Assessing the Feasibility of Implementing a Parenting Intervention with Karen Refugees

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Dedication

This dissertation is dedicated to:

My mom, who taught me not to be afraid,

My dad, who taught me to face the world at its worst.

The women at Center for Change, who taught me to see the strengths in stories of trauma.

Abstract

Parents and children exposed to war and relocation have high rates of negative relational and mental health outcomes. This dissertation tested the feasibility of implementing an adapted evidence-based parenting intervention for contexts of traumatic and relocation stress. In the first phase of the feasibility study, I conducted three focus groups with Karen caregivers (*N* = 12, 5, and 12) to assess parenting practices in the Karen refugee community. Key themes identified related to mothers' physical care for their children, parenting difficulties after relocation to the U.S., and practices of discipline, direction-giving, and encouragement. In the second phase, I adapted the evidence-based intervention and assessed its feasibility. Two groups comprised of eleven female Karen refugee caregivers participated in the intervention. Participants and a focal child completed structured assessments at baseline and follow-up as well as an ethnographic interview at follow-up. Caregivers reported changes in their teaching, directions, emotional regulation, discipline, and in child compliance. Children reported changes in teaching, directions, discipline, their own compliance, and in positive parent involvement. Caregivers reported higher mental health distress immediately after the intervention, potentially due to increased awareness. Children reported a decrease in mental health symptoms.

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More than 60 million people worldwide have been forcibly displaced (United Nations High Commissioner for Refugees; UNHCR, 2016). This represents nearly one percent of the world's population. In the past decade, Minnesota has become home to more than 20,000 of these displaced persons (MN Human Services, 2017). These refugee families in our community face significant challenges. Refugee parents and children both experience high rates of anxiety, depression, and post-traumatic stress disorder (PTSD) due to past conflict exposure and related traumatic stressors (Schick, Morina, Klaghofer, Schnyder, & Müller, 2013). Resettled families also face culture shock and limited resources available in their language or cultural framework (Lewig, Arney, & Salverson, 2009).

Parenting is one area where Minnesota-resettled families have asked for culturally responsive support. Parents are often motivated to resettle by their dreams for their children, and yet after resettlement they must learn how to navigate new rules about discipline, new school systems, and children's development of different cultural values (Lewig, Arney, & Salverson, 2009). Parenting in this context is quite difficult. Parents are frequently further strained by mental health challenges following traumatic and resettlement stress exposure (Schick et al., 2013). When parents can provide effective parenting, it can promote resilience in both children and parents (Gewirtz, Forgatch, & Wieling, 2008; Patterson, Forgatch, DeGarmo, 2010). In this dissertation, I present the process of adapting a parenting intervention for Karen refugees, a post-conflict resettled community in an urban setting in the Midwest of the U.S., and test the feasibility of its implementation with female caregivers.

Theoretical Framework

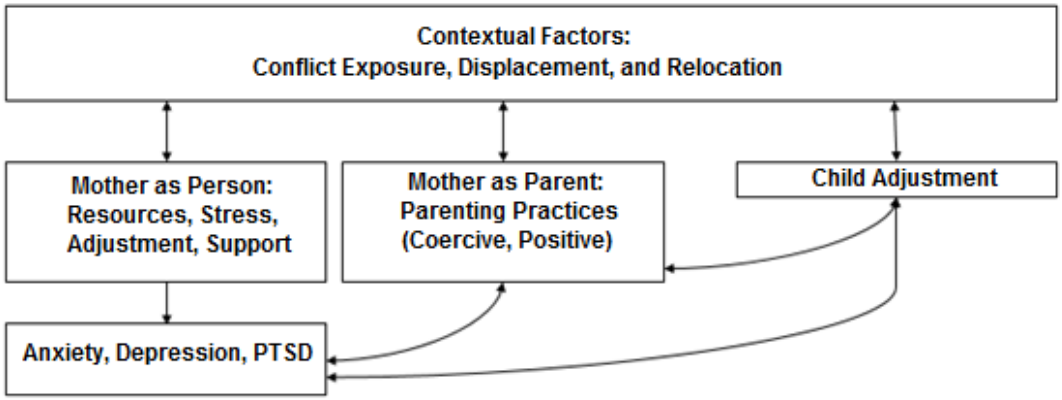
My program of research is guided by the intersection of the critical and feminist postmodern perspectives (Chase, 2011), human ecology (HE) framework (Bronfenbrenner, 1979), and social interaction learning (SIL) theory (Forgatch & DeGarmo, 2002). Postmodernism is a philosophical movement that asserts that knowledge is constructed within social, historical, and political contexts (Chase, 2011). Critical and feminist research more specifically assume that our interactions with our environments are mediated by power relationships, which are both socially and historically constructed (Chase, 2011; Kincheloe, McLaren, & Steinberg, 2011; Olesen, 2011). Researchers who operate from a feminist perspective are committed to challenging constructed social divisions, and to acknowledging how structural mechanisms produce inequalities (Chase, 2011; Olesen, 2011). Critical and feminist research aims to benefit research participants, and devotes resources only to those projects that will provide a specific benefit to the community. Critical and feminist ethnographers specifically seek to address unfairness within a lived domain (Madison, 2012). In my research, I challenge socially constructed divisions and structural inequalities and aim to amplify marginalized voices.

The HE framework assumes that families interact with multiple environments, and that families and their environments mutually influence each other (Bronfenbrenner, 1979). There are five levels of environments. Each impacts a family experiencing traumatic and resettlement stress, and the family can impact each. The chronosystem relates to the timing of events and sociohistorical circumstances, such as the length of

time since displacement. The macrosystem includes social, historical, and political contexts such as discrimination or policies that prevent family reunification. The microsystem includes the groups with which an individual regularly interactions (e.g., a partner providing emotional support or the availability of quality housing in the neighborhood). The mesosystem includes connections between microsystems, such as the relationship between a husband and his mother in law. The exosystem includes social systems outside an individual's immediate context, such as refugee resettlement offices processing an uncle's refugee application. The family could influence each environment in turn.

SIL theory fits within HE theory and more specifically identifies how child behavior is shaped through interactions with parents within a social environment (See Figure 1; Forgatch & DeGarmo, 2002). Stressful environments such as war increase parents' use of coercive parenting and strain the parents personally (Catani et al., 2008). Coercion increases children's problematic behavior and negative outcomes, while positive parenting increases prosocial behavior and reduces negative outcomes (Domenech Rodriguez, Baumann, & Schwartz, 2011).

Figure 1. Social Interaction Learning Theory in Post-Conflict Communities



Note: This original image is adapted from the theory illustrated in Forgatch & DeGarmo, 2002

My clinical research takes an action-oriented approach to promoting social justice. The ultimate goal of targeting this intervention at the micro- and meso- levels is to interrupt the intergenerational transmission of the sequelae of adverse coping and its impacts on parent-child relationships. Community engagement is critical to identifying and addressing needs in these impacted populations. This research emerged in response to a series of local needs assessments with Karen refugees and community professionals indicating a need for greater parenting support.

Researcher Reflexivity

Critical theorists have stated "there is no clear window into the inner life;" each gaze is filtered through individual tints (Denzin & Lincoln, 2011, p. 12). It is important for me to identify the aspects of my background, motivations, and goals that tint my window glass (Cresswell, 2006). I am a White American born to a suburban, middle-class

family. I have never experienced family violence, organized violence, political threat, or even financial instability. I was raised by parents whose language, culture, and goals matched my own. My parents used encouragement extensively and never used physical discipline. I was born into great privilege. With this background, I am at risk of sustaining a savior and a guilt complex. Though I have experienced both of these in my past, I believe and hope that I have since developed a sense of humility and recognition of resilience in others, particularly those who have experienced traumatic stress.

My desire to work with traumatic stress initially grew out of fear. As a child, I watched an episode of *Superman* that referenced sex trafficking in a brief comment. I was paralyzed by the realization that people experienced horrors I could not imagine. From that time forward, I actively avoided thinking about trafficking, war, or organized violence. Acknowledging their existence was physically painful to me. As I grew, I decided that I did not want to be bound by fear. I wanted to try to alleviate the burdens of traumatic stress. I began seeking volunteer and work opportunities with survivors of sexual abuse. I worked in an inpatient hospital for women with eating disorders, most of whom had experienced significant trauma. I became interested in gender issues and how they intersect with trauma exposure, self-confidence, and self-efficacy. I sought more experience specifically with female children and adult women who had experienced trauma.

Early in my professional development, I still avoided thinking about mass trauma. However, the more that I worked with trauma survivors, the more I saw their strength. I stopped feeling a responsibility to save anyone from stress. I began to feel a desire to

work alongside these magnificent women.

It was with this new sense of survivors' strength that I applied for doctoral programs. I hoped to work alongside women who experienced mass trauma and to use my privilege to offer support. I now feel I have two, equally-important responsibilities. First, I have a responsibility to use my great privilege to benefit those with less privilege. Second, I have a responsibility to listen and then respond to marginalized voices. I believe that my work with the Karen has allowed me to further both responsibilities. I made a consistent effort to remain humble and attentive to the wisdom and needs of the Karen community. I hope this has allowed me to serve with the Karen community without overstepping my bounds or causing harm.

Ethnographic Experience of Karen Context

The Karen are a group of ethnic minorities from Burma (also known Myanmar). During the British colonization of Burma, the Karen agitated for an independent Karen state. Western missionaries advocated Karen statehood and offered resources for the Karen to fight the Burmese government if needed. When the British withdrew from Burma, they left no formal provisions for a Karen independent state. A group of Karen took up arms and formed the Karen National Union. The Burmese military government has enacted forced relocations of rural villages and has executed, tortured, and raped Karen people. Nearly half a million people, including both Karen and other minority groups, have fled Burma to relief camps (Internal Displacement Monitoring Centre, 2016). The U.S. has received more refugees from Burma than from any other country. In 2016, more than a quarter of all refugees resettled in the U.S. were from Burma (U.S.

Department of State, 2016).

I have worked with, learned from, and become friends with Karen people over the past two years. I have visited with families in their homes, shopped weekly in Karen groceries, and attended special events such as a birthday party and New Year celebration. I have participated in tasks such as completing citizenship paperwork and requesting interpreters for teacher conferences.

As I have worked with Karen refugees, I have seen the real effects of traumatic and relocation stress. I asked all our parenting group participants, "Have you ever been harmed or threatened by the government, police, military or rebel soldiers, or other?" The most common response that I heard was, "No. The Burmese just shot at us." These families did not expect that "just" being shot at met the criteria of being "harmed or threatened."

These families faced much more immediate resettlement stressors of financial strain and language barriers. In the first Karen home I visited, I caught a glimpse of the inside of a refrigerator. It was nearly completely empty, and a dead mouse laid in the bottom rack. It seems plausible to me that it was set aside as potential food. The families that I have met have been committed to using all available resources to provide for their family's needs. In the past, they needed all available resources to feed themselves and their children. Families were thrilled to have more security for themselves and their children, and they still had little. They had to navigate many language- and cultural-barriers. One of the mothers I talked with described several concerns about one of her children, and then mentioned that it was difficult to manage his behavior because she did

not speak English and her child spoke only a little Karen.

The women I talked with were remarkably dedicated to their children. Though women were not optimistic about the future of their home country, these women were very hopeful about their children's future. One mother went to her child's teacher conferences even though she knew there would be no interpreter and she would not be able to speak with him. I saw some mothers kiss their children and pull them in for hugs. I heard other mothers talk about how they would never die by suicide because their children needed them. Mothers wanted to know how to help their children in this new country. This commitment sparked this feasibility study. In initial needs assessments, Karen community members said they would like support for parenting. Mothers, sisters, and aunts came to presentations about our parenting group, attended sessions, and tried out new parenting practices presented. Fathers helped provide transportation to parenting group. Our cultural informants told us that the role of fathers is different from that of mothers and I had more opportunities to see interactions between female caregivers and their children. Every interaction I saw between male caregivers and children was supportive. I saw male caregivers carrying children, putting on toddler's shoes, and playing games with infants. These Karen caregivers' care for and commitment to their children was obvious in every interaction.

Overview of Research Phases

In this dissertation, I present a feasibility study for an evidence-based parenting intervention adapted to address the strains of resettlement and trauma exposure. This feasibility study was conducted as a collaboration with my faculty advisor and a broader

research team. Our investigative team's program of research aims to develop multi-component systemic interventions to support families impacted by mass traumas, particularly related to war and organized violence. However, I will use first person language throughout the dissertation to reflect my primary contributions and involvement in these two study phases.

I have divided the dissertation into two phases. In the first phase, I present initial steps of community engagement and multi-method assessment of parenting practices among Karen refugees. Prolonged community involvement and multi-method assessment is necessary to assess current community practices and needs, as well as to guide development of effective, culturally-adapted programming (Baumann et al., 2014). I conducted three focus groups (N = 12, 5, and 12) to assess parenting practices and the role of different caregivers in the Karen refugee community. I also collected standardized relational, mental health, and behavioral assessments from Karen caregivers and a focal child (N = 11).

This first phase of research guided development of a culturally adapted parenting intervention. In the second phase, I adapted a parenting intervention for Karen refugees and tested the feasibility of its implementation with 11 female caregivers. Participants and a focal child completed an ethnographic interview. They also completed structured assessments at baseline and follow-up. Each of these phases are presented below.

Phase 1: Parenting Practices in the Karen Refugee Community

More than three million refugees have moved to the United States within the past 40 years, and 50,000 more are expected annually as they flee conflict and violence in

their home countries (Bureau of Peoples and Migration, 2015; Executive Order No. 13769). Refugee families face unique parenting challenges due to both their transition to a new country and trauma exposure in their home country. Parents exposed to traumatic events are more likely to withdraw, have hostile interactions, and abuse children (Bek-Pedersen & Montgomery, 2006; Catani et al., 2008; Van Ee, Kleber, & Mooren, 2012; Walter & Bala, 2004;). Children and adolescents report that incidents of family violence are even more disturbing than war trauma (Catani et al., 2008). Families who resettle after war or conflict face large cultural shifts, which can lead to lack of access to supports and greater parent-child conflict (Lewig, Arney, & Salverson, 2009; Schofield, Parke, Kim, & Coltrane, 2008).

Parenting interventions may be an appropriate method to prevent and to treat refugee family withdrawal and/or conflict. However, to develop effective prevention and intervention programs for refugee parents, clinicians and program developers must learn about refugees' cultural backgrounds, current parenting practices, strengths, and struggles. Programs that are culturally adapted have better rates of utilization and retention, as well as better outcomes (Griner & Smith, 2006; Reese & Vera, 2007).

This paper represents the first stage of a feasibility study for an evidence-based parenting intervention adapted to address the strains of resettlement and trauma exposure (further described in Phase 2). I began the feasibility study with community engagement and multi-method assessment of parenting practices among Karen refugees, a trauma-exposed, recently resettled community. Prolonged community involvement and multi-method assessment is necessary to assess current community practices and needs, as well

as to guide development of effective, culturally-adapted programming (Baumann et al., 2014). The purpose of the current study was to specify the parenting practices of Karen refugees resettled in the U.S. and use that information to further adapt and test a parenting intervention.

Background

This scholarship is guided by human ecology (HE) theory and critical and feminist perspectives. Children and parents interact with multiple environments, and these interactions may be mediated by power relationships. My clinical research is therefore action-oriented to promote a social justice agenda. Community engagement and responsiveness is critical to identifying strengths, needs, and current practices in populations impacted by organized violence. I outline below the background context of Karen refugees in the U.S., parenting after exposure to trauma and relocation stress, and the potential impacts of positive parenting.

Karen Context

The Karen are a refugee community facing the strains of trauma exposure and resettlement. They represent an ethnic minority who have traditionally lived in the hills of Burma (also known as Myanmar) and parts of Thailand. Ethnic conflict in Burma has led to forceful resettlement, torture, and killings of the Karen. Nearly half a million people have fled Burma to relief camps, where they are eligible for resettlement as refugees (Internal Displacement Monitoring Centre, 2016). More than 85,000 Burmese refugees, primarily Karen, have come from Thailand to the U.S. (U.S. Department of State, 2016). In recent years, the U.S. received more refugees from Burma than from any other country

(representing more than a quarter of all refugees resettled in the U.S. in 2016; U.S. Department of State, 2016).

The Karen have been exposed to significant trauma war-related trauma. In a study of 179 recently arrived Karen refugees in Minnesota, 86% had experienced life-threatening war trauma such as destruction of homes, shooting, exposure to dead bodies, or injury by landmines (Shannon, Vinson, Wieling, Cook, & Letts, 2015). Experiences of primary torture (experienced firsthand) and secondary torture (experienced by a family member) were 27.4% and 51.4%, respectively. This is consistent with experiences of Burmese refugees in Australia, where nearly 60% experienced a combat situation and more than a third had experienced being close to death, forced separation from family, and/or murder of family (Schweitzer et al., 2011).

Karen refugees describe physical, emotional, and behavioral distress as a result of this trauma exposure (Shannon, Wieling, McCleary, & Becher, 2014). Research among 500 Karen refugees in Thailand (Cordozo, 2004) and 70 Burmese refugees in Australia (Schweitzer et al., 2011) has shown high rates of psychiatric disorders. More than a third of these refugees2015). For those who resettle, new everyday stressors can strain mental health. Among Karen refugees in Australia, resettlement stressors (such as communication difficulties, difficulties accessing services, and worry over family left behind) contributed to depression, anxiety, and somatization concerns (Schweitzer et al., 2011).

Parenting after Trauma Exposure

Trauma exposure, such as that faced by the Karen, can greatly strain parenting practices. Parents exposed to traumatic stress are more likely to withdraw, to be hostile, and to use harsh discipline methods (Bek-Pedersen & Montgomery, 2006; Kelley et al., 2010; Van Ee, Kleber, & Mooren, 2012; Walter & Bala, 2004). They are also more likely than parents not exposed to traumatic stress to abuse their children (Bek-Pedersen & Montgomery, 2006; Catani et al., 2008; Van Ee, Kleber, & Mooren, 2012; Walter & Bala, 2004).

Exposure to violence can lead to PTSD, which also has significant impact on parenting. Parents with PTSD have greater aggression, indifference, and neglect in their parenting (Stover, Hall, McMahon, & Easton, 2012). They also have lower parenting satisfaction (Samper, Taft, King, & King, 2004) and lower relationship quality with their children (Lauterbach et al., 2007).

Parental PTSD and related poor parenting practices harm children. Children of parents with PTSD have greater trauma distress (Kilic, Kilic, & Aydin, 2011; Polusny et al., 2011), anxiety (Brand et al., 2011), and depression (Harpaz-Rotem, Rosenheck, & Desai, 2009). Children who experience family violence are then more likely to perpetrate family violence as adults; this can lead to intergenerational patterns of poor parenting and poor child adjustment (Capaldi, 2014).

The impact of parental traumatic distress can begin in utero (Brand, Engel, Canfield, & Yehuda, 2006), though it can vary based on children's developmental stage. Refugee mothers with greater posttraumatic stress are less sensitive to their infant children, and their infants are less responsive to the mother (van Ee, Kleber, & Mooren,

2012). Younger children have more acute symptoms of distress when they are separated from their parent or when their parents have intense reactions than do older children (Masten & Narayan, 2012). For example, among families exposed to the Gulf War, mothers' distress predicted children's PTSD symptoms for children aged 3 years old, but not for those who were 4-5 (Wolmer, Laor, Gershon, Mayes, & Cohen, 2000).

Parenting after Resettlement

Refugees also face resettlement stressors, which can have a large impact on parenting. Refugee families must face large cultural shifts after arriving in the new country (Lewig, Arney, & Salverson, 2009). Refugee parents report that their children are more knowledgeable about the host country culture, and that they have greater independence and freedom (Levi, 2014; Lewig, Arney, & Salveron, 2009; Tingvold, Hauff, Allen, & Middelthon, 2012). This is a change from previous norms and may be challenging or frustrating to parents (Levi, 2014). When children are more acculturated than their parents, parents have greater conflict with children and poorer relationship quality than families with similar acculturation levels (Kwak, 2003; Ying & Han, 2007).

Refugee parents commonly report a loss of parental authority (Levi, 2014; Lewig, Arney, & Salveron, 2010). Parents move away from traditional methods of physical punishment to respond to host country laws about child abuse, but they do not have alternative parenting skills to discipline (Lewig, Arney, & Salverson, 2010; Tinvold et al., 2012). Parents often do not fully understand the laws (Lewig, Arney, & Salverson, 2010; Tinvold et al., 2012). Additionally, parents often feel they are parenting alone, while the support of extended family would be a helpful resource (Levi, 2014; Lewig,

Arney, & Salveron, 2010; Tinvold et al., 2012).

Impact of Positive Parenting

Positive parenting (including skill encouragement, limit setting, monitoring, problem solving, and positive involvement) is an effective way to support and protect children exposed to war and resettlement. Children with good parental care have lower rates of negative outcomes after exposure to traumatic events (Gewirtz, Forgatch, & Wieling, 2008). After natural disasters, children had lower PTSD symptoms when their parents used less corporal punishment (Kelley, Self-Brown, Bosson, Hernandez, & Gordon, 2010), and adolescents had lower PTSD and depression symptoms when they had high-quality relationships with their mothers (Wickrama & Kaspar, 2007). Among children who had been exposed to civil war in Sri Lanka, parental care moderated the relationship between conflict exposure and children's internalizing problems (although it did not moderate the relationship with externalizing problems; Sriskandarajah, Neuner, & Catani, 2015).

Positive parenting can also ease the strains of resettlement. Parent-child relationship quality moderates the relationship between cultural shifts and increased family conflict. This suggests that positive parenting practices and relationships can reduce the family strains of transitioning to a new country and culture (Schofield, Parke, Kim, & Coltrane, 2008).

Method

I assessed the current parenting practices in the Karen community through 1) qualitative data from focus groups and 2) quantitative and parent-child observational data

from structured assessments with 11 caregivers and children recruited to participate in a 9-session parenting intervention. Data were collected and analyzed concurrently, to draw from the strengths of each method and to further validate the results (Powell & Single, 1996). Observational parent-child data will be presented in a future manuscript. The use of multiple reporters, child and parent, and multiple data sources, further expand our understanding of relational dynamics in Karen parenting.

The first focus group was conducted as part of the first stages of this feasibility study to understand how parenting practices are experienced within the Karen community. Focus groups are an appropriate methodological choice when current knowledge is limited (Powell & Single, 1996). This approach informs future research, particularly when the research attends to needs and current practices (Krueger & Casey, 2000). Focus groups are also appropriate for work with refugee populations, as they allow for the researcher to have a less controlling position and magnify the voices of those disempowered (Krueger & Casey, 2000; Madison, 2012; Ochocka & Janzen, 2008; Oke, 2008). Two more focus groups were conducted after the parenting intervention started to provide additional insight to findings from the standardized measures collected with intervention parents and as a means of sharing information I learned back to the community.

In addition to these focus groups, I collected self-report data from psychological and relational standardized measures from 11 parents and 11 children in the Karen community. These measures assessed about parenting practices, parent mental health, and child mental health and behavior. These additional data can support the triangulation of

findings in both directions (Powell & Single, 1996).

I integrated two interpreters as full members of the research team in order to collect accurate information cross-culturally. Each of our interpreters were Karen refugees themselves and members of the local community. I reviewed all focus group protocols and structured assessments with the interpreters, training them on core concepts, assessing cultural appropriateness, and facilitating concept-for-concept interpretation.

Sample

Focus group participants were recruited through flyers distributed by familiar community-based organizations and through local community leaders. For the focus groups, inclusion criteria included: 1) be at least 18 years old, and 2) identify as Karen. Participants received a $10 gift card for participation in the focus group. Participants in the first group were recruited for the upcoming parenting intervention; two focus group participants later participated in the intervention.

For the observational measures and standardized assessments, inclusion criteria included: 1) be at least 18 years old, 2) care for a child age 5-13 years old, and 3) identify as Karen. An assessor and interpreter reviewed informed consent document with each parent and child jointly, provided an informed consent document in both Karen and English, and obtained consent from the parent. The assessor and interpreter then met with the focal child alone, reviewed the assent document, and obtained assent from the child. Adult participants received a $20 gift card for participation in the assessments. Children chose a small toy or snack for participation.

A total of 27 people participated in three focus groups (*N* = 12, 5, and 12). In the first focus group, ages ranged from 21 to 24 years old. In the second and third focus groups, ages ranged from 33 to 56 years old. The majority of participants were recent arrivals, and only one participant had been in the U.S. for more than five years. Though both men and women were invited to participate in the focus groups, only one male participant attended. Demographics of participants in the standardized assessments are displayed in Table 1.

Table 1. Participant Demographic Characteristics

Characteristic	Mean (SD)
Caregiver age	33.50 (9.66)
Interviewed child age	10.45 (1.97)
Age at flight to Thailand	1.86 (2.79)
Age at resettlement in U.S.	7.80 (2.57)
Years in U.S.	2.66 (2.21)
Years in refugee camp	10.68 (4.47)
Education (years)	5.91 (4.44)
Biological children	3.91 (2.59)
Other children caring for	1.5 (1.58)
Daily meals	2.32 (0.72)
Income (monthly)	1069.00 (631.14)
Relationship to focal child	
Mother	73%
Sister	18%
Aunt	9%
Gender	33%
Marital Status	
Married	82%
Single	18%
Family resettlement	
Family left behind	45%
Family travelled intact	55%
Refugee Camp	
Mae La Oo	91%

Noh Poe	9%
Employment	
Full-time caregiver	45%
Student, not working	18%
PCA	27%
Unemployed	9%

Measures

Ethnographic research begins with descriptive and exploratory questions (Spradley, 1979). Focus group interviews opened with the grand tour question, "Please share with me how you see the role of parents in your community." Mini tour questions addressed specific parenting practices (e.g., "Please tell us about how encouragement is used in your community?" and "How is discipline used in your community?"). Follow-up questions asked for examples of these practices. In the second and third focus groups, related structural questions were asked to further explore information provided in earlier groups (for example, "are there different types of hitting?" and "are there other jobs of a mother?"). All interviews were translated by Karen interpreters. For the first focus group, interpreters were trained in the focus group interview questions and acted as cultural consultants to review their cultural appropriateness. The translated interviews were then transcribed and I checked the transcriptions for accuracy.

To contextualize this focus group data, I kept a full ethnographic record. Field notes, audio recordings, transcripts, pictures, and news articles were kept in the record, along with any other items that provided a view into the Karen culture. While these materials were not directly analyzed, they provided context to the focus group content. For example, our focus group participants made only one comment about fathers. A

cultural consultant gave context to this focus on female caregivers, stating, “the parenting is very gendered. The raising, the disciplining – the mom does most of that” (for greater detail, see the field note in Appendix A).

All participating caregivers and a focal child completed psychological and relational standardized measures. An assessor and a trained interpreter administered the instruments verbally and recorded the answers, to account for literacy concerns.

Parents completed a demographic questionnaire and a culturally validated Karen Mental Health Screening Instrument, which assesses symptoms of depression, anxiety, PTSD, somatic concerns, and relationship stresses (Shannon, Vinson, Wieling, Cook, & Letts, 2015). Few other psychological or relational standardized measures have been culturally validated in Karen samples. I reviewed selected psychological and relational standardized assessments with a team of four interpreters from the Karen community to assess cultural appropriateness and to ensure effective interpretation. Parents completed each of the assessments described below.

- The Parent Issues Checklist (Robin & Foster, 1989) identifies areas where parents and children have conflict and the intensity of that conflict.
- The Conflict Tactics Scale (Parent/Child; Straus, Hamby, Buncy-McCoy, & Sugarman, 1996) assesses parent discipline strategies used in the lifetime and in the past month, including non-violent discipline, psychological aggression, physical assault, and very severe assault.
- The Drug Taking Habits Survey (Wieling, & Erolin, 2009) assesses alcohol, cigarette, marijuana, and “other” drug use past and present.

- The Strengths and Difficulties Questionnaire (Goodman, Meltzer, & Bailey, 1998) parent-report form assesses emotional, conduct, hyperactivity, and peer problems as well as prosocial behaviors, total impact score, and total difficulties score.

The focal child completed these assessments:

- The UCLA PTSD Index (Steinberg et al., 2013) assesses child PTSD symptoms and traumatic experiences.
- The Child Depression Inventory (Kovacs, 1992) assesses child depression symptoms, and additional questions assess suicidality and self-harm impulses.
- The Youth Issues Checklist (Robin & Foster, 1989) identifies areas where parents and children have conflict and the intensity of that conflict.
- The Parental Bonding Instrument (Parker, Tupling, & Brown, 1979) assesses parental care and overprotection
- The Strengths and Difficulties Questionnaire (Goodman, Meltzer, & Bailey, 1998) is a child-report form assesses emotional, conduct, hyperactivity, and peer problems as well as prosocial behaviors, total impact score, and total difficulties score. This questionnaire is only validated as a self-report tool for children age eleven and older, so it was administered to seven of the eleven children.

Analysis

All focus groups were analyzed using Spradley's Developmental Research

Sequence (DRS; Spradley, 1979). The DRS is appropriate for analysis in this phase of research because it was designed to articulate cultural knowledge shared by a community of participants. The steps of this analysis are detailed below.

Making a domain analysis. After the first focus group, I selected a sample of verbatim interview notes and identified all names of things (e.g., baby, little kid, stick; see Appendix B for an example of domain analysis). I then identified any items that could be cover terms, or categories that include other terms (for example, "kids" is a cover term that includes "baby" and "little kid"). I then reviewed the remainder of the transcript for additional cover terms and included terms. I created a list of cover terms (or categories) and all the included terms that fall into each category.

Asking structural questions. The next step of the DRS is to ask structural questions. I built several structural questions into the initial focus group, such as "Who are the different people who take care of kids?" and "What are things parents want their kids to do?" In subsequent focus groups, I built on past analysis to ask additional structural questions like "What are the jobs of a parent?" and "What are the different reasons for hitting?"

Making a taxonomic analysis. I then reviewed the transcripts thoroughly for relationships between and among terms. Spradley (1979) identifies nine universal relationships, including strict inclusion (a baby is a kind of kid), spatial (Mae La Oo is a place in Thailand), cause and effect (hitting is a cause of children listening), rationale (wanting kids to be good is a reason to hit them), location for action (refugee camps are a place for seeking food), and function (a stick is used to hit). I reviewed the transcript

from the first focus groups to identify and record all strict inclusion relationships, then all spatial relationships, and so on (see Appendix C for a sample of these taxonomic relationships). I used this information to create a preliminary taxonomy of cover terms, included terms, and their relationships (preliminary taxonomy provided in Appendix D).

Asking contrast questions. The next step of the DRS is to ask contrast questions such as "What is the difference between…" Limited time and number of focus groups did not allow for me to ask contrast questions about items in my already identified taxonomy, but several participant comments demonstrated dimensions of contrast without prompting.

At this point in our analysis, I had many domains and relationships. I narrowed the focus to only those forty-five relationships which were described on multiple occasions (either multiple times within the same focus group, or in multiple focus groups).

Make a componential analysis. The componential analysis identifies the essential components within the domain, as well as contrasts and similar attributes between the included terms.

Discovering cultural themes. The themes are the implicit values which undergird the terms and relationships in the domains. Themes generally emerge from extensive ethnographic experience and can be confirmed by member checks. In these three focus groups, I identified two cultural themes (caregivers value children's listening and children's physical well-being) and confirmed them through conversation with cultural consultants.

Making a cultural inventory. The completed cultural inventory generally identifies domains, examples, and cultural themes. My results section describes key domains and taxonomic relationships associated with the two identified themes. I give examples in participant quotes.

Trustworthiness criteria were emphasized throughout research design, data collection, and analysis (Morrow, 2005). I completed the initial analysis of the translated focus group interviews, maintaining an audit trail of all analysis decisions and documenting reflexivity in personal memos. My advisor reviewed all three transcripts and independently coded one. My advisor's coded domains and relationships matched mine. I had identified additional relationships, and my advisor and I discussed these and agreed they should remain part of the taxonomy. Additionally, I maintained prolonged engagement with the community and conducted member checks with two of the original focus groups. I conducted member checks through an interpreter after creating my taxonomic analysis. I reported what I had identified in my taxonomic analysis and asked participants 1) if they agreed and 2) what I was missing. Participants confirmed that my identified taxonomy reflected their culture. All data are presented with contextualized quotes and triangulated with standardized assessment data.

Means and standard deviations are displayed as descriptive data from standardized assessments. There was 4.37% missing data due to item nonresponse and one instance of scale nonresponse. Missing data were handled with listwise deletion. Three subscale scores (hyperactivity, total difficulties, and impact of problems from the Strengths and Difficulties Questionnaire) had more than 35% missing data and were

dropped from analysis.

Results

Two primary cultural themes were identified in the focus groups, including a value on children's physical well-being and on children listening to caregivers. Six taxonomic relationship surround these values. Each is described below, along with participant quotes giving examples and counterexamples (where applicable). The themes identified from the focus groups and the quantitative data from standardized assessments were analyzed simultaneously to triangulate the results. They are reported together here to reflect the integrated analysis and to present a contextualized picture of parenting practices in the Karen community. In Table 2, I list the qualitative data and the quantitative, structured assessments that are presented together.

Table 2. Quantitative and Qualitative Data Presented Together

Qualitative themes	Quantitative data
Mothers physically care for children and grandchildren	(None)
Parenting and child disrespect became difficult after resettlement	Child behavioral health and mental health measures
Disrespect leads to parent frustration and to parents wanting to hit the child	Caregiver mental health measures
Physical discipline is necessary to manage child misbehavior	Conflict Tactics Scale
Some kids like a hard voice, some kids like a soft voice	Parental Behavior Inventory (1 item)
Parents value children listening, and they encourage those children who do	Parental Behavior Inventory

Mothers Physically Care for Children and Grandchildren

One of the primary roles of a mother or grandmother is to care for children's physical needs. Mothers and grandmothers prepare food, water, clothing, and medical care. When participants were living in Burma, this responsibility took considerable time and physical effort. As one mother stated,

Because we were in -- in the village. Which is -- which is like in forest, not really... So we are the one who have to take care the family member who is sick. Like, she was the one -- like the nurse in the house. You have to take care everything. You have to prepare food and like medication and you was like, you are the one who have to care everybody. Direct physical care was nearly always described in connection with a mother or grandmother. Other roles, such as discipline or giving directions, were described as being performed by caregivers more generally.

The strain of this role increased with resettlement to the refugee camps.

Participants described the difficulty of mothers and grandmothers trying to obtain food for their children in the camps. One mother described this difficulty and its emotional impact on her, stating,

> When I was in the camp, that was really, really difficult because the baby or the kids, want to eat snack or food. But then we don't have money. That was really -- they just screaming and they're crying that they want to eat something but then we don't have money to buy food or snack for them. And after that, we just both crying.

The lack of food and money put a great burden on mothers. Participants described that food and water are more readily available in the U.S., but they faced new strains in parenting.

Parenting became Difficult and Child Disrespect grew in the U.S.

Participants were quick to describe how it is more difficult to raise Karen children in the U.S. than it was in Thailand or Burma. As one parent described, "Back in our country, we don't have a, did not have a problem raising our children. Our children listened to us very well and when we came to this country, you know... our children did not want to, do not want to listen to us."

Participants described the disrespect (such as not listening to parents and/or talking back to parents) generally changes with child age, but that disrespect had become more intense across age groups in the U.S. After one parent was asked what was different in the U.S. and in the refugee camps, she responded:

> That was a big difference. Yeah. When they were eight, nine, around there, I said

> to you earlier, when you ask to do something, they gonna listen to you, but when--kids here, eight, nine, ten. (Facilitator: They don't listen to you here.) Yeah. They will never listen to you. When they grow up and they have--they just grow up in this kind of environment.

A few participants described how the changes in disrespect stemmed from access to more rights, opportunities, or freedoms. One participant described how this occurred in her extended family.

> [My] mother in law have a son. When he live in the camp, he does whatever the parents say but then when he comes here, he gets too many freedom and is happen. The father and mother get to fight and then go to the court. Because of the son.

Quantitative data. The means and standard deviations from measures of child behavioral and mental health are presented here, due to their close relation to the theme of increased child disrespect. Descriptive statistics relating to child behavior, including the Strengths and Difficulties Questionnaire, Parent Issues Checklist, and Youth Issues Checklist, are presented in Table 3. Although there are no culturally validated norms for the Karen, all of these scores fall within the average ranges in broad community samples (Goodman, Meltzer, & Bailey, 1998; Robin & Foster, 1989). Past research with refugee populations has found that the emotional subscale was substantially higher in refugee populations generally than in ethnic minority or indigenous White populations (Fazel & Stein, 2003), but this scale score is in the normal range.

Table 3. Structured Assessments at Baseline and Post-Intervention

	Parent report		Child report	
	Baseline	Follow-up	Baseline	Follow-up
Substance Use				
Parent substance use	22%	10%		
Child substance use	0%	0%		
Caregiver Mental Health				
Anxiety	33%	50%		
Depression	22%	63%		
PTSD (full criteria)	0%	38%		
PTSD (partial criteria)	22%	0%		
Child Mental Health Disorders				
Suicidality			0%	0%
PTSD (Full or Part.)			0%	0%
Depression (Full Criteria)			9%	0%
Depression (Part. Criteria)			36%	20%
Caregiver Mental Health				
Anxiety	6.89(3.79)	9.00(5.32)		
Depression	9.33(4.64)	14.63(10.04)		
PTSD	8.22(4.63)	13.88(8.29)		
Somatic	7.50(4.87)	8.44(4.03)		
Child Depression Symptoms			2.00 (1.79)	1.10(1.29)
Parental warmth	6.27 (1.10)	6.60 (1.35)		
Parental warmth	28.64 (4.39)	29.70 (6.11)		
Number of conflict issues	7.89 (1.54)	10.20 (2.78)	8.50 (2.80)	10.20 (2.04)
Intensity of conflict	1.90 (0.43)	1.88 (0.94)	1.55 (0.55)	1.51 (0.64)
Discipline Strategies				
Nonviolent (ever)	1.91 (0.83)	2.50 (0.53)		
Nonviolent (past month)	1.64 (0.81)	2.00 (0.94)		
Psych. aggress (ever)	1.73 (1.10)	1.11 (0.67)		
Psych. aggress (past mon)	0.90 (0.99)	0.78 (0.71)		
Corporal pun (ever)	2.27 (1.19)	2.00 (1.25)		
Corporal pun (past month)	0.55 (0.69)	0.50 (0.71)		
Phys maltreat (ever)	0.00 (0.00)	0.00 (0.00)		
Phys maltreat (past mon)	0.00 (0.00)	0.00 (0.00)		
Conduct problems	1.30 (1.25)	1.10 (0.88)	1.29 (1.50)	0.86 (0.90)
Peer problems	1.78 (1.72)	1.30 (1.64)	1.14 (1.35)	0.86 (0.69)
Prosocial	8.00 (1.85)	7.11 (1.83)	8.29 (2.06)	8.00 (1.63)

Participants did not specifically mention child mental health during any portion of the focus group comments. However, it is likely that child mental health is linked to child compliance and other family interactions. Descriptive statistics related to child mental health are presented in Table 3. The children in this small sample reported no presence of PTSD or suicidality, but a high level of depression (36% met partial criteria for depression, and 9% met full criteria, compared to 2% of children in U.S. community samples meeting full criteria; Son & Kirchner, 2000).

Disrespect leads to Parent Frustration and to Parents Wanting to Hit Children

Participants described a sequence in which children disrespected them (for example, talked back or did not listen to them). When children disrespected their parents or did not listen, parents would then become sad, angry, upset, or frustrated. One parent described how this process was more strenuous in the U.S. than in Burma or Thailand:

> "Being a parent is very difficult in this country, and then we are hurting, like we have sad feelings because of our children sometimes (yeah) because they did not listen to us."

In many cases, these intense feelings then led to wanting to hit the child. As one participant described,

> But for Karen people, if you ask them to sit there, they're going to run like monkeys there. And then if -- if they did several times like, every time. I just want to -- we just frustrated, and we just want to hit them or we just got really upset and mad.

Although it was a common response, not every parent described wanting to hit or

hitting their children in response to disrespect. Two counterexamples included using self-control or prayer as responses to child disrespect. One mother stated, “But my son doesn’t want to talk to me at all, even though I try to invite him. But I’m not going to, like, hurt him for any reason. I can control myself over him.” Another mother described using prayer, stating, “So if you are not listen to me, so I cannot do anything else, but the only thing that I am going to do for you guys is praying for you guys that you will listen.”

Quantitative data. Standardized instruments to assess caregiver mental health provide greater insights into these processes of strong emotions after child disrespect. Caregiver mental disorders are presented in Table 3. In this small sample, caregivers faced depression (n = 2, 22%), PTSD (n = 2, 22% met partial criteria indicating an area of concern, though none met full criteria), and anxiety (n = 3, 33%). These rates are high relative to U.S. community norms (depression affects 6.7% of U.S. adults, while anxiety affects 3.1%; Anxiety and Depression Association of America, 2016). Such disorders are associated with more difficulty to regulating emotions (Dvorak et al., 2014).

Physical Discipline is Necessary to Manage Misbehavior

Participants emphasized that hitting or slapping were the primary effective method to manage child disrespect. In one focus group, the opening comment was, “Karen parents, if their child naughty, they hit them with a stick.” One participant described this as a difference between American and Karen children, stating, “I think American kids, they’re kind of clever. I mean, they don’t naughty - yes, if Karen people, if you don’t hit or slap them, they won’t listen to you.”

The need for physical discipline was difficult to navigate after resettlement, as

participants described that physical discipline is forbidden in the U.S. As one participant described:

> But then when - when we were in the camp or in Thailand or Burma, yes, we have different kind of - different kind of method to discipline our kids. We can like - we can slap them and we can hit them with stick like, totally different from here.

Another described the barriers to using physical discipline in the U.S.:

> And in this country because they have rights, they know that if the parents, you know, going to like hit them or do, going to hurt them for any reason they going to like report it to their teacher, and then . . . That's why they call those things so that's why they don't want to listen to us.

Discipline was different by age, although the exact differences were difficult to pin down. One participant described how physical discipline was adapted by age. "If you hit the baby or the kid too much, that person not gonna listen." Discipline was also adapted for older ages. "Yes, but then when I got here my kids were getting older, like getting age already, so I won't hit them but then if they're naughty, I'm going to do that again."

Participants described how parents needed to tell their children when they are doing something wrong, whether this is a stand-alone statement or accompanies discipline.

> When they do something wrong you have to tell them... if you don't then they will do things wrong like that... No, if they do something wrong, you have to tell them don't do it. If you not then they will keep doing it. For example, her daughter...

> she liked to kick but when she kick, she said don't kick, no kicking, she would stop. So she know then that her kid is being respectful.

Quantitative data. The prevalence of physical discipline strategies was also demonstrated in the structured assessment data. The means and standard deviations of the Conflict Tactics Scale are displayed in Table 3. All of the participants reported explaining why something was wrong "in the past month." The two second most common discipline techniques were "slapping on the hand, arm, or leg" and "calling them dumb or lazy or some other name like that," each reported by nine of the eleven participants for lifetime use. For the two participants who did not endorse slapping on the hand, arm, or leg, both reported using another form of physical discipline such as pinching. Five of the participants reported hitting a child with a hard object. All of these physical discipline approaches were used much less frequently in the past month. Six participants had called a child dumb or lazy in the past month, while only three reported slapping in the past month and none reported hitting with a hard object.

"Some Kids Like a Hard Voice, Some Kids Like a Soft Voice"

In addition to physical discipline, a "hard voice" (also called "strong voice" or yelling) is a parenting approach used by the Karen. One mother described how she used this voice in response to child disrespect.

> My kids are already seventeen - eighteen around already. Teenager already. But then I ask her to wake up, you get to go to school. the first time, use really soft voice but second time, little bit stronger. Most of the time you have to use those kind of type of technique. Most of the Karen women use those kind of voice.

Parents described that this method was necessary with some children, and with other children they could use another approach. One participant said, “Some kids they like, you know, the soft, you know, when we talk to them very soft, they like it. But some of them they don’t... And then we have to discipline them in different way, each child.”

Facilitators demonstrated examples of giving instructions, including both “hard voice” and “soft voice” examples. In response to these examples, participants described the benefits of a soft voice. For example, one participant said, “It felt good... to ask in a soft voice. If it were like, really hard, she not like it. It’s soft and they will feel good and were able to do it.” Another person specifically labelled that this approach was good for young children. “Yeah, you had to say it soft, like nicely... so they will, like, be a good person. Talk softly for the little kids.”

Quantitative data. The quantitative data indicates that these caregivers primarily use a soft or friendly voice. One question of the Parental Bonding Instrument asks, “(My parent) spoke to me in a warm and friendly voice.” In response to this question, six of the 11 children said the statement was “very likely,” and four said it was “moderately likely.” Only one child reported it was “very unlikely.”

Parents Value Children Listening, and They Encourage Children Who Do

The Karen word for “good child” is the same as the word “good listener,” as explained by one of our interpreters. Parents value good listening in their children. When participants were asked about the role of encouragement in Karen parenting, participants described how encouragement was offered when children were listening and doing good things. For example, one participant said, “It depends on the kid, too. If the kid is being

very good, and being a good kid, the compliment part and the love part and the encouragement part and the praise part, will give more to the kid but if the kid is not doing well, that's not going to happen." Another participant said, "So if the kid like does something right... the parent says oh, you did something right, just keep doing... Give compliment to what the kid have done."

One participant gave a counterexample, stating that she gave encouragement when her children had concerning behaviors. She stated that after coming to this country:

> And then sometimes when I see one of my children, like, they not listen to me, I just, like, invite his and her to my room, one by one and talk to, you know, talk to them about how to live their life in this country. And then I encourage them to try their best and then to be a good son and daughter and then to make, you know, me happy. That's why I talk to them and discipline them.

Quantitative data. Though participants reported that parents provide encouragement in only certain situations, the children's standardized assessments indicate that caregivers are frequently performing these behaviors. The mean score on the Parental Behavior Inventory was 28.64 (*SD* = 4.39). This score is slightly above the cut-off of 27 for "high" care. As one example of parent encouragement, five children indicated it was "very likely" that their mother would praise them, and an additional three indicated it was "moderately likely." However, two children reported it was "moderately unlikely" and one reported it was "Very unlikely."

Discussion

The findings of this study highlight the commitment of Karen refugee mothers

and caregivers to their children. Mothers went to great lengths to provide for their children's physical needs in Burma and in the refugee camps in Thailand. Providing food, water, and medical care was a heavy responsibility. My quantitative, structured assessments never addressed physical care, while participants identified this as a key component of the role of a mother. Though I understood the importance of keeping children alive in the context of war, I did not recognize the ongoing salience of this responsibility to Karen mothers. Karen mothers in Burma had greater responsibilities for their children's physical care than most mothers in the U.S. For example, medical care and running water were not available, and so mothers were responsible to collect medicinal supplies and water. In the context of war and refugee camps with limited food supplies, mothers' responsibility to provide food for their children became quite difficult. Karen mothers came to the United States partly to better provide for their children's physical needs. Previous research has indicated that while resettlement centers prioritize the label of "refugee," refugee mothers prioritize their label and role as a mother over any other label (Vervliet, De Mol, Broekaert, & Derluyn, 2013). Similarly, Karen refugee mothers may prioritize their responsibility to provide for their children.

Karen refugee caregivers face many challenges after resettlement. Karen caregivers notice an increase in child disrespect after resettlement and exposure to Western culture. At the same time, however, caregivers' previous physical discipline methods become unacceptable. Refugee caregivers are taught that they must avoid physical discipline in the U.S. The strain from these simultaneous changes is considerable. Caregivers described great emotional distress when children do not comply.

Given the high levels of mental health distress in this refugee community, this strain may be particularly difficult to manage.

Despite these strains, children report high levels of care from their caregivers. Caregivers' values on caring for their children shined in these comments. Caregivers clearly valued their role to care for their children, and were invested in finding strategies that would work to care for their children in a new country.

Limitations and Future Research Directions

In this paper, I present a preliminary investigation of parenting practices in the Karen community. Consequently, the sample size is very small. There is insufficient power to determine if the means derived from the structured assessments are representative of the larger population, although they are useful as triangulation points with the qualitative research. I am currently conducting an additional parenting group and collecting data necessary to document parenting practices quantitatively.

Additionally, there are few culturally validated instruments for the Karen. I reviewed all structured assessments with our interpreters to assess cultural appropriateness and consistent interpretation. However, it may be that these instruments missed key components of parent or child experiences due to inadequate cultural fit, such as mothers' and grandmothers' role providing for children's physical well-being Future research should systematically assess scale cultural fit and psychometric properties with the Karen. Future research should more fully identify the reasons for emotional distress after child noncompliance. Participants did not specifically identify causes, but several of the themes identified here may be related. Noncompliance may evoke 1) painful

reminders of the great cultural shift and changes after resettlement, 2) perceived powerlessness and lack of ways to manage non-response, and/or 3) perceived lack of gratitude for the caregivers' efforts to provide for and protect their children, including the effort to resettle. Future research identifying or confirming the causes of emotional distress after child non-compliance would aid in developing more effective parenting interventions, particularly as this distress commonly leads to a desire to hit the child. Alternatively, future interventions could address resettlement stressors such as acculturation gaps directly. As the increase in non-compliance and related distress parallels the stress of resettlement, addressing resettlement stressors may translate into better parenting and better parent-child relationships.

Clinical Implications

These participants described large changes in parenting difficulty and parenting practices after arriving in the U.S. Mental health providers can take three steps to support Karen families experiencing this transition. First, providers can normalize how resettlement impacts parents and ask clients about parenting changes during their transition. Second, providers can address the strain of mental health disorders and difficulty in emotion regulation following child non-compliance. Psychoeducation and role-plays can enhance use of emotion regulation skills after child non-compliance. Role-plays were warmly received by Karen participants in our parenting group (see Phase II). Finally, Karen parents describe discomfort using traditional physical methods of discipline after arriving in the U.S. Providers can ask if families have gaps in their available discipline methods. Providers can offer suggestions in place of physical

discipline, such as time out or privilege removal.

These findings also point to broader system level recommendations that might be of critical importance for resettling families. These parents reported high levels of mental health concerns and difficulty regulating emotions in their role as parents; these concerns are common as families cope with traumatic and resettlement stress (Schweitzer et al., 2011). Social systems can provide help to support successful adjustment for parents and children. Initial health screenings should also assess for mental health and appropriate referrals should be made (Shannon et al., 2014). Community organizations such as churches and cultural organizations might offer trauma psychoeducation support groups or other mental health supports. School systems can support the transition by motivating parent interactions in children's education and overall development.

Karen refugee caregivers are deeply committed to their children, and have found ways to support their children through transitions across three countries. I drew from this information about parenting practices in the Karen community to develop the first wave of cultural adaptations for a parenting intervention study (see Phase II). As we reflect cultural values and strengths in this and future interventions, we can better bolster resilience for parents, children, and families.

Phase 2: Feasibility of Implementing a Parenting Intervention with Karen Refugees

We are living in one of the greatest humanitarian crises of our time. Hundreds of thousands of refugees have fled conflict and violence to seek refuge in countries such as the United States (BPM, 2015). There are more displaced persons currently than at any other time in history, including after World War II (UNHCR, 2016).

These families face significant challenges. Child survivors of conflict have high anxiety, depression, and post-traumatic micro stress disorder (PTSD) rates, even long after the conflict ends (Schick et al., 2013). Parents who experience traumatic stress are more likely to engage in behaviors that increase child risk, including withdrawing and physically abusing children (Catani et al., 2008; Van Ee, Kleber, & Mooren, 2012). After resettlement in a new country, refugee parents must navigate differences in parenting beliefs, parenting practices, expectations of children, and availability of supports (Lewig, Arney, & Salverson, 2009).

To address the needs of currently resettled refugees and in response to the ongoing influx of refugees worldwide, how can family scholars and mental health professionals promote healthier mental health and family developmental outcomes? One method is to support parents and caregivers. Positive parenting leads to lower rates of negative child outcomes (Gewirtz, Forgatch, & Wieling, 2008). Parenting interventions are an effective way to promote resilience in at-risk children (Patterson, Forgatch, DeGarmo, 2010), such as those in post-conflict or resettlement contexts. To be most effective, such interventions must be adapted for cultural and contextual factors such as past and current exposure to traumatic events and resettlement stress (Griner & Smith,

2006). In this paper, I present the process of adapting a parenting intervention for Karen refugees, a post-conflict resettled community in an urban setting in the Midwest of the United States (U.S.), and test the feasibility of its implementation with female caregivers. This feasibility study is part of a larger program of research conducted by an interdisciplinary workgroup that focuses on developing multi-component systemic interventions for populations exposed to traumatic stress, particularly resulting from war and organized violence. This work represents an early stage in the science of dissemination and implementation targeted at preventing the intergenerational transmission of psychological and relational symptomatology for populations exposed to traumatic and resettlement related stressors.

Background

Our research team's program of scholarship is guided by the intersection of the critical and feminist postmodern perspectives (Chase, 2011), human ecology (HE) framework (Bronfenbrenner, 1979), and social interaction learning (SIL) theory (Forgatch & DeGarmo, 2002). HE positions children, parents, and their interactions within multiple contextual environments. SIL posits that child behavior is shaped through interactions with parents within a social environment (See Figure 1; Forgatch & DeGarmo, 2002). Stressful environments such as war may lead to an increase in parents' use of coercive parenting and also strain the parent personally (Catani et al., 2008). Coercion increases children's problematic behavior and negative outcomes, while positive parenting increases prosocial behavior and reduces negative outcomes (Domenech Rodriguez, Baumann, & Schwartz, 2011).

Our clinical research takes an action-oriented approach to promoting social justice. The ultimate goal of targeting this intervention at the micro- and meso- levels is to interrupt the intergenerational transmission of the sequelae of adverse coping and its impacts on parent-child relationships. Community engagement is critical to identifying and addressing needs in these impacted populations. This study emerged in response to a series of local needs assessments with Karen refugees and community professionals indicating a need for greater parenting support. I outline below the context of Karen refugees in the U.S., the sequalae of traumatic and resettlement stress, and the need for adapted parenting groups to support refugee families.

Karen Refugee Families

The Karen are an ethnic minority from Burma (also referred to as Myanmar) facing the strains of trauma exposure and resettlement. Under the new Burmese government, many have been forcefully displaced, raped, tortured, or killed. More than 450,000 people have fled to neighboring countries such as Thailand (UNHCR, 2016). More than 85,000 refugees, primarily Karen, have come from Thailand to the U.S. (BPM, 2016).

Karen refugees resettled in the U.S. experience significant stress related to past trauma exposure and resettlement stressors. In one study of 179 Karen refugees recently arrived in the U.S., 86% had experienced a life-threatening war trauma and described psychiatric and somatic distress as a result (Shannon, Vinson, Wieling, Cook, & Letts, 2015). Among Karen refugees in Australia, a majority reported moderate or severe communication difficulties and worry over family left behind. These and other

resettlement stressors contribute to depression, anxiety, and somatization (Schweitzer, Brough, Vromans, & Asic-Kobe, 2011).

Impacts of Traumatic and Resettlement Stress on Families

Refugee families face a host of stressors, due to past and ongoing trauma exposure and resettlement concerns (Lewig et al., 2010). These traumatic and resettlement stressors lead to high rates of PTSD, depression, anxiety, somatization concerns, and adverse coping (Schweitzer et al., 2011). Parental traumatic and resettlement stress can cause relational disturbances in the family, such as conflict, withdrawal, and physical abuse (Schofield, Parke, Kim, & Coltrane, 2008; Van Ee, Kleber, & Mooren, 2012), which lead in turn to mental health and behavioral difficulties for children (Catani et al., 2008; Polusny et al., 2011). These strains can be passed on intergenerationally (Gialdi & Bell, 2013). For strained families, prevention and intervention can mitigate these effects (Giladi & Bell, 2013).

Need for Culturally Relevant Parenting Programs for Refugees

Parenting interventions hold promise to promote good outcomes for children, parents, and families facing intense stressors (Gewirtz et al., 2008). For refugee families, interventions should be adapted for both traumatic stress and resettlement. Contextually adapted programs have better utilization rates, retention rates, and outcomes (Griner & Smith, 2006). Parenting interventions that address traumatic and resettlement stress can normalize their impact on parenting and integrate skills to manage their effects. Cultural and contextual adaptations also address several recommendations for parent support

services for refugees, including considering the impact of life stressors and training staff for cultural competency (Schmidt, 2005).

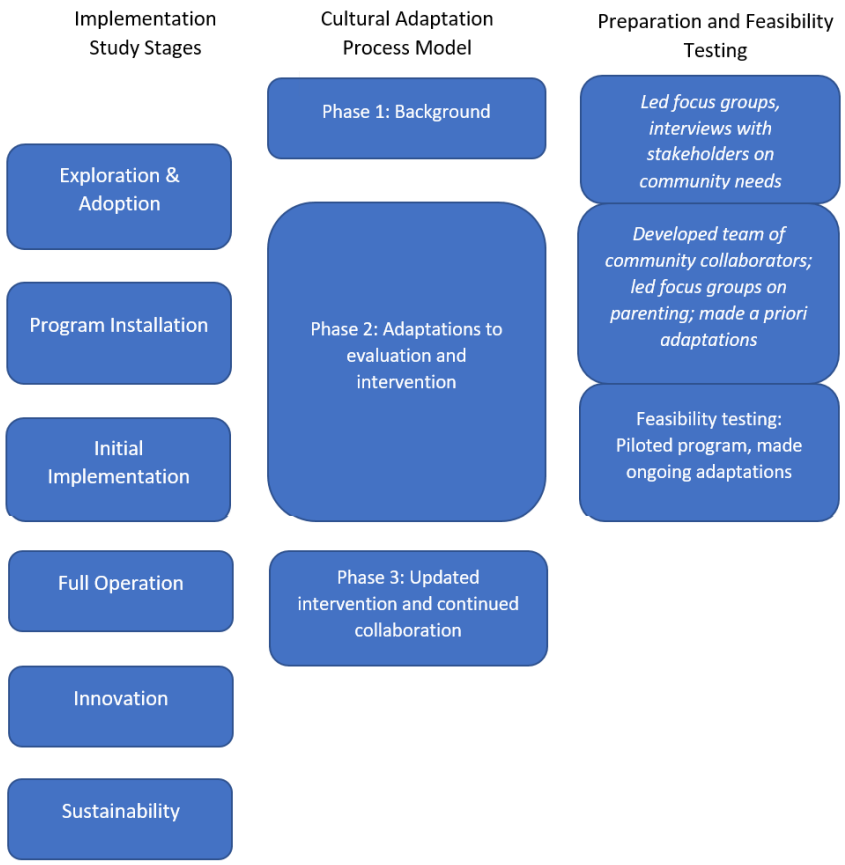
A few research teams have adapted parenting interventions for contexts of trauma, including organized violence in Uganda (Wieling et al., 2015a), violence during deployment (Gewirtz, Pinna, Hanson, & Brockberg, 2014), and historical traumas of American Indian families (Dianne, Davis, Sheeber, & Madrigal, 2009). These interventions have demonstrated improvements in parenting skills and in child behavior (Dianne et al., 2009; Wieling et al., 2015a and 2015b) and have high levels of parent satisfaction and engagement (Dianne et al., 2009; Gewirtz et al., 2014; Wieling et al., 2015a). Similarly, a few developers have adapted parenting interventions for contexts of resettlement (Domenech Rodriguez et al., 2011; Renzaho & Vignjevic, 2011) that have improved parenting skills. To our knowledge, no evidence-based parenting programs have been adapted to address both traumatic stress and resettlement (Weine, 2011).

The Parent Management Training – Oregon Model (PMTO; Patterson, 2005) is an evidence-based parenting intervention that has been adapted for contexts of trauma and deployment (Gewirtz et al., 2014; Wieling et al., 2015a). It has documented efficacy in improving parenting practices and child outcomes in highly stressed families (DeGarmo & Forgatch, 2005; Domenech Rodriguez et al., 2011). It has not previously been systematically implemented with post-conflict communities resettled in the U.S. I begin to address this gap in the current paper.

Initial Stages of Implementation

This second paper represents the initial stages of implementation research, including early adoption, program installation, and initial implementation (Fixsen et al., 2005; see Figure 2). The cultural adaptation process (CAP) model describes in greater detail the steps necessary to develop cultural adaptations during these initial phases of intervention implementation (Baumann et al., 2014; Domenech Rodriguez et al., 2011). CAP includes background, adaptation, and continued collaboration phases and is used alongside the ecological validity model (EVM; Bernal, Benilla, & Bellido, 1995) to detail the adaptations made.

Figure 2. Implementation Study Stages and Phases of the Cultural Adaptation Process Model



Intervention. PMTO is a manualized, evidence-based intervention to help parents manage children's misbehavior (Patterson, 2005). Core principles include encouragement of positive behavior, systematic mild consequences for negative behavior, monitoring, problem-solving, and positive involvement. It is delivered by trained providers. It can be delivered in several formats, including ten weekly 1.5-hour group sessions with home application exercises. I adapted this ten session group PMTO intervention for Karen participants, attending to contexts of resettlement and traumatic stress.

Sessions of the adapted intervention, entitled *Enhancing Family Connection*, addressed Karen family and community legacies and challenges, traumatic stress, and PMTO components of encouragement, positive involvement, emotional regulation, listening skills, and limit setting. This intervention is abbreviated from the PMTO 10 session intervention, due to budget constraints for this initial feasibility testing. My advisor and I saw the scope and session duration as appropriate for the purposes of feasibility testing; a similar scope has been effective in trauma-exposed Uganda (Wieling et al., 2015a).

In order to deliver an evidence-based intervention with fidelity, providers must be trained in the intervention. I facilitated the adapted intervention along with two other associate marriage and family therapists who were also trained by certified PMTO trainers. Two Karen interpreters were trained in how to interpret and help deliver the intervention (further discussed in the "language" adaptations section below). All groups were video-recorded to track for model fidelity and supervised by a PMTO coach. After the intervention, two assessors who were not providers conducted the follow up

assessments.

Adaptations

I made comprehensive adaptations to the PMTO intervention to address cultural background, trauma exposure, and resettlement strain. A priori adaptations were made in two stages. First, the exploration phase of implementation research and the background stage of CAP were completed through focus groups and interviews with stakeholders that identified community needs, intervention interest, and the need for cultural adaptations. Second, during the adoption and adaptation phases I developed a team of collaborators of local health care workers, interpreters, and teachers in the Karen community. I also conducted initial focus groups to assess current parenting practices in PMTO core areas (e.g., positive involvement and limit-setting; for more information, see Phase I). In these focus groups, I also used intervention components such as role-plays and to confirm cultural fit. The role-plays were warmly received, confirming the fit of the intervention processes within the Karen community. The focus groups and ongoing consultation with the community collaborators during the implementation "adoption" and CAPM "early adaptation" phases allowed me to make a priori cultural adaptations.

Cultural Adaptations

During the initial implementation phase, I piloted the program and made ongoing adaptations. The a priori adaptations and initial implementation phase adaptations built on one another. I present these adaptations together. The adaptations are grouped by the EVM categories of language, persons, metaphors, content, concepts, goals, methods, and context (these adaptations are further described in Appendix E).

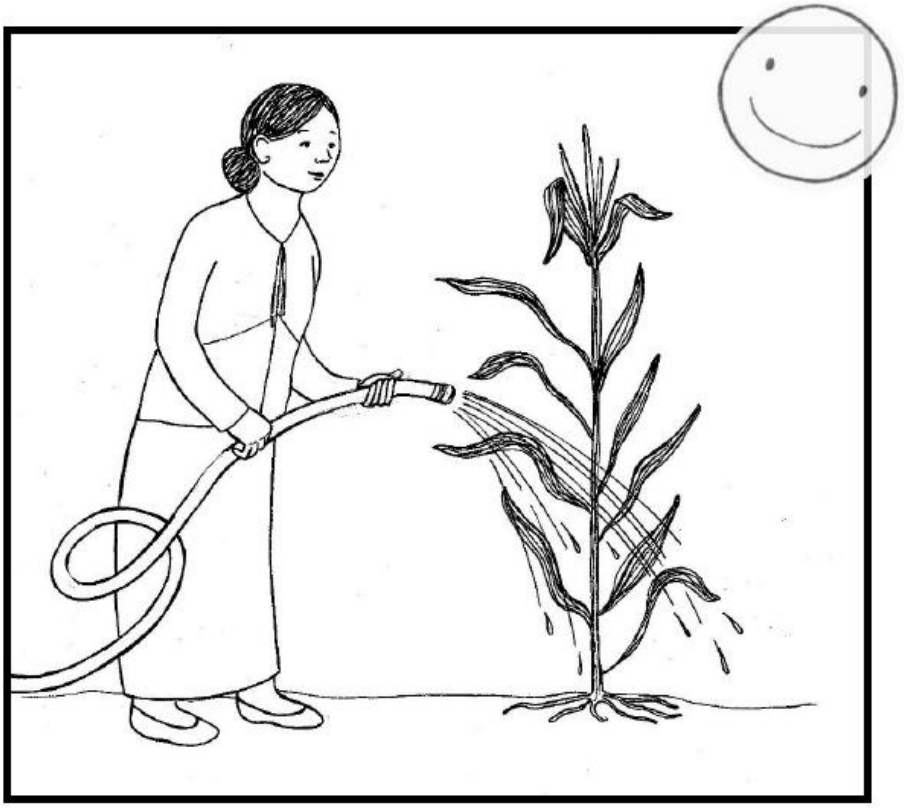
Language. All sessions were provided in Karen through interpreters. The interpreters were trained in content before each session to provide concept-for-concept interpretation. I also developed, alongside collaborators, a visual manual to account for literacy concerns. I, my advisor, and another provider conceptualized images to display all principles and PMTO homework assignments. A local artist created the images. We consulted with cultural leaders and focus group participants to assess cultural appropriateness (see Figure 3 for an example image). Wherever possible, providers used physical cues and visual notes in session to address language and literacy concerns. For example, providers demonstrated waiting for a child to comply or using a soft voice to give a direction. Based on the warm response and ready repetition I saw in the group, it appears these components can be conveyed across language barriers.

Persons. Group providers explicitly identified their points of commonality with the participants (such as shared identities as a parent, caregiver or refugee) and acknowledged their differences. Parents seemed comfortable with the providers, socializing with them before and after groups and engaging in role-plays and group discussions. .Participants showed gratitude at the end of the intervention by giving Karen cultural clothing to the providers as a thank you.

Metaphors/Cultural symbols. I included Karen cultural symbols in the facility, manual, and idioms of treatment. The intervention was delivered in a predominately-Karen school decorated with Karen symbols and language. The manual featured images of Karen families from a local artist. When one cultural informant saw the manual, she said, “It feels so good to see images like this, of the Karen, with Karen clothes. This is the

first time I have seen images like this." Figure 3 shows a sample manual page. Finally, Karen idioms were used in treatment. The Karen idiom, "If you do not water the plant, you will not get the fruit" was used in place of the catchphrase used in the PMTO manual, "Shine a light on what you want to grow."

Figure 3. Visual Manual Image



Content. Providers framed treatment within participants' values. They began treatment by asking about and labelling parent values, including hopes for children, strengths as parents, and the influence of traumatic and stressful experiences in Burma and the shift to the U.S. They used genograms to learn about participants' mental, physical, and relational health legacies. These values were then integrated throughout

treatment, and psychoeducation about mental and relational health was tailored to participants' experiences. Case examples were drawn from group discussions to be responsive to participants' values and traditions. The issue most consistently reported was parental concern over children's iPad use. One mother said, "The reason I came to these groups is to learn how to manage the iPad." Karen parents were unfamiliar with the technology themselves and did not know how to regulate its use for schoolwork versus recreation. Providers therefore used case examples to reflect iPad use. Providers also used respectful customs, such as shaking hands while holding one's elbow with the opposite hand.

Concepts. Participants voluntarily sought participation in the parenting groups, indicating that they agreed with the overarching goal of improving parenting skills. Each of the concepts used in group was framed within cultural values. For example, when discussing limit setting, the providers expressed that the Karen value teaching their children good behavior and respect and that they have traditionally done this through physical discipline. The new method of discipline taught was labelled as another method of teaching good behavior and respect. Providers highlighted that this method could be used without fear of legal reprisal in the U.S. and that can promote closer parent-child relationships.

Goals. To be culturally appropriate, the provider and group participants should agree on the goals of treatment (Bernal, Bonilla, & Bellido, 1995). As one cultural informant explained,

> People may say, 'Oh, yes, this is good information,' but it is hard to keep it. That is the Karen way. Don't give a lot of information, don't tell them 'This is what you should do, this is what will work.' Ask them about what they are dealing with, tell them you understand the kinds of problems with authority, ask what kind of help they want. Give little, simple steps.

Providers began treatment by asking about parents' struggles and goals for their families. They confirmed that the overall goals of PMTO treatment agreed with participants' goals. Providers then framed each session's goals within cultural values. For example, Karen parents highly value children listening to their parents (for more information on this value, see Phase I). The session on encouragement and incentive charts was therefore introduced by saying, "We know that it is important to us as parents that our kids listen to us when we give them directions. Nobody can listen all the time, but we want our kids to listen at least most of the time, Today, we are going to learn a new tool to help our kids listen to us."

Methods. Each of the intervention procedures was chosen for its cultural fit, including recruitment, modality, and schedule. Cultural informants emphasized that the Karen are unlikely to ever call a number on a recruiting flyer, and instead will prefer to work through a person they have met. Recruiting was thereby conducted through personal contacts and invitations to bring friends. The group format was chosen as it is one of the most successful among Karen services in our community. Our cultural informants described how groups are particularly successful when they offer fun

activities, food, and social time, and so these experiences were highlighted in our intervention. Meeting times were chosen to accommodate church and school schedules.

In accordance with the suggestion to "give little, simple steps," as well as with the principles of PMTO, providers taught and then practiced principles in small steps. Providers actively solicited participants' thoughts and opinions. There are Karen norms that make it difficult to talk about oneself. Frequently when participants made comments, they would duck their heads or turn away after making the comment. Participants rarely asked questions about the presented content. Providers incentivized sharing comments by offering a token for each comment, which could be traded in for prizes. When possible, providers approached quieter participants during breaks to talk individually about their thoughts and applications. Additionally, providers voiced questions that participants might have to normalize and address potential concerns. To assure that the teaching modalities were effective, providers conducted role-plays where participants could practice the skills taught in that session. Interpreters were trained in these role-plays in advance, and they worked in smaller groups with participants to provide a more personal point of contact to help participants with any questions or confusion. Interpreters also checked in with participants throughout each session to assess and address comprehension.

One notable adaptation used personal referral for services to address a safety concern. All participants were provided a list of therapeutic services available in the community to the Karen. However, as outlined above, the Karen are unlikely to call a number without a personal contact. One of our participants was reporting high levels of

depression, issues related to violence in the home, and suicidal ideation. To be responsive to her needs, our assessor personally found a provider in the area who could see her, then contacted her to let her know this person was available.

Context. Treatment content was adapted to respond to contexts of traumatic stress, acculturative stress, and low economic resources. Two sessions were dedicated to addressing trauma and its antecedents. In one session, providers offered psychoeducation about posttraumatic stress. In another session, participants drew their genograms and talked about the role of mental health, substance use, physical injury, and abuse in families. Participants recognized these symptoms in themselves and in their community.

Providers addressed resettlement stress by normalizing behaviors and problems that spanned all cultures, and normalizing child behavior shifts following resettlement. Acculturation stress was also addressed in the case examples. For example, when discussing emotional regulation, providers said, “Let’s say that you have just gotten a lot of mail but you aren’t sure what it is and it is still a few days until you meet with your social worker, and the kids just came home with homework they think is too hard…” Such examples normalized and addressed the experience of navigating a new culture and culture clashes within the family.

Treatment was also responsive to the low economic resources of the participants. At each group, providers offered food, transportation reimbursements, and practical incentives. Without the transportation provisions, most participants would have been unable to attend.

Method

Providers led two nine-session culturally-adapted parenting groups with a total of 11 Karen caregivers. Our team collected quantitative data from structured assessments with the 11 caregivers and the focal child pre- and with 10 caregivers and a focal child post- intervention. Our team also conducted ethnographic interviews with 10 of the 11 caregivers and a focal child to assess to assess feasibility and cultural fit. Structured assessments were offered at three-month follow-up, but participation was too low for analysis (n = 2, 18%). Quantitative and qualitative data were analyzed concurrently to further validate the results of the qualitative interviews.

Sample

Participants were recruited through flyers distributed by familiar community-based organizations and through local community leaders, including mental health workers, religious leaders, teachers, and interpreters. Inclusion criteria were: 1) be at least 18 years old, 2) care for a child age 5-13 years old, and 3) identify as Karen. The focal child also needed to assent to participation in the study. No incentives were offered for participation in the parenting intervention sessions. An assessor and interpreter reviewed informed consent document with each parent and child jointly, provided an informed consent document in both Karen and English, and obtained consent from the parent. The assessor and interpreter then met with the focal child alone, reviewed the assent document, and obtained assent from the child. Adult participants received a $20 gift card for participation in the assessments. This amount was chosen in consultation with community collaborators to avoid diminished consent in a low-income community. Children chose a small toy or snack for participation.

However, caregivers received a $20 gift card for participating in an ethnographic interview and parent-child family interaction task before and after the assessment (for a possible total of $40 in gift cards).

Demographic characteristics are presented in Table 1. I use the word "caregiver" rather than the word "parent" due to the nature of refugee resettlement. While many Karen families travel intact, many others must travel at different times or some resettle while others remain in Thailand. In such cases, siblings or aunts may become caregivers for children.

Measures

Psychological and relational standardized measures were administered at baseline, after participation in the intervention, and at three-month follow-up. Parents completed each of the assessments described below.

- Demographic questionnaire
- Karen Mental Health Screening Instrument, a culturally validated instrument which assesses symptoms of depression, anxiety, PTSD, somatic concerns, and relationship stresses (Shannon, Vinson, Wieling, Cook, & Letts, 2015)
- The Parent Issues Checklist (Robin & Foster, 1989) identifies areas where parents and children have conflict and the intensity of that conflict.
- The Conflict Tactics Scale (Parent/Child; Straus, Hamby, Buncy-McCoy, & Sugarman, 1996) assesses parent discipline strategies used in the

lifetime and in the past month, including non-violent discipline, psychological aggression, physical assault, and very severe assault.

- The Drug Taking Habits Survey (Wieling, & Erolin, 2009) assesses alcohol, cigarette, marijuana, and "other" drug use past and present.
- The Strengths and Difficulties Questionnaire (Goodman, Meltzer, & Bailey, 1998) parent-report form assesses emotional, conduct, hyperactivity, and peer problems as well as prosocial behaviors, total impact score, and total difficulties score.

The focal child completed these assessments:

- The UCLA PTSD Index (Steinberg et al., 2013) assesses child PTSD symptoms and traumatic experiences.
- The Child Depression Inventory (Kovacs, 1992) assesses child depression symptoms, and additional questions assess suicidality and self-harm impulses.
- The Youth Issues Checklist (Robin & Foster, 1989) identifies areas where parents and children have conflict and the intensity of that conflict.
- The Parental Bonding Instrument (Parker, Tupling, & Brown, 1979) assesses parental care and overprotection
- The Strengths and Difficulties Questionnaire (Goodman, Meltzer, & Bailey, 1998) child-report form assesses emotional, conduct, hyperactivity, and peer problems as well as prosocial behaviors, total impact score, and total difficulties score. This questionnaire is only

validated as a self-report tool for children age eleven and older, so it was administered to seven of the eleven children.

After the intervention, caregivers and children participated in semi-structured ethnographic interviews to assess feasibility and cultural fit. Caregivers were asked, "Share your overall experience as a caregiver in the group." Follow-up questions asked which skills were helpful and which were challenging. Children were asked "How are things going in your relationship with your (mother/aunt/sister)?" and "Have you noticed any changes?" Similar questions have been used in other feasibility tests of PMTO adaptations (Wieling et al., 2015a). Semi-structured questions allow the participants to address areas most relevant to their experience.

Caregiver engagement was also measured as one indicator of participant satisfaction. Consistent with other PMTO group approaches, caregivers were considered engaged in treatment if they missed no more than two sessions (Domenech Rodriguez, Baumann, & Schwartz, 2011). Nine participants (82%) were engaged, attending at least seven of the nine sessions. The remaining two participants attended six of the nine sessions.

Analysis

Interviews

I analyzed the interviews using deductive content analysis (Elo & Kyngäs, 2008). In deductive content analysis, data are analyzed through an existing conceptual model. Deductive content analysis can expand understanding of theoretical constructs, develop new research questions, or test the fit of a model in a new setting (Elo & Kyngäs, 2008).

In this case, I tested the fit of the SIL model in a new population, Karen refugees.

I identified the whole interview as the primary unit of analysis. I therefore first read through each of the complete transcripts several times to be familiar with the complete data (Elo & Kyngäs, 2008). I read each family's transcripts as a set (caregiver and child) in order to understand the family context. I noted themes that emerged within the families. I then read all of the caregivers' transcripts as a set and all of the children's transcripts as a set. I noted themes that seemed significant within each of these respective groups. My advisor and I met once after this initial immersion to discuss our reflections and emerging themes (Elo & Kyngas, 2008).

The next step of deductive content analysis is to create a categorization matrix, or a table of initial coding categories drawn from the guiding theory (Elo & Kyngäs, 2008). My advisor and I first reviewed the Forgatch and Degarmo (2002) description of SIL theory and the core parenting skills of PMTO. We then met and created a categorization matrix drawn from these concepts (see Appendix F).

All passages were then coded using the categorization matrix (Elo & Kyngäs, 2008). I coded all transcripts, my advisor audited two transcripts, and an external researcher audited an additional transcript. Passages that were classified into the same categories were discussed within the research team to verify that they held the same meaning (Elo & Kyngäs, 2008). There was only one major difference between my advisor's coding and my coding. I had incorrectly coded a comment about hitting a child with a stick as coercive discipline. My advisor and I reviewed the SIL literature and confirmed that coercion must involve a threat. Threatening to hit a child with a stick

would be coded as coercion, but hitting alone is not coercion. I updated our coding manual with this clear description and revised my coding accordingly.

Any passage that was not categorized in our original matrix was discussed together and given a new code. We added two codes to our matrix under the "context" category, including "memory loss" and "challenges with technology." We added two codes under the "Mother as person" category, including "social connection" and "social isolation."

Quantitative Data

Means and standard deviations are displayed as descriptive data from standardized assessments at baseline and post-intervention (see Table 3). Missing data in each wave were handled with listwise deletion. There was 8.33% missing data in these data waves. One participant dropped out in the second wave of data, representing 5.36% missing data (n = 11 at baseline and n = 10 at post-intervention). The other 2.97% missing data reflects item and scale missing data. Any scales where more than 35% of data were missing were excluded from analysis. Three subscale scores (hyperactivity, total difficulties, and impact of problems from the Strengths and Difficulties Questionnaire) had more than 35% missing data and were dropped from analysis.

At three-month follow-up, only two of the 11 caregivers participated. The other participants could not be reached (n = 4), had become too busy (n = 3), moved out of state (n = 1), or were too stressed by the assessments (n = 1). Consequently, no data are presented from this wave.

Data Trustworthiness

Interview protocol and coding were designed to enhance trustworthiness, including credibility, dependability, transferability, and confirmability (Morrow, 2005). Credibility is how well data collection and analysis addressed the intended research focus, including how data are systematically included or excluded (Graneheim & Lundman, 2004). To ensure credibility, interviews were semi-structured to allow participants to focus on the aspects most important to them. Additionally, interviews were conducted with multiple reporters (caregivers and children) to include multiple perspectives.

Dependability refers to consistency and responsive adaptations in data collection and analysis processes (Graneheim & Lundman, 2004). I demonstrated dependability through regular peer debriefing. I consulted with my advisor before creating the categorization matrix to facilitate reflexivity and documented reflexivity in personal memos (see Appendix G; Morrow, 2005). Categories were conceptually grounded in SIL theory (Elo & Kyngas, 2008). I read the manuscripts multiple times. I maintained an audit trail of analysis decisions, and my advisor audited portions of all coding to confirm accuracy (Morrow, 2005).

Transferability is the extent to which findings can be transferred to other groups (Graneheim & Lundman, 2004). I provide a clear description of the culture and context of our sample along with participant characteristics to help the reader assess transferability. It is ultimately "the reader's decision whether or not the findings are transferable to another context" (Graneheim & Lundman, 2004, p. 110). I reviewed our findings with cultural consultants and I am in the process of coordinating standardized assessments and

interviews with a second group of Karen refugee caregivers to assess consistency of these themes. Finally, confirmability is supporting statements with examples. I provide quotations to illustrate all themes.

Results

Following the intervention, qualitative interviews and structured measures assessed changes in mental health, relational health, and parenting practices. In the qualitative interviews, caregivers and children described changes in parenting practices and also identified contextual stressors that influenced parenting. The parenting practices are presented below in order of how frequently they were discussed. I do not elaborate on all structured assessments here, as I am currently collecting from a third parenting group and will present the data in a future manuscript. However, I highlight three particularly notable changes: an increase in caregiver mental health problems, a decrease in child mental health problems, and an increase in nonviolent discipline.

Parenting Practices

Teaching strategies and incentive charts. All of the ten caregivers interviewed described using incentive charts or a prize system to teach or reinforce behaviors in their children. Five parents described that children were excited about this system. Two examples demonstrate their excitement: “They always ask about the chart and the sticker.”

> It helped my kid too, they do it because, because I put the sticker for them, so they know if they've done a good thing then they will get something as well… (And how can you tell it was helping your kids?) Because the kids look more happy.

Two children described changes in their parents' teaching techniques. One child described the incentive chart, and another child described how his caregiver now gives him more time to learn a new behavior.

Giving directions. Nine of the caregivers described changes in the way they give directions, and one caregiver described it as the most influential component of the group. Within this category caregivers described changes in their use of praise, a soft voice, and patience.

Eight caregivers talked about using praise when their child listened. For example, "So what I learn is from the parenting is whenever I use my kid to do something and if they do, I praise them and, yeah, I did. Yeah. I did what I have learned." Three parents talked about the emotional impact of praise, as demonstrated in this example.

> It's like the happiest moment, when you praise your kid and they feel it and then I feel the same as them after I praise them. Yeah, not only your kids felt happy when you gave them praise but you found that you felt happy too. Yeah. Feel very calm, humble.

Each of the three children also commented that their caregiver smiled or said "thank you" if they obeyed. Most parents noted that encouragement was easy to learn.

Five caregivers described using a soft voice. All described how using a soft voice was linked to children listening more, as this quote demonstrates: "Before I used my loud

voice to my sister, so she doesn't quite listen but now I use my soft voice so she listens more. I treat her differently than before." Children noticed the change in caregivers' voices. Three of the eight children interviewed commented on a soft or calm voice. For example, when asked if there were any differences in how her caregiver talked, a child said, "Yes she'd ask more nicely to do something." The child added, "her voice is like calm" and "She says like please or something."

Four caregivers talked about the need to be patient. Two quotes clearly demonstrate this: "Yes, it's been working. When you give a direction... then you have to wait, like yeah.", and "If you say, like, hard voice, they won't listen to you and if you say soft, they won't listen to you right away... but they will do what you want them to do." This highlights one concern following the group. These two caregivers both described that their children did not listen right away. The intervention is designed to reward quick compliance, but that point was not clear to these parents.

Emotional regulation. Seven caregivers described changes in their ability to control their emotions. When asked about the biggest changes they experienced as a parent, five mothers described controlling their emotions as the biggest change.

> After I in it, I be calm, I calm myself better than before. Before whenever I asked my kid to do something, if he don't do it I get mad, like, right away, but now I can control my feelings.

Caregivers also described how challenging it was to regulate their emotions. Four of the mothers who described emotional regulation as a big change also described how it

was difficult when children did not listen. For example, when one caregiver was asked what things she found hard to do, she responded as follows.

> When you order kids to do something and they don't do it, is that you have to control yourself, is that you show your face angry face, it's that you have to show you happy face and keep smile and keep yourself calm… And the kid will feel good for that.

Child adjustment. Seven of the ten parents noted improvements in their child's compliance. A mother reported:

> It's getting better, the child will listen to you more, like that. Before the parenting group, even I order something they wouldn't do it and after I get the lesson from the parenting group, and then come and teach them and what I have to do to be a parent, like give a direction and what I have to do to get the kid's attention, and the kid will do it, it's getting better.

A sister said, "So before, it's pretty to use my sister to do something, but now if I ask her, she will do it. She did it more often." Three children also reported improvements in their own behavior. When asked if he was acting different, one child said, "Good kid. Good listener."

Three caregivers noted that their children felt good in response to their new parenting practices (as documented in the praise and emotion regulation sections). Two children reported they felt happy when their caregivers used practices such as the incentive chart or soft voice.

Discipline. New discipline techniques were the most challenging skill to implement, yet several parents noted changes in their previous techniques. Four parents described previously using or wanting to use harsh physical punishments, and described a change after participating in the group. As one mother explained, “Previously what I always do to my kids is if they don’t listen, I hit them with a stick. But now that I’m here and I learned things like this, I don’t hit them anymore.” Similarly, one child noticed a change away from yelling. She stated, “Now she talks in a softer voice. Before when she asks me to do something she usually comes up with a soft voice but if I don’t listen, then she will raise her voice, but now she never do it. She don’t do it.” Only one mother reported continuing to use coercive discipline after the group.

Although seven caregivers reported using time-out as a new discipline strategy (another reported using it and then discontinuing it), there were significant difficulties in implementing it. There were two examples of misapplication, including one mother who put a child in time out for an hour and another who used a room that the child enjoyed (rather than a space that the child finds to be boring). Another caregiver was trained in time-outs but discontinued it and reported she did not know how to respond to noncompliance.

Despite these challenges, caregivers were still happier in their discipline methods after the group. This may be because they needed to use discipline less often, as this mother reported:

> The time out is pretty hard for me to use. Yeah. It's hard for me to use as well, to use and to learn… Also, my kids are already old but if I use my soft voice to them, they listen.

It is relevant to note that the parenting group ended shortly after introducing time out and caregivers may not have had the opportunity to troubleshoot and receive adequate support for implementing this new strategy with their children.

Traumatic stress. Participants were highly involved in the session that specifically addressed traumatic stress and its symptoms. Many caregivers shared stories about fleeing the war, losing family members, life in the camps, and current resettlement stressors. However, participants did not elaborate on this topic during the follow-up interview. Of the seven participants who were asked about the traumatic stress information, two responded generally about emotion regulation. It may be that these participants directly linked traumatic stress education with emotional regulation. One caregiver had a response unconnected to the question, and three stated that they did not remember this section. For example, when one participant was asked, "And you also learned, as you talked about, how to control your own emotions better, and how to teach your kids about emotions... and what traumatic stress is... What was it like learning more about emotions?" she responded "It's good but I already forgot."

> One person described what she had learned about traumatic stress. She stated: So, before if I experienced traumatic, I don't really know how to handle it. But after I learned this, it helped me... if I feel depressed or I feel sad, I can just go around,

> just go outside and look around, so I don't keep thinking about what happened to me.

It is noteworthy that even though participants did not elaborate on traumatic stress symptoms during the open interview, they reported higher levels of mental health distress on the standardized measures than at baseline.

Positive parent involvement. While there were almost no comments from the caregivers about changes in their positive parent involvement with their children, four children noticed changes in this area. These children reported that caregivers smiled more, let children help more with shopping, bought more prizes, and helped more around the house together.

Changes in Structured Assessments

Three key changes were noted in the structured assessments (see Table 2). First, caregivers reported an increase in mental health problems. At baseline, none of the caregivers met full criteria for PTSD (although 22% met partial criteria): by follow-up, this increased to 38%. Mental health symptomology and rates of depression and anxiety also increased, though less substantially. Second, children had a decrease in depression decreased from a mean of 2.00 (SD = 1.79) to 1.10 (SD = 1.29). Similarly, children's self-reported emotional problems decreased from 1.71 (SD = 1.38) to 0.71 (SD = 0.95). Finally, caregivers' lifelong use of nonviolent discipline as measured by the conflict tactics scale increased from 1.91 (SD = 0.83) to 2.50 (SD = 0.53).

Contextual Challenges

In addition to the specific mental health and relational domains identified in the interview protocol, caregivers' comments revealed three contextual challenges to implementing new parenting practices.

Challenges with media. Six parents reported challenges relating to their child's media use. This comment demonstrates the struggle':

> The hardest part is playing iPad. I have to, like, play, I tell them to go play outside, to go out, or go out of the house. Right now they don't have school, they watch the phone too much. I just have to beg them to go outside, and be outside.

Other caregivers reported that children are less compliant when using media. Replying to a question about time-outs, a parent said: "It's easy but when he uses iPad it can be hard. (It's harder to use the time out when you're trying to take away iPad) Yeah. But I don't have to wait until I have to take away the iPad. They do it but it takes more time."

Social isolation. Three of the parents reported social isolation when asked if they had shared information about the group with others. For example, one mother reported, "Usually no one comes and visits me or sees me…They're usually busy with work."

Memory. Three participants described significant challenges with memory. As one described,

> It's too much if I listen to the old word (old session) and then come on the new session. The old session I will forget it. It's like, when I go to the session the teacher gave the information on what I had to do when I got back home, like

homework. And then I don't remember. I just remember a few parts, so I have to use them."

Engagement and Satisfaction

Sharing group with friends. Our team asked all mothers whether they had talked with friends or family about the group, and what they had shared with them. Six of the mothers reported that they had told their family and friends what they were learning from the group. Of these, four reported that their friends or family were interested in attending a future group themselves.

Engagement. Nine of the eleven participants attended seven of the nine sessions. The remaining two participants attended six of the nine sessions. This 82% retention rate is at least comparable to PMTO intervention trials with White American Families and Latino/a families (Domenech Rodriguez, Baumann, & Schwartz, 2011; Martinez & Eddy, 2005). Participants also demonstrated engagement in a number of other ways. The younger participants (who had greater literacy) consistently took notes during session, and homework adherence was nearly 100%.

Discussion

This study provides preliminary evidence for the feasibility of implementing an adapted parenting program for Karen refugees. Bowen et al. (2009) suggests that all feasibility studies identify program acceptability, practicality, and implementation; each of these areas are outlined below.

Acceptability

This *Enhancing Family Connections* parenting program, adapted for traumatic and resettlement stress, had high levels of participant engagement and satisfaction. More than 80% of participants attended seven of the nine sessions. A majority of participants reported that they recommended the group to family and friends.

Qualitative interviews with caregivers and children indicated that the group was effective in changing parenting practices. Participants also described changes in their emotion regulation, directions, teaching strategies, and discipline, and they described that these changes led to improved child compliance and parent confidence. Children noticed some of these changes in parenting practices as well as in their own behavior and emotions. Child mental health problems decreased following the intervention, suggesting that parenting practices may have shifted to support better emotional health.

Interestingly, caregivers reported higher rates of mental health and PTSD symptoms after participation in the intervention while children reported lower rates of depression. Past research has found decreases in maternal PTSD and depression after a PMTO intervention, whether consistent over time (from baseline to 12-month follow up; Gewirtz, DeGarmo, & Zamir, 2016; from baseline to 6, 12, 18, and 30 month follow up; Patterson, DeGarmo, & Forgatch, 2004) or delayed (with variation around zero change for the first eighteen months and then a significant decrease at eighteen months; DeGarmo, Patterson, & Forgatch, 2004). However, I am not aware of any research on caregiver distress immediately following the intervention. There are several possible explanations for this increased caregiver PTSD symptomology in this study. It may be that the psychoeducation about mental health increased awareness and decreased stigma,

leading to increased reporting of symptoms. It is also possible that participation in the group led to increased mental health symptoms, rather than awareness. However, this seems unlikely as seven of the ten interviewed participants described better emotion regulation after the intervention. Finally, the increase in symptomology may be due to factors outside of the intervention, such as the shift to an unstructured summer schedule.

It may be that shifts in parenting practices are particularly useful for those caregivers whose symptomology increases. In one study, PMTO benefited mothers who had an increase in depression after the intervention, suggesting the intervention is a buffer against the impact of depression on parenting practices (Sigmarsdottir, DeGarmo, Forgatch, & Gudmundsdottir, 2013). An increase in positive parenting practices and improvements in children's behavior, in turn, are associated with improvements in maternal depression (DeGarmo, Patterson, & Forgatch, 2004). Longitudinal research is needed to assess if these participants had a later reduction in mental health symptoms.

Practicality

It was possible to deliver the intervention with existing resources. Though an ideal program would have trained intervention leaders drawn from the Karen cultural group, this program was successfully implemented with outside trained providers and interpreters who were full partners in the treatment team. There are currently schools, churches, and other locations which are providing culturally appropriate services to the Karen. It is reasonable to be able to deliver the program within these comfortable, culturally-tailored locations.

While the intervention was practical to deliver, further adaptations are needed to the assessment design. Our research team was only able to conduct three-month follow-ups with two individuals. Several participants described that the assessment was too long, and it was difficult to be sufficiently flexible to clients' changing contact information and location. Additionally, the assessment may have assessed trauma symptoms with too little introduction. If an individual has been exposed to trauma but rarely discussed it, then a standardized assessment that runs through a list of trauma-related questions is potentially problematic. For example, providing self-help booklets listing common reactions and coping strategies is not linked to decreased PTSD distress (Breslau, Davis, Andreski, & Peterson, 1991). Future assessments could be discussed with elders and community members for feedback specifically on how to most appropriately assess distress. Assessments could be re-conceptualized to include a more flexible format. Assessments could be conducted as a semi-structured interview rather than a structured list of questions, so that the interviewer could be more responsive to participants.

Implementation

The implementation, or the ability to deliver the program within the defined context, was reasonable and could be further improved. The intervention integrated adaptations to address both traumatic stress and resettlement. It was useful to address both of these contexts simultaneously. An overemphasis on past trauma exposure would ignore the stressors and potential ongoing traumas impacting refugees' lives presently (Kira & Tummala-Narra, 2015). This intervention appropriately responded to resettlement contexts by providing transportation reimbursement, food, visual manual,

and interpretation services. Our providers addressed social isolation through the group format and addressed familial acculturation stresses through case examples. Future interventions could more fully address coping with poverty. For example, parent supports could provide information on how to access low-cost foods, free clinics, clothing exchange programs, and legal counsel.

Including psychoeducation regarding traumatic stress is important to identify and address the impact of trauma on families and to support emotional regulation skills. Experiences of past trauma also exacerbate the impact of post-migration stressors (Li, 2016). This intervention provided psychoeducation and integrated case examples to address the impact of trauma on families. Integrating both resettlement and traumatic stress into a parenting intervention addresses key stressors with negative impacts on families. I must underscore that culturally adapted parenting interventions may be a powerful mechanism to support functioning and parent-child relationships for families affected by traumatic stressors. However, parenting interventions with psychoeducation regarding traumatic stress are not a substitute for specific trauma interventions, such as exposure therapies, for parents who are struggling with PTSD (Gewirtz, DeGarmo, & Zamir, 2016).

Limitations

In this paper I presented a preliminary evaluation of feasibility. Consequently, the sample size was very small. Additionally, our research team was unable to conduct three-month follow-up assessments. A future, expanded study will be necessary to document any lasting benefits of the program. Additionally, there are few instruments that are

culturally validated for the Karen. It may be that the assessments are not accurately assessing the desired mental and relational health components.

There were also several challenges of implementing this initial assessment of feasibility. It was a challenge to have time to adequately cover topics, given the time needed to interpret all comments. Time for role plays and debriefing homework assignments was limited. Our team conducted an abbreviated version of the intervention (nine rather than 14 sessions), due to initial budget constraints for this feasibility study. While it was feasible to deliver this abbreviated intervention, future interventions could consider expanding the length or duration of sessions to include additional content or practice opportunities.

Implications

A broad goal of this research is to produce guidance for future parenting interventions for trauma-exposed, resettled communities. I recommend three adaptations to address the mental health concerns faced by many refugees. First, include a focus on emotion regulation, integrate awareness of traumatic stress, and offer resources for mental health management. Participants valued the emotion regulation section but did not specifically remember the traumatic stress sections of the intervention (or at least did not remember the interpreted phrase “traumatic stress,” which alone would not be necessary to have the desired effect of managing traumatic stress). It may be appropriate to fully integrate traumatic stress psychoeducation and emotional regulation sections. Such an approach would not pressure participants to discuss their own past traumatic experiences, and would normalize symptoms of PTSD and offer opportunities to practice coping skills

relevant to PTSD and to general emotional regulation. One example could be: "Sometimes it is hard for us to control our emotions! Let's practice. For this first example, I am remembering when the Burmese shot at my village. What could I do to manage my emotions now?" Second, interventions should carefully consider how to facilitate participant use of mental health services, such as in-home therapy providers and local community therapy groups. Given the high rates of mental health disorders in these communities, facilitating access to services where appropriate is a key part of supporting the family. For example, group providers could invite mental health providers into the group to provide a point of personal connection. Group providers could learn participants' insurance coverage and options for mental health services, and could advocate for better insurance coverage and mental health service availability. Third, interventions should attend to the full scope of trauma-related barriers. For example, cognitive functioning and memory can be impaired by exposure to trauma and by PTSD (Qureshi et al., 2011). Mid-week reminder calls could help integrate new knowledge.

In addition to these implications specific to mental health, I recommend three adaptations to groups for resettled populations. First, interventions can respond to participants' concerns about media use. This is likely to be a common concern for resettled families as media use becomes possible in new formats and with new frequency. Future groups can anticipate this salient component of acculturation and address appropriate ways to set limits around media usage. Groups can also offer new ways to use media, such as accessing family games and parenting resources. Second, we note that discipline was the most difficult component for participants to integrate. This struggle has

been found in parenting groups in both native, post-conflict settings (Wieling 2015a) and refugee/relocated populations (Lewig et al., 2010). It is likely that baseline cultural ways of disciplining children, conflict exposure, and resettlement stress contribute to difficulties integrating new discipline methods. Future clinical research should assess how to more effectively shift discipline for refugee parents. Additionally, mental health disorders are often accompanied and exacerbated by social isolation (Cacioppo, Hawkley, & Thisted, 2010). Interventions could build social networks by providing food and social time, or by using peer support workers.

Further cross-cultural, translational prevention and intervention research is needed to mitigate the effects of traumatic and relocation stress. Our research team is currently conducting a third parenting intervention with Karen refugees, and we are collecting observational data with parents and children to further assess its effects and needed adaptations. We will engage the community with direct questions about what they think is needed.

These caregivers have surmounted obstacles across three countries to support and nurture their families. Local Karen refugees, including one of our interpreters, are now offering parenting resources to the larger community. As community members, peer supports, and providers support parenting skills and respond to traumatic and relocation stress, they can bolster resilience in refugee parents, children and families.

Integrated Discussion and Implications

The complete feasibility study demonstrates the importance of responding to the multiple relevant contexts in refugee families' lives, including past conflict exposure, resource-poor circumstances, and resettlement stresses. In the first research phase, caregivers reported that providing for their children's physical needs was a key role, particularly given how difficult this was in their home country and in refugee camps. Although providing for their children became easier in some ways with relocation, they faced new resettlement strains. Caregivers did not know how to handle increased child disrespect after relocation, particularly as previous physical discipline methods were unacceptable in the U.S. These caregivers struggled with emotional regulation, which would be expected after exposure to traumatic stress and the sequalae stressors.

This pileup of stressors could strain any family. Each stressor individually past conflict exposure, resource-poor circumstances, and resettlement stresses – appears to have daily impact on many Karen families, and these also interact with other stressors. The second research phase drew from this information to make a series of adaptations to an evidence-based parenting intervention to be responsive to the culture and contexts of Karen families. In addition to thorough adaptations for cultural appropriateness, our research team made adaptations for these contexts impacting Karen families. Our research team adapted the transportation, food provision, and incentives to be responsive to the resource-poor context. We adapted the content, concepts, goals, and context to address strains of traumatic and resettlement stresses. The program was acceptable and

practical to implement with Karen families, with high engagement and reported satisfaction from the Karen caregivers.

The two research phases together provided similar guidelines for clinical work with resettled, post-conflict groups. Parenting interventions for resettled, post-conflict groups should directly address the strains of conflict exposure, resettlement stresses, and resource-poor contexts. Parent supports (including providers, community leaders, peer supports, etc.) should assess, normalize, and provide psychoeducation about each of these strains. Parenting interventions can include case examples and role-plays integrating this contextual information. Two examples may be particularly relevant. First, parent supports should provide psychoeducation about the rules for discipline in this country, normalize the difficulties families face in disciplining after resettlement, and offer suggestions in place of physical discipline, such as time out or privilege removal. Second, parent supports should address the strain of mental health disorders and difficulty in emotion regulation after child non-compliance. Emotional regulation skills can be introduced and practiced in session, as well as providing resources for counseling as appropriate.

Conclusion

This scholarship represents one part of a broader program to develop multi-component systemic interventions for populations exposed to mass traumatic stress. The next stages of my research, alongside the broader research team, will be to ensure sustainability through close collaboration with the Karen community. We will jointly re-conceptualize the assessment process to be more comfortable and culturally appropriate. In collaboration with Karen cultural leaders, we will discuss new methods of delivering

this parenting interventions within the Karen community, such as trained peer support workers. We then plan to implement this adapted parenting intervention as part of a randomized controlled trial to further assess its efficacy, feasibility, and methods of treatment delivery. Randomized controlled trials of locally-situated interventions can sometimes be off-putting to small communities, particularly when friends or neighbors receive an intervention while others are randomized to a wait-list. Our trial will be responsive to community discussion and collaboration on this point. A control group may be drawn from another city, or from participants receiving an alternate intervention schedule (such as a parenting group followed by a social group, with the control group receiving a social group followed by a parenting group). This dissertation project has set the stage for these next research steps, and it has the potential to more widely inform interventions with conflict-exposed resettled families.

Through the course of this research, I have learned three lessons that will guide my future work. First, what I do speaks louder than what I say. One comment from the follow-up interviews stands out to me above all others. The comment came from a woman who reported that she struggled with her memory and did not know how to respond to our questions as instructors. When she was asked about the largest change she noticed after the group, this mother replied: “When I get angry, I remember Jaime smile with her white teeth at the little baby... then I touch and like, be controlled and have a soft voice. If I remember that, I can go over with that, too.” Though I spent countless hours of preparation, psychoeducation, and interactive skill development throughout the parenting intervention, this mother was most touched by the moments she saw me interact with my

newborn baby during our last two sessions. I did not realize just how strongly my personality and my personal interactions could influence others. Who I am is just as important as what interventions I can deliver.

Second, I need to question everything I think I know. I had learned this lesson intellectually in my coursework, and it sank in viscerally during this hands-on work. This lesson is most clearly demonstrated in an example from our assessments. One of our caregiver-child activities was a game where the caregiver instructed the child in how to make a many-colored block tower. During one of our administrations, the interpreter started pointing to each block with a brief explanation. I asked her what she was explaining. She said, “Oh, this woman does not know the words for colors. So I was just telling her.” My first thought was, “But everyone has to know the words for colors. It is something everyone has to know.” When I stopped to think about it, however, I could not think of a single instance where knowing the words for colors is essential. It is something we learn as toddlers in the United States, but it is a cultural phenomenon. I learned that I need to question all of my assumptions to work in another culture.

Finally, I serve with communities by being humble, inquisitive, and responsive. As a White, Anglo-Saxon, protestant, I know that I am at risk of well-intentioned “nice White lady” syndrome. I must actively avoid engaging in colonialist and potentially harmful approaches. I have needed a daily commitment to listening and responding to the Karen community. I asked for feedback in parenting group sessions, in the follow-up interviews, and in regular consultation with community consultants. I attempted to always consider that our intervention might not be useful or appropriate, and to listen for

what other resources or approaches might be more fitting. For example, I learned that there were elders' groups that were highly valued as opportunities to connect and share wisdom. I considered if this resource might be more fitting for addressing parenting concerns. However, I heard from participants and other cultural consultants that it would still be useful to have resources for navigating American rules of discipline and media use which were presently unfamiliar to the elders, and so I moved forward with creating our parenting groups. Only by holding tight to these values of humility, curiosity, and responsiveness can I ethically continue to work in communities of which I am not a member.

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Appendix A.

11/19/15 Content memo (EhTa Zar community contact meeting)
Common problems in families in the Karen community

- There are three big problems:
    - Communication. We talk about when do you get your check, where are you going, when will you come home from there. We don't talk about plans, we don't talk about 'let's spend this much this week, and this much next week.'
    - Abuse. There is a lot of abuse between parents.
    - Discipline. There is a problem with authority, especially when the parents do not speak English. The kids, they know how to call the police and say their parents are hitting them – if you are 6 years old and your parent disciplines you, this is not a good thing, this is not how to keep authority by calling the police. When the kids really flip around, the parents do not know what to do. Parents say, "I hope you go to jail for the rest of your life." That is really a sad thing, when they have raised them for the first 18, 20 years. But they just don't know what to do, at that point.
- These three big problems become little problems, it branches out. So there is abuse between the parents, and then it becomes hard for the parents to seek sources. As there is abuse between the parents, then they start to separate, as they start separate, the kids get into drugs. I do not know for sure, but I mostly see this with teenage boys.

Suggestions for running a parenting group

- People may say, "Oh, yes, this is good information," but it is hard to keep it. That is the Karen way. Don't give a lot of information, don't tell them "This is what you should do, this is what will work." Ask them about what they are dealing with, tell them you understand the kinds of problems with authority, ask what kind of help they want. Give little, simple steps.
- The older generation – they act so old! And it is good to keep old thinking, so it is good thing. I think the younger generation struggles more. The older generation doesn't seem to have as many struggles in the family.
- The parenting is very gendered. The raising, the disciplining – the mom does most of that. So I would encourage dads to be involved – if you have a group, I would encourage the dads and moms to come, not just one. And that would mean you would need childcare! That would help people come. Some moms will come with their babies, and the babies will suck, but they can still get a lot of information.
- The Karen parents, they think from one point to one point. So if their child is struggling with school, they won't think, "What is the best school for my child, how can they do their homework, can we talk to the teacher." They will think, "That is the teacher's job, to help them in school. It is my job as a parent to get them to school." So they need help to connect the points. Again, this is Karen culture. That is just part of our culture. When we were living in the hills, we got enough food for today or tomorrow, and then we would go get more for the next day.

11/19/15 Personal memo:

- This was a whirlwind of information! I knew that she had an hour available to talk with me, and I was trying to be mindful of time. I was able to get through all of my questions, thanked her, and she walked me out. When I looked at my clock after leaving the building – we had only talked for 35 minutes! It felt like longer not because I wasn't enjoying it (I was!), but because there was so much information being shared. She was willing to share information very readily about her thoughts on lots of different aspects of Karen families and Karen culture that could impact our groups.
- When she talked about it being hard to keep information and use it, I found myself questioning her. I want the group to work, so I assumed it must be possible, and I did not want to believe her that people might not use it. I had to remind myself that she is the one who knows her community, and I have to set what I think aside in order to learn. Within a few moments she explained ways that it would be possible for people to use what we taught in the groups, but for a moment I had to remind myself that the community needs and community fit are far more important than whatever I want, and that others know far more than me.
- It makes me sad that after transitioning here, Karen families would struggle with handling their kids' drug use. I know this is not an uncommon problem for refugees, but it's a sad one. I wonder what kind of drug use there is in Thailand/Burma?
- I love the way she conceptualized three issues that branch out into everything else. It makes sense to me!
- I wish I would have asked what the "old ways" are, and I wish I would have asked more about what methods of discipline are used.
- I wonder why partner violence is a prevalent problem. She said it was between both partners, even though parenting roles are very gender stereotyped.
- It feels good to be jumping in. This felt like a wave of information all at once, and that felt good! Now I can start adding to it and sorting through it.

Appendix B. Initial Domain Analysis

1. Select a sample of verbatim interview notes

I used the first half hour of our focus group. I removed the leaders' summary statements and put their questions in parentheses to focus on participant speech.

Role of a parent:

Karen parents, if their child naughty, they hit them with a stick.

Back there. / In Thailand, also here, some. / It just – they yell. Just always yelling. / (So, is that the role of parents? Yes.) / It's a good thing that parents do this to us. Because parents want us to be a good kid, (yeah) so that's why they do to us. (Is there anything else that's part of the role of a parent?) Yeah, you had to say it soft, like nicely... so they will, like, be a good person. Talk softly for the little kids. Be patient with them, when you are playing with them, because they are still kid.

Different people who take care of kids

Mother, grandmother / sister, brother / auntie / (Are there different jobs those people have? What is the job of the grandmother?) / Take care of the baby when their mom is not home and play with the kid. / (Is there anything else?) / Shower, clothing, feed them... / (What about um... brothers and sisters? / Do they have different jobs?) / School, change the diaper when they come school and also clean up their messes. / (The sisters? / The siblings. / Brothers also? / Yeah, brothers.) / (So that was grandmas, that was siblings... what about dads?) / I don't know. /

Go to work and tired, just come home and eat and sleep. / No, like, some dads, they take care of… Dads cook. / If they have time they play with their babies. / Some dads, they cook for the family / Some dads, like, they cook for the whole family when they come back home from work. Different ways that you treat sons and daughters

Same thing / If you buy something for the baby / for a baby girl they do the baby girl stuff, and for a baby boy they play with different stuff like guns, toys, a ball.

2. Look for names of things (that stand out).

Initial list of names: parents, kids, little kids, mother, grandmother, sister, brother, siblings, auntie, babies

Process memo: The initial names I identified were all people. I assume this is because I was primed by reviewing the questions we asked in the focus group. I will now review the text again for additional names that stand out.

Additional names: stick, shower, diaper, clothing, mess

Process memo: Looking for nouns definitely is grounding: it makes me think more about the physical world that this culture is operating in. But as I am particularly interested in the behaviors of parents, it would be good to look for verbs as well.

Verbs: hit, yell, want (to be good kid), say (it soft), talk (soft), be (patient), take care, play, shower, feed, change the diaper, clean (up their messes), eat, sleep, cook, buy

Process memo: Different verbs are used with different figures.

3. Identify possible cover terms and included terms in the sample
Possible Cover terms (used in the plural or used to refer to more than one thing): parents, kids, little kids, siblings, babies

Hypothesized cover terms and included terms (to address in reviewing other interviews:
Are there different kinds of parents? (mother, grandmother)
Are there different kinds of kids? (little kids, babies)
Are there different kinds of siblings?

Process memo: None of the object words were used in the plural. Are there kinds of sticks? Kinds of showers? Kinds of diapers? Kinds of clothing? Kinds of messes?
I cannot yet identify any cover terms among the verbs.

Appendix C. Sample of taxonomic relationships

Included Terms	Semantic Relationship	Cover Term	Semantic Relationship	Form	Sample quote
Baby	Is a kind of	Kid, Child	Strict Inclusion	X (is a kind of) y	Over here they have a program that teach the little kid, like the little baby how to roll and how to stand.
Little kid, little child	Is a kind of	Kid, Child	Strict Inclusion	X (is a kind of) y	
Young kid, younger child	Is a kind of	Kid, Child	Strict Inclusion	X (is a kind of) y	For the really young kid, like, if the young kid ask her for food, she just gonna hit it, yeah, the parent.
Age 8, 9 (Less than 12)	Is a kind of	Kid, Child	Strict Inclusion	X (is a kind of) y	That's her punishment would be, for her, 8 years old girl and boy.
Good kid, good child	Is a kind of	Kid, Child	Strict Inclusion	X (is a kind of) y	Good kid. To be a good child.
Naughty kid	Is a kind of	Kid, Child	Strict Inclusion	X (is a kind of) y	Karen parents, if their child naughty, they hit them with a stick.
Hit	Is a kind of	discipline method	Strict Inclusion	X (is a kind of) y	If you did the right thing you wouldn't get hit but some people, they would still get hit, but some people, they wouldn't get hit when they do good things. They only get hit when they do something wrong.
Buying a prize	Is a kind of	Encouraging	Strict Inclusion	X (is a kind of) y	For her example, she had a sister that to take the permit test... if she passed the parent would give her $100...a prize.

Appendix D. Preliminary Taxonomy

1. Specific roles of a mother
    a. Prepare food
    b. Take care of children
2. Things parents do to children
    a. Discipline
        i. Discipline practices
            1. Yell (loud/mean/strong voice)
            2. Hit
                A. With stick
                B. Hard/Much/Bad
            3. Slap
        ii. Discipline sequences
        Note that “not listening” is “being disrespectful”
            1. Children not listening
                A. Child not doing what parent asked -> loud, Mean voice, strong, screaming, yelling (Soft voice precedes loud voice)
                B. Child not listening -> Parents frustrated, upset
                C. Parents frustrated, upset -> Wanting to hit
            2. Children misbehaving
                A. Child naughty -> Hitting
                B. Parents not telling children they are doing something wrong-> Children doing something wrong
            3. Child doing something right -> Compliments, encouragement
            4. Not hitting or slapping -> not listening
    b. Encouragement
        i. Buy prize
    c. Telling, Asking, saying
        i. Soft/Hard
        ii. Soft/loud
3. Locations for parenting
    a. Refugee Camps
        i. Lacking food
        ii. Difficulty feeding children
        iii. Hitting children
    b. Our/my country
        i. Children listening

- ii. No problems raising children
- c. This country (US)
  - i. Not slapping or hitting
  - ii. Kids not listening
  - iii. Parenting to be difficult
  - iv. Too much freedom

4. Types of kids parents care for
   - a. Demographics
     - i. Age
       - i. Baby
       - ii. Little Kid
       - iii. Young kid
       - iv. Older Kid (under 12)
         1. Help when asked
       - v. Teenager
         1. Do not listen, do not want to help
     - ii. Relationship
       - ii. Grandchildren
   - b. Individual Characteristics
     - i. Good kid
       1. Helps when asked
     - ii. Naughty kid
       1. Not listening
       2. Not wanting to help

Appendix E. EVM Categories

Language. The language of an intervention should be culturally appropriate. The ideal language moves beyond a mechanical translation. Culturally-centered language takes into consideration differences in subcultural groups and uses language that will be familiar and comfortable to the participants.

Persons. This dimension refers to the client-therapist relationship. Bernal and colleagues (2006) recommend discussing and acknowledging ethnic and race matching in the client-therapist dyad. The therapist clarifies client's expectations at the beginning of the process, identifying the limitations of their role.

Metaphors. This refers to the symbols and concepts of the cultural group. Symbols of the client's culture should be incorporated into the treatment facility, to help the client feel comfortable. Including cultural saying or idioms is also a good way of including shared culture in treatment.

Content. Content includes cultural knowledge of the values, customs, and traditions of the ethnic group. Cultural and ethnic uniqueness should be integrated into assessment and treatment planning.

Concepts. These are the constructs of the theoretical model. Two questions must be addressed in this domain: Does the client understand and agree with the definition of the problem and the treatment? Are treatment concepts framed within cultural values?

Goals. The provider and client should agree on the goals of treatment. The goals should be framed within cultural values, customs, and tradition.

Methods. These are the procedures that lead to achieving treatment goals. The procedures should be congruent with client's culture. Cultural compatibility may require inclusion of other family members in treatment, or reframing family problems as clashes between cultural values.

Context. Does the treatment consider the client's social, economic, and political contexts? Bernal and colleagues (2006) specifically consider cultural processes such as acculturative stress, phases of migration, developmental stages, availability of social support, and relationship to country of origin.

Appendix F. Categorization Matrix

Social Interaction Learning Theory Category	**Code**	**Example**
Context	Context	Comments relating to stresses of resettlement or traumatic exposure would be included here.
Mother as person	Emotional regulation	"Could you identify some of biggest changes you experience in yourself after the group? For me control yourself, keep yourself calm, is a big change for me, yeah."
Mother as parent - coercive discipline	Coercive discipline	1) "You empty the trash or I'll spank your butt." 2) "If you don't come here I won't love you anymore." 3) "Stop hitting your sister or you'll be sorry."
Mother as parent - effective parenting practices	Giving Directions/Praise	"Does your caregiver ask you to do things in a different way, like use a different voice or say different words or is it the same, as she always has?) What? She - different. (Like sometimes I could say, (Name) go do the dishes or I could say (Name) go do the dishes please. Or I could say (Name) please do the dishes. In a bunch of different ways. Has she changed a little …) Please. (That she says things.) Yes she says please. (Oh she says please?) Yeah."
	Teaching/Incentive Charts	"Okay. So, you had talked about the chart that they did. Do you...how is it for you to learn the skills on how to use the chart.It's helpful because the chart is showing what he do, what he have to do, step by step...to do a job, what he have to do, to like, sweep the floor. What he have to do. Shows him what to do."
	Discipline/Time Out	"(Okay, when you and your sister are angry with each other. How does she, what does she do?) Let me go outside. (She lets you go outside?) Yeah and if I go outside I just stay 5 minutes. (Okay.) Just stay 5 minutes. (Okay and then you have to come back in?) Mm. (Okay, do you guys talk about it? Does she tell you why she's upset?) No."
	Positive Parent Involvement	"(Like what kind of things are nice things that you do with each other?) Go with my sister in store."
Child Adjustment	Child Adjustment	" So before, it's pretty to use my sister to do something, but now if I ask her, she will do it. She did it more often. So, when you ask her to do things she's more likely to do it? Yeah. Have you noticed any other changes in your sister's behavior? What I can tell is she's getting a little better."

Appendix F. Categorization Matrix (cont.)

Additional Categories added		
Mother as person	Social connection - Mother told others about group	" My friends said that it's good and they want to do the same thing what she's been doing to her sister by using the chart...if they have a chance they would like to go and attend this parenting meeting. So, cool, they saw it and they were interested in using it themselves? Yes they were."
Mother as person	Social Isolation	"Usually no one comes and visits me or sees me."
Context	Challenges - Media	" Like, for when they using Internet, she want to learn the skill that can help her even better. "
Context	Challenges - Hard to remember group material	"I just can't remember because I cannot write so it's really hard for me to remember things that I have learned"

Appendix G. Personal Memo on Coding Interviews

Personal memo: There are a few biases I need to be especially careful of here. A few of the comments I find confusing and I do not understand. My first thought was, "Well, I will just exclude those because they don't make sense." That reaction makes me sad: my primary job here is to try to understand another culture, and so I should be actively attending to the things that don't make sense to me! But it is easier to highlight what seems straightforward. I need to be careful to give extra attention to what I do not understand. These are the comments that are most concerning or confusing to me.

- *11: "Then I have to wait, like, four or five minutes until they do it."*
- *11: I use a time out... She uses the room for the (inaudible) and they have a drum and they would be so happy.*
- *10: Yeah, she, when she orders the kids to do something and the kid don't do it, and they walk away...I remember that we shows the example in the section...they have the kid, and the mom, the kid play with the toys and the mom say, pick up the toys and put it in the box, and the kid doesn't do it and the kid walk away. I remember that example. She said that story.*
- *10: but I ask the son, then she have to say that you're nice and say it in a soft way and be controlled, and then, say, you're nice, you're the good child than the rest child. So if you attempt to order them, once or twice, she will get up and do it.*
- *10: She said that we had to go to the session but me, I don't like to go to school. You didn't like going to the sessions? No, she said she don't like to go to the school. Oh, going to the school.Yeah. She said that when I go to the session, I don't know how to answer the questions and people were talk (disc-) about things. And she didn't know. She just looking like…*
- *8: Yeah, it's hard...he likes to play, like, not going in the room but he did. Then the other thing, if you order him to do, he will do that. But then she puts her in time out for five minutes, it's okay for him, ten minutes, it's okay, but she puts more than that and he cries...and then she calls him to come out. So, you found that different lengths of time for the time out mattered to him? Yeah. Five, ten, 30 minutes is will be okay for him but one hour, two hour, he will cry, he will start crying.*
- *2: Is there anything else you want us to know about your experience in the group? So, one thing is like...you order the kids to do a thing you want them to do. If you keep doing and keep saying and he won't do it, what do you have to do?*
- *1: Because he see the friend they on the phone and the parent told them they kind of scared like their mom going to take the (publish?) away.That was her experience or somebody else's experience? Yes they were hers [inaudible 4:52] he, the kid experienced that, he see the neighborhood friend and then the parent tell them once or twice and three time they not do it and then the parent just grab the publish away and he scared. So you see that other parents are doing it differently? No the kids, they kids see, how other parent are doing. how other parents going to do it, like when the parents order them to do something but if they don't do it then they parent would take the things that they like.*

I absolutely hope to hear that participants' behaviors changed, and that they saw the group as valuable. I am biased towards interpreting responses as describing a positive change. I need to consciously counter this, to give extra attention to the instances where behavior was unchanged or the group was unhelpful or uncomfortable. It helps that we are hoping to run more groups, so I actively need to look for this information to see what changes are needed.