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Developing Preventive Mental Health Interventions for Refugee Families in Resettlement

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Abstract

In refugee resettlement, positive psychosocial outcomes for youth and adults depend to a great extent on their families. Yet refugee families find few empirically based services geared toward them. Preventive mental health interventions that aim to stop, lessen, or delay possible negative individual mental health and behavioral sequelae through improving family and community protective resources in resettled refugee families are needed. This paper describes 8 characteristics that preventive mental health interventions should address to meet the needs of refugee families, including: Feasibility, Acceptability, Culturally Tailored, Multilevel, Time Focused, Prosaicness, Effectiveness, and Adaptability. To address these 8 characteristics in the complex environment of refugee resettlement requires modifying the process of developmental research through incorporating innovative mental health services research strategies, including: resilience framework, community collaboration, mixed methods with focused ethnography, and the comprehensive dynamic trial. A preventive intervention development cycle for refugee families is proposed based on a program of research on refugees and migrants using these services research strategies. Furthering preventive mental health for refugee families also requires new policy directives, multisystemic partnerships, and research training.

Keywords

Refugee family; Prevention; Research

MENTAL DISORDER PREVENTION FORREFUGEE FAMILIES IN U.S. RESETTLEMENT

Since 1980 the United States has admitted more than two million refugees, with as many as 75,000 now coming per year (Office of Refugee Resettlement, 2008). Providing mental health services for newly arrived refugees is a recognized U.S. public health priority (Office of Refugee Resettlement, 2004; Refugee Act of 1980, 1980). However, only a subset of refugee adults and youth who are suffering seek mental health services. In the face of many

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obstacles, including stigma, lack of services, access problems, and cultural barriers, most refugees do not (Weine et al., 2000). Concern over those who are suffering, but not presenting for mental health services, as well as for those who may not be suffering from a psychiatric disorder but may be having individual or family difficulties, has led to the call for building capacities for preventive approaches to refugee mental health (Williams, 1989, 1996).

According to both the WHO and IOM, *mental disorder prevention* aims at "reducing incidence, prevalence, and recurrence of mental disorders, the time spent with symptoms, or the risk condition for a mental illness, preventing or delaying recurrences and also decreasing the impact of illness in the affected person, their families and the society" (World Health Organization, 2004). Through a prevention approach, refugee services may be able to enhance protective resources at a population level so as to stop, lessen, or delay possible negative individual mental health and behavioral sequelae in part through improving family and community protective resources for resettled youth and adults (Amodeo et al., 2004; Westermeyer, Lyfoung, Westermeyer, & Neider, 1992).

Mental disorder prevention among resettled refugees must address the fact that refugee youth and parents are at risk for a range of possible negative mental health outcomes that go along with poverty, discrimination, and other forms of social adversity, including other mental disorders (e.g., depression), substance abuse disorders, negative behavioral outcomes, early pregnancy, and HIV/AIDS risk behaviors (Blake, Ledsky, Goodenow, & O'Donell, 2001; Fenta, Hyman, & Noh, 2004; Hankins, Friedman, Zafar, & Strathdee, 2002; Lustig et al., 2004). Children and adolescents may have behavioral or learning problems, educational disparities, and problems with alcohol, drugs, early pregnancy, HIV risk, delinquency, and radicalization (United States House of Representatives, 2009; Kinzie, 2000; United Nations Population Fund, 1999).

Preventive interventions must be concerned with promoting those family and ecological factors or processes that lower the risk for mental disorders and behavioral problems (Albee, 1996; World Health Organization, 2004). These protective resources within refugee families, their schools, communities, and social environments may be harnessed toward prevention if they can be identified (Barrio, 2000; Bridging Refugee Youth and Human Services, 2007; Tolan, Hanish, McKay, & Dickey, 2002), and are best understood through a culturally specific lens.

Prevention researchers have studied family and school intervention programs and found that effective preventive interventions build upon existing protective resources associated with families and communities (Garmezy, 1971; World Health Organization, 2004). Preventive interventions with families in multiple situations have focused on enhancing the following types of protective processes in families and communities: (1) parental support in families; social support for parents; (2) knowledge, awareness, and skills of parents; (3) communication between youth and parents; (4) links between family members and health or mental health care organizations; (5) links between families and schools or social service providers (Weine, 2009).

A 2009 publication by the Institute of Medicine of the National Academies entitled *Preventing Mental, Emotional, and Behavioral Disorders Among Young People* focused new attention on the promise of and challenges to further scientific progress regarding prevention interventions. No entries cited preventive services for refugee families. This report makes clear what families, practitioners, and policymakers in the refugee service field already know: that preventive approaches for refugee families in resettlement are highly underdeveloped and in need of serious attention.

The Institute of Medicine's Committee Report (O'Connell, Boat, & Warner, 2009) reviewed a large number of preventive interventions that address a myriad of health and mental health problems (e.g. HIV risk prevention) and that have been implemented and evaluated in multiple different sociocultural contexts, domestically and internationally. Some of the cited studies and discussions focused on populations such as racial and ethnic minorities, which present challenges for developing preventive interventions similar to those presented for refugee families. For example, several manuscripts described the Chicago HIV Prevention and Adolescent Mental Health Project that utilized a community collaborative approach to engage impoverished African-American communities in Chicago (Baptiste et al., 2006). Another example is the Zuni Life Skills Development Program described by LaFromboise and Lewis (2008), which used community-based approaches with Native Americans to elicit and incorporate cultural beliefs and practices into a suicide-prevention program.

For the past 20 years, we have been conducting a program of services research concerning refugees and postconflict populations impacted by trauma and migration (Weine, 2008a, 2008b). Our research mission has been to develop, implement, and evaluate psychosocial interventions that are feasible, acceptable, and effective with respect to the complex real-life contexts where migrants and refugees live. This work has involved conducting interventions and intervention-focused studies with several populations in U.S. resettlement including those from Bosnia-Herzegovina, Kosovo, Liberia, Burundi, and Somalia, as well as populations in Bosnia-Herzegovina, Kosovo, Tajikistan, and Russia. We have found that ethnicity, culture, and social context play important roles in interventions and must be attended to in the intervention developmental process. Table 1 summarizes several studies and shows several key cultural constructs that were identified through ethnographic inquiry and the implications for intervention development. This paper draws upon the results of the studies themselves, as well as the challenges of conducting prevention research, and views these in relation to the existing literature on preventive mental health.

The purpose of this paper is to address the following questions: (1) What are the key characteristics of preventive interventions that should be addressed in order to better meet the needs of refugee families? (2) How might these key characteristics be addressed in the complex environments of refugee resettlement through innovative mental health services research strategies? (3) What is a possible preventive intervention developmental cycle using these services research strategies? (4) What other broader changes are needed to make progress in mental disorder prevention for refugee families?

KEY INTERVENTION CHARACTERISTICS OF PREVENTIVE INTERVENTIONS IN REFUGEE RESETTLEMENT

Question one directs attention less to particular intervention aims (e.g., to increase parental knowledge) or intervention activities (e.g., multiple-family group) but rather to the desired key characteristics of any preventive intervention with refugee families, irrespective of its particular target outcomes. Eight key intervention characteristics were identified through the developmental and intervention studies in our prior research (Weine, 2001, 2008a, 2008b, 2009; Weine et al., 2000, 2003, 2005, 2006, 2008; Weine, Ware, & Lezic, 2004; Table 2).

Feasibility

Is the preventive intervention doable? It is necessary to demonstrate whether it is possible to carry out the intervention components, including the intervention evaluation, with refugee families. The feasibility assessment should encompass operational, technical, ethical, legal, and fiscal dimensions of the intervention and address the obstacles that are typical of refugee settings, such as lack of coordination between different service systems and organizations (e.g., resettlement, educational, mental health), insufficient funds for families and for service organizations, issues of trust between families and service organizations and among families, and language differences.

Acceptability

Will families and providers accept the preventive intervention? The intervention must adequately fit with the needs, strengths, traditions, and beliefs of the refugee families, as well as those of the service providers and service organizations that will carry out the intervention. Participation level is perhaps the most important indicator for acceptability given the multiple competing demands (e.g., demanding work hours, school, ESL, childcare) faced by refugee families. Will refugee families be able to come to the intervention sessions? In order to make the intervention acceptable, it is often necessary to take steps to maximize the convenience of the intervention for refugee families, such as holding meetings in a community setting on weekend hours, providing food and childcare for young children, and subsidizing or arranging transportation. A general principle is that even more effort needs to be directed toward engagement activities (getting people to join and keep attending) than to the intervention itself (what you do with those who come). If the aim is for all family members to attend (mothers, fathers, children) then engagement efforts must be explicitly designed to reach out to all family members, especially husbands/fathers, who may be the most inclined not to attend.

Prosaicness

Does the preventive intervention use understandable and compelling language and images? Family members, including adults and youth, females and males, need to be able to comprehend the intervention and find that it speaks to them, both verbally and visually, and to their concerns, needs, strengths, and meanings in clear and convincing ways. Overly professional and technical language, including clinical mental health language, is likely to

deter participation. Special efforts to include family members who are not literate or educated must be made.

Culturally Tailored

Does the preventive intervention fit the particular characteristics of the targeted refugee group's cultural background? Each refugee family group occupies a particular social niche and carries with them cultural values, traditions, beliefs, and practices. Each refugee group is also engaged in processes of social, economic, and cultural transition, which often means that more traditional cultural components compete with more "American" and "modern" cultural elements. In addition, different cultural groups define family in distinct ways, including the roles and expectations ascribed to gender and age, all of which have important implications for preventive intervention design. One of the most challenging culturally embedded issues to address is gender roles, given that many refugee families come from patriarchal cultures with rigid gender/power dynamics in families. Overall, the aim should be to promote greater family flexibility in gender roles, however, whether this or some other focus is the priority needs to be carefully considered.

Multilevel

Does the preventive intervention take into account more than one level of risk and protective process, both in terms of intervention approach and in terms of evaluation? Refugee families are in highly complex situations. They are exposed to multilevel stressors (traumatic, economic, familial, community, work, and school). They are interacting with multiple systems (resettlement agency, schools, clinics, neighborhoods, other families, workplace, state welfare system) that do not necessarily communicate or collaborate effectively with one another. They are at risk of negative outcomes in multiple domains (diagnosis and symptoms, school functioning, behaviors, and family, and social). Risks and protective processes may have their main effect at multiple levels. Although no one preventive intervention can possibly address so many dimensions, and most try to work at the family and individual levels, interventions that do not take into account other dimensions or are possibly limited to addressing or investigating one dimension are likely to be flawed.

Time Focused

Does the preventive intervention take into account time-dependent processes? Refugee families are subject to multiple simultaneous time-dependent processes including individual life cycle, family life cycle, time since exposure to war trauma and loss, time in the United States, time in on entitlements, and the time cycle of U.S. education curriculums. Partly in response to these time-dependent processes, interventions must be time specific both in terms of the timing of intervention impact and the timing of assessment.

Effectiveness

Will the preventive intervention yield measurable positive changes in key outcomes amidst real world conditions? The preventive intervention must make a positive difference in the lives of refugee families and this must be demonstrable with rigorous scientific methods. The gold standard for testing intervention effectiveness in clinical medicine has been the

randomized controlled trial (RCT), and to a degree this is the expectation for preventive intervention trials (O'Connell, Boat, & Warner, 2009). However, before conducting a RCT, one may show empirical evidence from prior trials in other populations, or may conduct a smaller scale feasibility trial. In either case, it is necessary to attend to trial design issues such as sampling, integrity of intervention, reliability of measures being applied cross-culturally, potential biases of interviewers, contamination of nonintervention group by intervention group in a close-knit refugee community, how to specify and accurately measure key indicators of family-level changes, and statistically significant pre- to postchanges.

Adaptability

Is the preventive intervention generalizable and flexible enough to be modified for other possible intervention contexts? No one intervention is going to work for all groups, at all times, in all contexts. But one hopes that if an intervention is effective in one space, it could be carried over to another group, space, and time with appropriate modifications. Thus there is an advantage to creating preventive interventions that are readily modifiable to fit with different circumstances, including modifications specific to time, location, and ethno-cultural group.

USING INNOVATIVEMENTAL HEALTH SERVICES RESEARCH STRATEGIES TODEVELOP PREVENTIVE INTERVENTIONS FOR FAMILIES IN REFUGEE RESETTLEMENT

Research plays an important role in developing preventive interventions for families in refugee resettlement. However, the complexity of resettlement environments poses significant challenges to traditional research approaches of intervention development. This complexity stems from trying to address multiple types of potentially negative outcomes, in multiple culturally distinct refugee groups, across multiple systems that are often not well coordinated, in ways that vary across time, with persons living in or near poverty, in low-resource environments.

Clinical mental health research has been largely framed as an efficacy approach to research, where the effort is to test whether or not a treatment impacts a narrow range of outcomes in a tightly controlled research environment where the variables of daily living are minimized. For example in psychopharmacologic research, the process moves from *lab research* where a substance is produce and then first tested in animals, to *efficacy research* where treatment under highly controlled clinical conditions is investigated, perhaps eventually leading to *effectiveness research*, which evaluates a treatment under real world conditions, and to *dissemination*, which aims to put the treatment into use in different settings (Zatzick & Galea, 2007).

In behavioral therapies research, Rounsaville proposed a stage model for organizing the activities of development and evaluation (Rounsaville & Carroll, 2001). *Stage 1a* is focused on "therapy development" (6 months) and "manual writing" (12 months). *Stage 1b* is focused on pilot testing a final or near-final manual (12–18 months). *Stage 2* is efficacy

testing, which takes place in a RCT. After 24–30 months, the next phase would be the randomized controlled evaluation, which in today's research environment would itself likely require a minimum of 3 years, for a total of 5–6 years.

When the clinical or behavioral therapies approaches are applied to the complex setting of refugee resettlement there are obvious disadvantages. One concern is that these approaches allow for little to no channels for feedback that could respond to evolving changes in the participating refugees or could integrate lessons learned along the way. A second concern is that too much time is passed in attending to the issues of intervention development before a preventive intervention could be of much use to newly resettled groups, especially at the earlier stages of their resettlement.

Therefore, to address the challenges to preventive intervention development for refugee families it would help to draw upon mental health services research approaches that have focused less on efficacy and more on effectiveness. Services research implements and evaluates interventions in real world conditions. It does not seek to reduce or eliminate variability that is inherent in the community or family level context of the population being treated. Services research seeks to build knowledge on "the fundamental questions faced by clinicians in everyday practice: what works for whom, under what circumstances, and why?" (Hohmann & Shear, 2002). Services research is interested in designing and conducting trials in community environments, being more responsive to the familial, social, cultural, and economic dimensions of people's lives, and demonstrating their effectiveness in this context. Services researchers have found some research methods to respond to these challenges and to work in a more reasonable time frame.

To address the specific challenges of complexity in refugee resettlement environments, preventive intervention designers need tools that can be found in services research strategies. These include: (1) a resilience framework; (2) community collaboration; (3) mixed methods including focused ethnographic methods; (4) comprehensive dynamic trial (CDT). Each will be briefly described in relation to addressing the desired key characteristics of preventive intervention development for refugee families.

Resilience Approach

Resilience is defined by Norris (2008) as "a process linking a set of adaptive capacities to a positive trajectory of functioning and adaptation after a disturbance." This term has been applied to psychosocial interventions at individual, family, and community levels. Individually, resilience may be evidenced by the self-belief that an individual can influence events and by a personal sense of confidence (Ripley, 2008). In families, resilience has been conceptualized by FromaWalsh (2006) in terms of specific process in: (1) family belief systems; (2) family organizational patterns; and (3) family communication/problem solving. Norris (2008) reviewed the literature on responses that enhance "community resilience" and framed it in terms of "networked adaptive capacities" in the areas of (1) developing economic resource and reducing inequities and vulnerabilities; (2) engaging everybody in the mitigation process to access social capital; (3) utilizing preexisting organizational and social networks; (4) boosting and protecting naturally occurring social supports; (5) community planning and flexibility.

A resilience approach offers several advantages to addressing the key intervention characteristics of preventive interventions for refugee families. First, acceptability of the preventive intervention will likely be enhanced because the intervention approach makes the explicit assumption that families have resilient properties ("strength," "knowledge," and "skills") as opposed to deficits that need to be remedied. Families who may be reluctant to engage in mental health approaches because of their stigma may not have the same problems with preventive interventions organized around resilience themes. Importantly, a focus on resilience should not be taken to mean that risks, suffering, or disability get discounted; these can coexist and interact with resilience in both predictable and surprising ways. Also, the prosaic characteristics of preventive interventions will be enhanced because the underlying theoretical approach leads to efforts to identify and tap into the ways in which family members typically articulate their resilience properties. In addition, resilience is inherently a multilevel concept, so it lends to intervening at multiple levels.

One central challenge is how exactly to operationalize resilience in ways that facilitate building preventive interventions that are tailored to refugee families in resettlement. One approach to this challenge is to focus on "protective resources": family and ecological characteristics that stop, delay, or diminish mental health and behavioral problems in family members. Before designing a preventive intervention to enhance protective resources for refugees, existing resources must be clearly understood. This means being able to explain: (1) protective factors, that is what causes change; (2) protective mechanisms, that is how change unfolds over time; and (3) outcomes, that is the products of change processes.

One example regarding protective factors from our current research is the preliminary results from the Liberian and Burundian study. Table 3 indicates the protective factors and mechanisms that pertain to educational disparities, including both those that are "within family" and those that are "family to schools, organizations, community, and other families." Interventions can be designed to enhance protective factors, which can ameliorate risks, such as those related to family instability.

Community Collaboration

Community collaborative approaches involve community members, family members, and other key stakeholders in the community as partners in building preventive interventions from conception to dissemination of results (Arcury, 2000; Epstien & Dauber, 1991; Israel, Schulz, Parker, & Becker, 1998; Stevenson & White, 1994). Community collaborative approaches have been described in the literature as community- based participatory research, family collaboration, and community collaboration (McKay & Paikoff, 2007). Community collaborative approaches are valuable in prevention research because they help to address some of the commonly encountered obstacles to implementing prevention programs (e.g., stigma, poverty, and distrust; Baptiste et al., 2006; Madison, McKay, Paikoff, & Bell, 2000). Key collaborative principles include: (1) building on cultural and community strengths (e.g., family values); (2) colearning among all community and research partners; (3) shared decision making; (4) commitment to application of findings with the goal of improving health by taking action, including social change; (5) mutual ownership of the research process and products. Although many studies have mentioned collaborative approaches,

there are no known published studies examining the role of collaborative approaches in adapting efficacious preventive interventions with refugees.

Community collaborative approaches can help to achieve many of the key intervention characteristics of preventive interventions for refugee families mentioned previously. This approach can provide more direct access to information about refugee youth and families directly relevant to the mechanisms and the context of the intervention that would likely otherwise not be accessible, such as the differing experiences of family members to the conditions of resettlement. It also builds relationships with community leaders and service organizations that may be very useful in intervention implementation, evaluation, and dissemination activities.

One example of a community collaborative approach comes from our work with Burundian and Liberian refugee communities as part of the NIMH-funded research study. From some refugee resettlement organizations we heard that “there is no real community,” but we found that is patently untrue. For example, the ethnography led to a better understanding of the incredible importance of churches in providing community support for refugee families. Working together with church leadership and congregations has led to designing family-focused preventive interventions for implementation in churches.

Mixed Methods With Epidemiology and Focused Ethnography

As researchers have confronted the challenge of how to build preventive and clinical interventions under complex social situations with urban families, immigrants, disaster survivors, and refugees, the need for new paradigms of doing research has become apparent. Several different approaches to confronting complexity have been attempted in recent years, applying mixed methods, epidemiologic, and focused ethnographic approaches.

Mixed methods research combines both qualitative and quantitative approaches to data collection and analysis in order to achieve a broader understanding of given phenomena (Tashakkori & Teddlie, 2002; Teddlie & Tashakkori, 2009). Mixed methods approaches have been used in the study of a wide range of health and social issues. There are several different types of mixed methods research: (1) “mixed model research” where quantitative and qualitative approaches are mixed within or across the stages of the research process; (2) “mixed method research” where a qualitative phase and a quantitative phase are included in the overall study (Caracelli, 1993). Greene (2007) described the most important rationales for mixed methods research: triangulation, complementarity, development, initiation, and expansion. In our opinion, mixed methods can help to develop and evaluate preventive interventions with refugee families, especially for the reasons of complementarity (using one method to clarify or illustrate results from another method) and expansion (provides richness and detail to the study exploring specific features of each method).

One example of mixed methods in intervention development concerns our ongoing research with male labor migrants from Tajikistan (Weine, 2008a, 2008b) with whom we conducted a survey in the bazaars and construction sites of Moscow and then a focused ethnography that included their wives in Tajikistan, their regular partners in Moscow, and the sex workers with whom they interacted. From the survey methods, we were able to determine which sites

(e.g., bazaars) were associated with more risky behaviors. But it took ethnography to better understand what was it contextually about those sites that accounted for the risks, providing the granular level of details that would help to design specific preventive interventions to reduce HIV/AIDS risks behavior.

Epidemiology, on the other hand, studies populations, risks, and the frequency and distribution of diseases. This approach has contributed to clinical research intervention development. For example, Zatzick and Galea (2007) have written about the role of epidemiology in contributing to the development of early, trauma-focused interventions, which is an appropriate concern for refugee interventions. Given that trauma mental health outcomes may be due not only to trauma exposure, but to preexisting or comorbid psychiatric or health conditions, there is a role for population based studies to investigate the prevalence of mood, anxiety, or substance abuse comorbidities. This information could lead to the targeting and tailoring of preventive interventions for a subpopulation at greater risk for poor mental health outcomes from traumatization.

Ethnographic research on refugee and immigrant populations has helped bring better understanding of the cultural, social, and psychological processes of migration (Suarez-Orozco & Suarez-Orozco, 2001; Zhou & Bankston, 2001), and improve the cultural relevance of programs (Barrio, 2000), but services up to now have been relatively neglected.

Hohmann and Shear (2002) described a procedure for conducting a “community-based intervention trial” in which ethnography is cast as “a critical first step in designing intervention trials that are successful.” To date, in mental health services research, ethnography has most often been used to critically analyze and develop concepts (Ware, 1999; Ware, Lachicotte, Kirschner, Cortes, & Good, 2000) and to represent the perspectives of relevant constituencies—principally, but not exclusively, those of consumers (Donald, 2001; Koegel, 1992; Robins, 2001). Ethnography in mental health services research has provided new perspectives upon (1) clinical practice and theory; (2) measurement of psychopathology with standardized instruments; and (3) service experiences (Lopez & Guarnaccia, 2000; Ware, 1999).

Other services researchers have focused on the role of ethnography and qualitative methods specifically in intervention development. Wainberg et al. (2007) described the use of “targeted ethnography” to inform cultural adaptation of HIV preventive interventions. Targeted ethnography investigates the multilevel factors that impact a health condition as well as relevant interventions. Targeted ethnographic methods include field observations, focus groups, and key informant interviews. Data are analyzed using a grounded theory approach (Charmaz, 2006) and Atlas/ti computer software (Muhr, 1997).

Schensul described the role of ethnography in formative research for delineating appropriate levels, stakeholders, and collaborators (Schensul, 2009; Schensul & Trickett, 2009). For example, in the RISHTA project in Mumbai (Schensul et al., 2009), ethnography was used in a formative research phase, asking: (1) What cultural norms and beliefs are related to HIV risk that appear at multiple levels and can be used as the basis for intervention? and (2) How can the intervention content, format, and modes of delivery be adapted to be complementary

at each level? Schensul et al. (2009) gathered ethnographic evidence to reframe community, provider, and patient narratives in Mumbai regarding “gupt rog” (secret illness) in relation to HIV/AIDS risk and prevention.

Several aspects of the ethnographic research method are well suited to intervention development with refugees, including the iterative research process, minimally structured interviews, focused field observations, and case study and grounded theory approaches to data analysis. These methods will be briefly described.

Iterative research process—In the iterative process of research, initial study questions and key concepts are refined through initial data collection and preliminary data analysis so as to generate better concepts and questions while data collection is still occurring, thus generating better data. This is important given that until one really gets to know refugee families in their context, one may not even know the right questions to ask.

Minimally structured interviews—These are discussions with family members or other informants begun with a small number of introductory questions. The conversation proceeds in whatever direction allows informants to speak most meaningfully to the research questions and domains from their personal experiences. The interviewer lets the informant be in the “driver’s seat.” Given the different perspectives of family members within refugee families, to achieve a systems understanding it is important to speak to females and males, and children and adults.

Shadowing observations—Shadowing means the ethnographer accompanies informants on their normal daily routines in a variety of sites (such as home, school, community, and services). Shadowing observations allow the ethnographers to directly witness the interactions between protective factors, protective mechanisms, outcomes, risk factors, culture, and service sectors over time. Mechanisms of change rather than static properties are of the greatest interest for understanding refugee families.

Focused field observations—Field observation may be defined as “a prolonged period of intense social interaction between the researcher and the informants, in the milieu of the latter, during which time data, in the form of field notes, are unobtrusively and systematically collected” (Bogdan, 1972, p. 3). Focused field observations target activities likely to shed light on the research questions such as in community or clinical service settings (e.g., a school or a clinic).

Grounded theory method of analysis—This method uses coding, pattern coding, and memoing and the process of constant comparison to build an explanatory model (Charmaz, 2006; Corbin & Strauss, 2008). Such a model is able to characterize important themes as well as to characterize heterogeneity and subgroups. Given that this type of analysis involves large amounts of qualitative data from interview transcripts and fieldnotes, it should entail using a computer software program specifically designed for this purpose such as Atlas/ti (Muhr, 1997). It is also important to utilize rigorous approaches to establish code reliability given that qualitative research is always vulnerable to critique for being overly

biased or mere opinion. Findings should be reviewed by the entire collaborative team to enable checking for contrary evidence.

Case study approach to analysis—A case study is defined as "a unit of human activity embedded in the real world, which can only be studied or understood in context, which exists in the here and now, and that merges with its context so that precise boundaries are difficult to draw" (Gillham, 2000, p. 1). The unit of analysis can be an individual, family, community, or organization.

Mixed methods including epidemiology and targeted ethnography can help to address many of the key intervention characteristics of preventive interventions for refugee families mentioned previously. Epidemiology may help to delineate population- level patterns that can inform key preventive intervention decisions for refugee families. Ethnography produces a detailed and in-depth understanding of culture, context, and processes at family, cultural, and community levels.

COMPREHENSIVE DYNAMIC TRIAL

Given the complexities of adapting interventions for new cultures and contexts, investigators have explored alternatives to the RCT, which is perceived as being too rigid to facilitate intervention adaptation. For example, the RCT is necessarily bound to investigating one or more intervention models that cannot be modified over time in response to lessons learned or to important contextual changes. One alternative specifically conceptualized for community prevention research, called the CDT, is characterized by multiple sources of information and recurring mechanisms for feedback and response (Rapkin & Trickett, 2005; Rapkin et al., 2006). These characteristics make the CDT a good fit with refugee families in resettlement.

One model of CDT is the Continuous Quality Improvement Design (CDT-QI). This design uses an oversight body (e.g., an intervention design team or a community advisory board) to optimize an intervention for a community setting through a feedback process of monitoring, decision making, and modification of a manualized intervention (Rapkin & Trickett, 2005). Between successive waves of the intervention the collaborative group: (1) reviews intervention manuals, interim analyses of data on outcomes and intervention processes; (2) considers what changes will make the intervention more feasible, acceptable, and effective in the community. In formulating their opinions, the collaborative members weigh local experience, community priorities, pilot data, theory, and existing interventions. Successive versions of the intervention are implemented, assessed, reviewed, and modified until intervention performance is optimized. One example of a cancer awareness intervention, conducted in conjunction with the Queens Borough Public Library System, was designed to promote community organization, outreach, and cancer education to diverse under-served communities by letting each community group design its own cancer awareness education plan (Rapkin et al., 2006).

The CDT-QI approach can help to address a number of the key intervention characteristics of preventive interventions for refugee families mentioned previously. It provides a research

design approach through which feasibility and effectiveness can be evaluated, and it remains flexible enough to also address matters of prosaicness, culturally tailored and multilevel, through adaptations that can be made by the collaborative board.

PREVENTIVE INTERVENTION DEVELOPMENT CYCLEWITH REFUGEE FAMILIES

To illustrate how the aforementioned approaches could be used together to develop preventive interventions for refugee families we will describe a trajectory of preventive intervention development activities that centers on the “intervention template.” The intervention template is an idea that came from the education field (Children, Youth, and Families Consortium, 2007). The aim is to design an intervention template based upon empirical evidence from research with multiple prior refugee and migrant groups, which offers a starting point for designing preventive interventions that are tailored specifically for newly resettled refugee groups. The intervention development cycle consists of the following four steps (Figure 1).

Step 0: Foundational Activities

A community-researcher collaborative forms and conducts mixed methods research, informed by a resilience approach, including targeted ethnography that elucidates the important risk and protective processes, contextual issues, outcomes, and subgroups that are necessary for either formulating a new preventive intervention or adapting an existing one.

Step 1:Template Preparation

The collaborative group, including interveners, researchers, community members, and family members, drafts a detailed intervention template. This involves reviewing the conceptual frameworks, selected data from Step 0 studies, and multiple existing mental health preventive interventions designed with comparable populations. The aim is to ground the intervention design work in both theory and empirical evidence. This stage of the work involves identifying those modifiable protective factors and processes that are most likely to counter known risks and to bear upon targeted outcomes in the expected community and services contexts. Decisions are made by consensus after deliberation. The completed template is like a restaurant menu in that it contains many possible intervention elements, not all of which will be used for a given group in a given space and time.

Step 2: Situation-Specific Adaptation

The collaborative team decides to implement an intervention with a particular group, focused on particular issues, at a particular site, at a particular time, toward a particular end. It then draws upon the intervention template to derive a specific preventive intervention manual (version 1.0). The intervention adheres to the principles and approaches of the overall template, but incorporates elements that address the unique social, cultural, community, and family contexts of this refugee group in place and time. It includes those aspects of the intervention that best fit within a particular service delivery site.

Step 3: Intervention Trial

Implementation and evaluation of the intervention are first piloted with a small sample size (e.g., 30 subjects) so as to: demonstrate feasibility; demonstrate that the intervention has the kind of effects within subjects over time that have been reported for comparable interventions; explore patterns of engagement, retention, outcomes, and mediators to inform the researchers in making intervention modifications; demonstrate the feasibility of the evaluation methods; determine important parameters with sufficient accuracy to allow reliable estimates of sample size and detectable effects for possible subsequent larger studies. After the pilot has been conducted larger studies can be contemplated including using a randomized control design.

Step 4:New Situations

The collaborative team may then conduct another intervention trial. This could be: (1) intervention version 1.0 conducted without modification at a new point in time or for a new site; (2) intervention version 1.0 adapted to version 2.0 for a new cultural group, a new mental health/behavioral problem, or an entirely new context. The latter cases would call for some new foundational research to supplement what is already known, then using the existing template to devise a new intervention manual, and conducting a new trial. If similar measures are used across interventions then it is possible to incorporate multiple different forms of the intervention into a single overall analysis by adding a fixed effect of intervention version to the model. Comparison of the three intervention versions can be performed by adding an intervention version by time interaction. Without being bound to the rigid confines of a RCT, a CDT-QI analysis permits putting a large number of subjects in a single analysis and determining the extent to which changes in the intervention have modified the relevant outcomes.

ADVANCING PREVENTION FORREFUGEE FAMILIES

Although the research tools exist for developing preventive interventions for refugee families, many obstacles to their implementation still remain. On the governmental level, despite the stated priority regarding mental health, federal and state governments offer less and less financial support to families and the service organizations that work with refugee families (including resettlement organizations, schools, and clinics), meaning that there are less services, especially in the psychosocial realm. Those services that do exist often have little basis in scientific evidence and little fit with diverse families. For example, in recent years, U.S. resettlement programs have implemented “family strengthening initiatives” based on an understanding of families that risk being overly dependent upon American and Christian ideas of the nuclear family (U.S. Committee for Refugees, 2010).

In resettlement organizations, the programming is often more youth focused than parent focused and many parents are happy to let organizations do everything for youth. To the extent that parenting is a focus, the major issues are child discipline and domestic violence, which are often a focus of tension and conflict between families and organizations and government. Volunteers play a large role in services for refugees, especially volunteers from

faith communities. Although many volunteers provide help that the refugees really appreciate, these volunteers are largely without training or supervision.

Organizationally, there is often much competiveness and little coordination between the voluntary agencies managing refugee resettlement. Presently the federal government provides little incentive for collaboration between organizations or between academic researchers and organizations and communities. Research is perceived as a distraction that agencies cannot afford. The assumption is that psychosocial interventions do not need to be empirically validated or tested. The level of collaboration with communities is variable and often insufficient.

Professionally, much of the mental health work done with refugees is individually focused and not family or community focused. There is no standard for using evidence-based interventions in community-based services for refugees. There are academic obstacles in the sense that much of the existing research and writing on refugee mental health has focused on PTSD, which utilizes an individual and pathological approach. Far less often are family or community domains a principal focus or are resilience frameworks considered.

New strategies are needed to overcome these obstacles and develop large-scale successful efforts at mental disorder prevention for refugee families in the United States. First, this would require that the U.S. Office of Refugee Resettlement and the 50 state coordinators of refugee services make funding and supporting mental health disorder prevention a clear priority. This could involve new ways to approach programs that they currently fund for communities, families, and children and it could also involve funding new programs.

Second, it would require strengthening research approaches to prevention in refugee families. To help guide such efforts, it would help to outline a potential prevention system for refugee families as has been done for other vulnerable populations (O’Connell et al., 2009). A national group of providers, researchers, policymakers, community advocates, and family members could be assembled to build a comprehensive model.

Third, it would require strengthening the federal investment in prevention research with refugees. The U.S. National Institutes of Health should prioritize prevention research with refugee families so that it gets the same amount of focus as it does in immigrant families or trauma treatment for refugees. New efforts at research training would be required given that not enough persons who do preventive research are connected with refugee communities and that few of those who work with refugees have experience conducting research.

Fourth, it would require new efforts at coordination between government (federal, state, municipal), voluntary agencies, faith communities, mutual assistance associations, businesses, professional associations, academics, and of course, refugee communities. Presently this kind of coordination in the public sphere on behalf of mental disorder treatment and prevention among refugees in the United States does not exist. To the extent that it does, it has been overly focused on treating individual trauma and it has dwindled in the face of the global financial crisis and cutbacks in social and health programs.

In conclusion, preventive mental health interventions that aim to stop, lessen, or delay possible negative individual mental health and behavioral sequelae through improving family and community protective resources in resettled refugee families are needed. The required efforts would be substantial, but then so would the pay-offs. Prevention efforts would be likely to contribute to the productivity of refugee families and diminished expenditures for addressing health, mental health, educational, occupational, and criminal problems that arise when basic psychosocial needs are not addressed.

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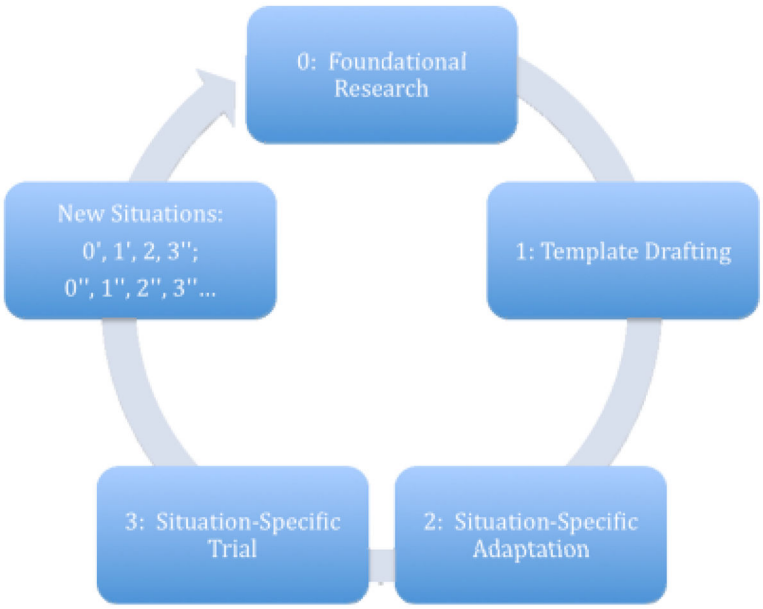

Figure 1.
Preventive intervention development cycle.

Table 1

Examples of Role of Sociocultural Constructs in Intervention Development

Sociocultural Construct	Definition	Intervention	Implication
Family solidarity	An desire to share experiences and beliefs with one another in the family	*CAFES* Coffee and Families Education and Support	Create a family-friendly atmosphere and assist families in broaching difficult subjects
Unprotected	Being subjected to difficult conditions, unfair treatment, beatings, without legal rights or health care access	*TRAIN* Transit to Russia AIDS Intervention with Newcomers	Frame enhancing migrants' risk awareness and HIV prevention skills in the context of enhancing migrants' preparedness for life in Moscow
"Like a refugee camp"	Parents' desire to return to living conditions of close proximity to friends and family, where children could run free, and where daily needs were met by organizations	*REDI* Refugee Educational Disparities Intervention	Teach parents to play an active role in shaping youth's experience through parental support, advocacy, and help-seeking

Table 2

Addressing Key Intervention Characteristics of Preventive Interventions for Refugee Families

		Approaches That Can Help Answer Questions			
Key Intervention Qualities	**Central Questions**	**Resilience Framework**	**Community Collaboration**	**Mixed Methods With Focused Ethnography**	**Comprehensive Dynamic Trial**
Feasibility	Is the PI doable?		X	X	X
Acceptability	Will families and providers accept the PI?	X	X	X	
Prosaicness	Does the PI use understandable and compelling language?	X	X	X	
Culturally tailored	Does the PI fit the particular characteristics of the situation and group?		X	X	X
Multilevel	Does the PI address more than one dimension of problems?		X	X	
Time-focused	Does the PI take into account time- dependent processes?		X	X	X
Effectiveness	Will the PI yield significant positive changes?	X	X	X	X
Adaptable	Is the PI flexible?		X		X

Table 3

Protective Factors and Mechanisms

Protective Factors	Protective Mechanisms (Selected Examples)
Within family communication	Adolescents feel supported and understood by parents regarding traumatic memories/experiences, emotional distress, school issues, and social and cultural transitions.
Parental monitoring and supervision	Parents invest time, gather information, and maintain relationships to promote adolescent safety and development.
Family emphasis on education	Parents actively and affirmatively encourage education through talking with their children.
Informed families	Parents and youth have adequate knowledge regarding their rights, responsibilities, and short- and long-term educational goals and plans.
Family advocacy for youth	Parents and youth advocate for youth's education rights, needs, opportunities, and help-seeking with appropriate persons and organizations.
Family communication with school	Parents are in ongoing and open communication with teachers and administrators regarding their children's performance, needs, and difficulties.
Family outreach	Parents and youth actively draw additional support from community supports such as churches, agencies, clinics, and other families.