for children to “help [siblings] with their homework.” Family meetings also increased family communication, creating a reinforcing relationship between communication and spending time together (Figure 1).

Another 17-year-old Bhutanese girl explained:

We started family meeting/activities together every Sunday since [the intervention]... We are more open to each other, more family meeting or gathering than before... We used to spend time in our room in phone or iPad but now we sit together, discuss about school, plan for buying homes, about moving to different states together and some agrees, some don’t, but it is better now.

Similarly, Somali Bantu families remarked that they enjoyed spending more time together as a family after the intervention, with an emphasis on time spent together among siblings. One mother remarked that “children [are] now getting along, spend[ing] time together and having fun.” When asked how the intervention affected family relationships, another mother explained, “None of my children use to talk from conversation before, but now we sometimes watch TV together. I always remind them about [the interventionist] and what [the interventionist] told them.”

Another mother described that,

Participating in the intervention impact[ed] my family. For example, my children were not a part of the family but now they involve with the house chores and help each other now... [They] were not coming out from their room[s] —[but] recently they sat in the living room to share how school was and share daily... activities.

Many Somali Bantu family members stated that they continue to use the family meeting as a regular part of their lives despite life’s demands. A 17-year old girl explained

that “the weekly meeting... still continue[s] even though sometimes our parent[s are] not available to join us.”

*Relationship dynamics.* Very few Somali Bantu participants mentioned that the intervention affected the relationships between caregivers in the family. One mother said, “I love my husband, too. Was it supposed to change?” On the other hand, another mother remarked that she and her spouse “stopped yelling each other.” Otherwise, Somali Bantu families rarely discussed this dynamic in the exit interviews.

Conversely, Bhutanese participants often shared how the intervention affected caregiver relationships. Many commented that their marriages had always been positive. For example, a mother remarked, “We had a good communicative relationship from the beginning so there weren’t any drastic changes that the program [brought].” However, many Bhutanese children talked about observing changes in their parents’ relationship. As a 12-year-old boy explained,

My dad and mom really care about each other... They spent more time with each other because sometimes my mom doesn’t go to work, so she gets to stay home and help my dad uh like take care of my sister... And my dad just started doing this last year. But my mom stays home to help my dad with the stuff and the house, because it’s really hard for him. And when my mom is sick, my dad takes over the cooking and the cleaning of the house and taking care of my sister.

This remark illustrates the reinforcing relationship between spending time together and improved relationship dynamics. Other Bhutanese children observed similar changes. One 16-year-old boy stated that his parents “don’t argue anymore,” explaining,

Before my dad just came from work and like just slept and said nothing to my mother. Now he comes back from work and actually sits down and talks to my mother and [asks] how her day was... I think they found a better relationship when they took part in the intervention, and I think they understand and like each other more.

Here we see the mutually reinforcing relationship between communication and improved relationship dynamics. Some caregivers remarked that the discussions that took place during the intervention helped to reexamine how the couple might approach parenting together. A Bhutanese mother explained, “In our culture, [the] father is more powerful of role model in the household, but he needs to work, as well. From the intervention, we learned that guidance from both parents [is needed]... to manage for the kids and family.”

### *Improving the intervention*

Participants were asked how, if at all, the intervention can be improved for the future. Two additional themes resulted that provide context for community needs and future intervention adaptation.

*Seeking tangible skills.* Participants across both communities suggested that future iterations of FSI-R include training in tangible skills. One Somali mother clearly requested:

Start a family program that help[s] children and their parent to get better plan for the future... If you give us ways to save money, learn English, job training, and many other things that other offices do, it [will] help the community... I think you need to start service[s] for the people like English class, parenting class, youth group for both girls and boys, parent group, [and] money saving programs.

A Bhutanese father felt similarly, stating that their community requires more services when it comes to disability, “whether connecting them to the services, or some financial assistance, or education. And transporting them [participants] to the providers.”

Engaging in further education was a critical component missing from this intervention for others, as well. Another Bhutanese father explained that:

If there were opportunities for college and things like that, that’d be great... We still would like to study... Why would you want to stay idly you know? I don’t work currently. I was given some SSL... I am free, so even if I get [the] opportunity to learn two English words, it would be easier to speak with friends.

Children from both communities discussed the need for their caregivers to learn English. A Bhutanese boy, age 16, described:

My mom and dad, they can’t speak English. If they need to go to the hospital, you need to be able to speak English... like if the intervention could help us... help our parents know English that would help us a lot. It would make our family good.

A Somali mother was concerned about her children’s future, asking for future interventions to address “how to help our young children not to end up [in] jail or any other legal system.” While the long-term wellbeing of children is the primary target of FSI-R, this caregiver’s experience of the intervention did not include addressing how to reach the long-term success of their children.

*From family to community.* Bhutanese children suggested altering the intervention setting from the family unit to

the community. An 18-year-old boy suggested the incorporation of a “community hour” for youth that would provide help with school and college applications.

A 13-year-old Bhutanese boy stated:

We are so happy with individual or family services but we are more than happy to see the groups services like youth group or women’s group or men’s group, or couple groups utilities to help all the members in the community to bring them together, to share to spend time together and everybody in our community wants some program... at least our generation. I think it will be very helpful for our community [if you have] such program or services to bring the community together.

A 17-year-old Bhutanese girl who also hoped for more integration into the community said,

if there was some hall for children or ... any ages, sometimes groups come together, play, dance, and just talk and learn Nepali language for kids, learn more Nepali culture. Everywhere it cost money and we cannot afford that for our kids.

## Discussion

Overall, these data reveal the mechanisms through which FSI-R was acceptable to the Somali Bantu and Bhutanese communities and led to positive and well-received changes in family dynamics. As we illustrate in Figure 1, FSI-R worked within socio-political challenges, including language barriers and economic stressors, by following CBPR principles and creating an intervention “for refugees, by refugees.” The CBPR approach helped make FSI-R acceptable and feasible to participants. In particular, interventionists being from the same communities as participants increased trust and comfort (acceptability), and simultaneously allowed the platform to be possible and effective, due to sharing a common language with caregivers and children (feasibility). The interventionists—who share caregivers’ migration experiences, yet have also been well-trained in parenting strategies, trauma and acculturation psychoeducation, and navigating U.S. systems—serve as ideal coaches for bridging divides within families. Additional contributors to feasibility were scheduling and location (i.e., not needing to travel to receive the intervention). Participants often brought up how the convenience, and thus feasibility, of FSI-R also caused them to like the intervention. Thus, we found that each contributor to feasibility was equally responsible for FSI-R’s acceptability. Rarely were criticisms of the intervention made beyond the time commitment or having to revisit the past, which is reflected in the predominantly positive results presented.

FSI-R participants noted many positive outcomes in their family due to the intervention. Our analysis revealed that the three primary outcomes—family communication, spending time together, and relationship dynamics—were mutually reinforcing, i.e., as one improved, so did the others. Additionally, when participants recognized these positive changes, they found FSI-R more acceptable; at the same time, because FSI-R had high acceptability in the first place due to its CBPR approach, the observed outcomes were possible to achieve. These results demonstrate the value of the FSI-R design.

Increased family communication and pleasure in one another’s company are promising results. We found that FSI-R’s focus on creating shared narratives within families enhanced family communication, especially as it offered families an opportunity to discuss experiences they had not previously discussed. Discussing the past also brought up varied reactions. Children in both communities enjoyed hearing about their families’ histories, which may have helped some understand their cultural heritage as they developed their personal identities. Bhutanese children seemed more familiar with their families’ histories than Somali Bantu children. In fact, Somali Bantu mothers frequently responded that they did not enjoy discussing the past, as it reminded them of past trauma. Trauma severity is likely a contributing factor to frequency or depth of discussion around family history. For this reason, FSI-R introduces the family narrative within a strengths-based, resiliency-focused lens, which may have allowed families to broach these topics for the first time. Even so, the frequency of this response from Somali Bantu mothers may warrant further research into how to approach narrative creation in families with specific trauma experiences. It may also be the case that female adults in our study have more of a trauma history that may also include sexual violence. Though we found that only female caregivers reported discomfort discussing the past, it is important to note that male caregivers, too, are likely to have trauma histories that warrant further attention (Affleck et al., 2018). Memories of the past may be difficult to resurface and require opportunities to seek individual treatment for traumatic stress reactions.

Differences in family communication and sharing past experiences could also be due to language abilities. Bhutanese children and caregivers both tended to have high Nepali fluency, whereas Somali Bantu caregivers often pointed out that their children speak mainly English, while they speak Maay Maay and limited English (this is because more Somali Bantu children were born in the U.S. than Bhutanese children in our sample). For some Somali Bantu households, the interventionist needed to interpret between English-speaking youth and Maay Maay-speaking caregivers. These language differences could also explain differences in family dynamics outcomes between communities. Bhutanese children often reflected

on the increased time spent together and communication among their siblings and caregivers; they refer to changes in spending time together as a shift experienced by the family unit as a *whole*. Somali Bantu children and caregivers, however, more often report that children spend more time with their *siblings* (with whom they share a common language), without mentioning that the intervention changed the time they spend with their caregivers. In addition to the language barrier, this may also be cultural as in the Somali Bantu culture, it is less typical for caregivers to engage in frank, emotional discussions with their children. The idea of frequent, open communication between caregivers and children is a concept that was quite different from their parenting traditions, but also something that this study and others have shown Somali refugee parents embracing (Osman et al., 2016).

Finally, our results also suggest new directions for future interventions. First, as low parental literacy posed challenges within some households, future work may explore the integration of literacy initiatives into family strengthening and mental health interventions for refugees. Though English instruction was beyond the intended scope of FSI-R, many participants suggested that they would benefit from its inclusion. Without addressing the language and literacy gaps among refugee caregivers, interventions to address family functioning may face limited success, as they will not move the needle on barriers in the socio-political environment (Figure 1). Second, Bhutanese children's desire for the intervention to move beyond the family and into the community to include children and adolescents their own ages is developmentally appropriate and offers exciting ideas for future iterations (Werner & Smith, 1982).

Study limitations must be acknowledged. Only half of the intervention families were sampled to complete exit interviews, thus the results presented here are from a small sample. Given the negative political context regarding refugees and migration that dominated at the time of this study, not every participant felt comfortable participating in an interview that included an audio-recording. Some families feared that participating in research about receiving an intervention might raise their risk of deportation despite having official refugee status. In fact, all Somali Bantu participants refused audio-recording. Though the interviewer endeavored to capture verbatim responses in written notes, it is possible that data taken from the detailed field notes lacks the complexity and nuance of an audio recording. An additional limitation is social desirability bias, particularly among participants from the Bhutanese community. It is possible that some participants' lack of suggestions for the intervention or consistent high praise was due in part to Bhutanese cultural expectations of politeness and gratitude. Though speculative, another possible limitation was having only male interventionists; some may have responded differently to the intervention as a whole with female interventionists.

Further, we found additional capacity building of RAs was necessary. Though the first few audio-recorded interviews were monitored for quality by our Nepali-speaking author, subsequent interviews were found to contain several leading questions and poor use of probing. Though any responses given to leading questions were excluded from the analysis, it is important to acknowledge that care and training were needed to ensure that both negative and positive feedback on the FSI-R experience was collected. Lastly, though these findings may be relevant within the immediate Somali Bantu and Bhutanese communities in which they were conducted, they are not generalizable to these communities at large, in other regions, or to other refugee groups' experiences. These findings may also not be generalizable to refugee families facing acute crises relating to recent death, severe illness, intimate partner violence, or divorce, as these were exclusion criteria. Further adaptation may be necessary to make FSI-R acceptable and feasible for families experiencing such crises.

## Conclusions

This work offers a uniquely nuanced account of the experiences of families receiving an intervention developed in close partnership with the Somali Bantu and Bhutanese refugee communities in the New England region of the United States. This work points to several mechanisms by which such an intervention may operate to promote improved family functioning and child mental health and points to new directions for improving and expanding such preventive interventions. Our findings suggest that successful implementation of refugee interventions hinges on culturally grounding the intervention design process, drawing heavily on community input, and prioritizing community members as interventionists.

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## Note

1. Symptoms and problems were generated in both communities' native languages through Free List Exercises and Key Informant Interviews. Terms given by the Somali Bantu community are in Maay Maay, and terms given by the Bhutanese community are in Nepali.

## Supplemental material

Supplemental material for this article is available online.

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