7-23-2016

Promoting Healthy Family Transition and Support in Somali Refugee Parents: Outcomes of a Community-Based Program

Vanja Pejic

UNIVERSITY OF NORTHERN COLORADO

Greeley, Colorado

The Graduate School

PROMOTING HEALTHY FAMILY TRANSITION AND SUPPORT IN SOMALI REFUGEE PARENTS: OUTCOMES OF A COMMUNITY-BASED PROGRAM

A Dissertation Submitted in Partial Fulfillment
of the Requirements of the Degree of
Doctor of Philosophy

Vanja Pejic

College of Education and Behavioral Sciences
Department of School Psychology

July 2016

This Dissertation by: Vanja Pejic

Entitled: *Promoting Healthy Family Transition and Support in Somali Refugee Parents: Outcomes of a Community-based Program*

has been approved as meeting the requirement for the Degree of Doctor of Philosophy in College of Education and Behavioral Sciences in Department of School Psychology,

Accepted by the Doctoral Committee

_____
Robyn S. Hess, Ph.D., Research Advisor

_____
Michelle Athanasiou, Ph.D., Committee Member

_____
Vilma (Betty) Cardona, Ph.D., Committee Member

_____
Kyle Anne Nelson, Ph.D., M.P.H., Faculty Representative

Date of Dissertation Defense _____.

Accepted by the Graduate School

_____
Linda L. Black, Ed.D.
Associate Provost and Dean
Graduate School and International Admissions

ABSTRACT

Pejic, Vanja. *Promoting Healthy Family Transition and Support in Somali Refugee Parents: Outcomes of a Community-based Program.* Published Doctor of Philosophy dissertation, University of Northern Colorado, 2016.

Refugee families encounter significant acculturative and resettlement stressors as they attempt to rebuild their lives in the host country. These stressors are exacerbated by histories of trauma, violence, and loss making them highly vulnerable to psychological distress. The Somali Parent Program was a culturally specific, 8-week parent program designed to empower mothers to increase their family resilience by engaging in cultural and social exchange, adapting their parenting strategies to their host country, and learning about community resources. Ten Somali refugee mothers were recruited to participate in weekly 2-hour sessions that incorporated a psycho-educational lesson, an experiential activity, and a closing discussion. Due to the program's open door policy, an additional seven Somali mothers attended sessions during the 8-week period. Transcripts of initial and concluding interviews, video-recorded sessions, process notes, and artifacts collected throughout the program were analyzed for themes using a phenomenological approach. The goal for this study was to understand how Somali mothers make meaning of their adjustment process and their involvement in the Somali Parent Program.

The group members expressed that being part of the program increased their cultural understanding and provided them with ways to navigate their own culture and that of the host country. They also grew more aware of adaptive ways to identify and

express emotions and strengthened their communication with their children. At the end of the program, Somali mothers felt more comfortable accessing community supports and resources. Finally they reported significant increases in social supports and networks as well as a newfound sense of meaning and empowerment in their lives. Somali Parent Program findings suggest that culturally specific family-focused programs that emphasize the post-migration experience may provide an effective way of addressing acculturation, adjustment, and recovery amongst refugee families.

ACKNOWLEDGEMENTS

It would be impossible to close this chapter of my life without taking the time to thank all of the incredible individuals who walked on this journey with me. My gratitude and appreciation for each of you is difficult to put into words. Not only have you contributed to my educational pursuits, you have given me my wings to fly.

A special thank you goes to my research advisor and greatest teacher Dr. Robyn Hess, who believed in me before I ever believed in myself. Your brilliance is inspiring and your humility humbling. I am so proud of all of the work that we have accomplished together. I look forward to many more years of guidance, collegiality, and friendship. Thank you to my wonderful committee, Dr. Michelle Athanasiou, Dr. Betty Cardona, and Dr. Kyle Nelson. Your expertise, insight, and guidance inspired me to challenge myself as a researcher and a storyteller. Thank you to all of the faculty, supervisors, and staff who helped shape my training and always encouraged me to think critically and creatively.

The success of the Somali Parent Program can only be attributed to the community members and refugees who wholeheartedly believed in this project. Thank you to the refugee community for giving me the passion, the drive, and the vision to pursue this project. Dr. Tad and Jane Gilmore, thank you for your unwavering support and commitment to making our communities welcoming and nurturing for all people. To the local refugee center, thank you for opening your doors to the Somali Parent Program and allowing it to flourish. Finally, to the Somali refugee mothers who participated in the

Somali Parent Program, you have taught me more than you will ever know and I will be eternally grateful to each and every one of you.

To my dearest family and friends, in my moments of success and disappointment, you have been my greatest supporters and confidants. Your unconditional love and encouragement has served as a source of motivation and stability. Most of all, I would like to thank and dedicate this dissertation to my parents, Dragomir and Milenka Pejic, and my brother Vladislav Pejic. You have been my greatest source of strength and inspiration throughout this journey. Thank you for instilling in me the love of learning, the value of compassion, and the courage to be my authentic self. Together we had a dream and that dream has come true, I share every ounce of this achievement with you.

TABLE OF CONTENTS

CHAPTER

I. INTRODUCTION 1

Theoretical Orientation 2
Problem Statement 5
Rationale for the Study 9
Purpose of the Study 10
Guiding Questions 13
Definition of Terms 14
Delimitations 16

II. REVIEW OF LITERATURE 17

Who is a Refugee? 17
Somali History and Culture 22

Marriage and Family 23
Traditional Health Beliefs and Practices 24

The Migration Process 26

Pre-Migration 27
Trans-Migration 29
Post-Migration 30
Family and Post-Migration 32
The Role of Acculturation 34

Emotional Health and Wellbeing 36

Defining Mental Health 36
Refugee Mental Health 38
Attitudes and Expression of Emotional Distress Among Somalis 42

Coping and Community Supports 43

CHAPTER
II. continued

Bridging the Gap....46

Disconnect Between Current Practices in Treating Refugees....47
Culturally Sensitive and Adapted Programs....48

Conclusion....55

III. RESEARCH METHODOLOGY....58

Rationale for Study Design....60
Researcher Stance....61
Program Interpreter....63
Context and Participants....63
Data Collection....65

Interviews (Initial and Concluding Interviews)....66
Demographic Information....67
Video Recordings....67
Artifacts....67
Facilitator Journal....68
Co-facilitator Interview....69

Procedure....69
The Program: The Somali Parent Program....73

Family Transition....74
Family Well-Being....75
Community Integration....76
Celebration....76

Data Analysis....78
Conclusion....83

IV. FINDINGS....84

Description: The Somali Mothers....84

Qani….....86
Ayana….....86
Basra…......88
Dawo….....88
Amal….....88
Samiira....89

Hodan..... 89
Nadifo..... 89
Hibo…..... 90
Mako…..... 90
Additional Program Participants..... 90

The Group Process..... 92

Group Attendance..... 93
Group Interaction..... 94
Group Contribution..... 96

Contextualization of Themes..... 98

Initial Interview Themes..... 98

Fear, confusion, and loneliness..... 98
Shifts in the family system..... 102
Navigating systems..... 105
Sources of safety and security..... 107

During: The Somali Parent Program..... 109

Session I: Defining the family..... 109
Session II: Family and transition..... 110
Session III: Parenting in the host country..... 113
Session IV: Marriage and parenting..... 114
Session V: Stages of social-emotional development..... 115
Session VI: Family health and well-being..... 116
Session VII: Community integration and resources..... 117
Session VIII: Celebration..... 119

Concluding Interview Themes..... 120

Understanding culture..... 121
Feeling identification and expression..... 123
Parent-Child relationship..... 124
Community outreach..... 125
Support, belonging, and empowerment..... 126

The Interpreter Experience..... 129
The Researcher Experience..... 131
Conclusion..... 133

CHAPTER
V. DISCUSSION 135
Guiding Questions 136
Practice Implications 145
Culturally Specific Family-focused Program 145
Somali Parent Program as a Source of Social Support 147
Somali Parent Program as a Source of Empowerment 149
Promotion and Prevention in Behavioral Health 150
The Need for Community Programs and Supports 151
The Role of Schools and School Psychologists 152
Critique and Limitations 154
Implications for Future Research 156
Conclusion 158

REFERENCES 160

APPENDICES
A. Initial Interview: Semi-structured Interview Questions 178
B. Concluding Interviews: Focus Group Questions 180
C. Demographic Survey--English 182
D. Demographic Survey--Somali 185
E. Institutional Review Board Approval 188
F. Consent Form--English 190
G. Consent Form--Somali 194
H. Somali Parent Program Curriculum 198
I. Data Analysis Process Table 214

LIST OF TABLES

Table

1. Somali Parent Program Curriculum Outline 74

2. Demographic Information of Participants 87

LIST OF FIGURES

Figure

1. The Tree of Life 110
2. Family Transition of Collage Created by Basra 112
3. Family Transition of Collage Created by Hodan 112
4. Parent Mask 114
5. Stages of Social-Emotional Development 116
6. Community Genogram 119
7. Photo Language 120
8. Theme Map 136

CHAPTER I

INTRODUCTION

> Above all cultural differences, the needs, feelings, and vulnerabilities we experience as people are the same the world over.
>
> -Van der Veer, 1998, p. 76

Since 1980, the United States has welcomed over more than two million refugees, with as many as 75,000 arriving each year (U.S. Office of Refugee Resettlement, 2011). Refugees are affected by violence and conflict in their home countries and therefore seek refuge because they fear persecution for reasons of religion, race, nationality, or some other aspect of their beliefs and practices. One country that has experienced this form of suffering and never-ending cycle of hostilities for over two decades is Somalia. As a result, Somali families are scattered all across the world, including the United States (Mohamed & Yusuf, 2011). The challenges that Somali families experience in Somalia and in refugee camps across Kenya and Ethiopia are extremely difficult and many may believe that once they reach their resettlement countries, their lives will be changed for the better. However, families will experience a new set of obstacles as they resettle in the host country. This transition involves significant social, economic, cultural, familial, and psychological stressors (Weine, 2001). These challenges are further exacerbated when Somali parents are faced with raising their children in a Western country that has a language and culture that is much different from their own.

It is, therefore, not surprising that the Office of Refugee Resettlement (2014) has recognized the provision of mental health services to newly arrived refugees to be a public health priority. Despite this recognized need, only a subset of refugee adults and children who are in need of mental health services seek those services (Bentley & Owens, 2008; Weine, 2011). Obstacles such as stigma, cultural and linguistic barriers, lack of services, and poor access to existing services, often prevent refugees from seeking help. Therefore, due to the multidimensional nature of the challenges that Somali families experience, mental health professionals have found it difficult to adequately address the needs of this refugee population. Furthermore, the number of family-focused mental health services for refugee families is minimal (Weine et al., 2006). Currently, mental health programs for refugees are predominately reactive and focus on treating individuals within a Western psychiatric concept of care (Weine et al., 2006). Within this perspective, there is little emphasis on preventive approaches that build capacity for refugee families by targeting family programs and services through a preventive, ecological framework.

Theoretical Orientation

There are two primary frameworks that lend support to this study. First, in order to understand the context of the refugee experience pre- and post- resettlement, it is essential to utilize a holistic, ecological approach. This framework allows one to consider how individuals interact with their environments and how the environment impacts them. From this perspective, refugees' individual characteristics, along with their pre-migration, trans-migration, and the post-migration experiences are considered in terms of how they impact their functioning within a family context.

Urie Bronfenbrenner proposed an ecological framework for human development by drawing attention to the role of context. Bronfenrenner (1979) viewed the developing individual not as a tabula rasa on which the environment had complete influence, but instead as a growing entity that was actively engaged with his or her environment through a bi-directional exchange. Furthermore, Bronfenbrenner did not only highlight the immediate environment as the only force of change, but instead considered important contextual settings that extended to include interactions between external influences within the larger community. In other words, Bronfenbrenner highlighted the interchange between the individual and his or her ecological environment. In his original Bio-Ecological Systems Theory, Bronfenbrenner (1979) detailed a scientific approach that emphasized "interrelationships of different processes and their contextual variation" (p. 21) within a nested arrangement of structures. These structures are referred to as the micro-, meso-, exo-, macro, and chronosystems. According to Bronfenbrenner (1994),

> The microsystem is a pattern of activities, social roles, and interpersonal relations experiences by the developing person in a given face-to-face setting with particular physical, social, and symbolic features that invite in, the immediate environment. (p. 39)

Examples of microsystem settings include family, school, peer group, and workplace. The interaction between two or more individual settings that directly interact with the individual (i.e., home, family, school, peer group) is defined as a mesosystem. In other words, the mesosystem is a system of microsystems. Outside of the mesosystem, is the ecosystem. The exosystem is made up of settings that may not directly interact with the individual, but indirectly influence the individual's immediate environment (i.e., the individual's family). These may include community-neighborhood contexts, parental employment setting, or broader social networks. For refugee families, health and social

services, the school district, and the neighborhood in which they live can be part of their exosystem.

While each of the systems outlined above focuses on a setting within the environment, the macrosystem highlights the overarching pattern of micro-, meso-, and exsosytsem characteristics of a given culture including laws, policies, belief systems, customs, resources, and life-styles. In other words, it explores the societal blueprint for a particular culture or subculture. Finally, the chronosystem examines the impact of the time period in which the individual lives. For example, advances in technology, climate-change, and fast-paced life style are all examples of the chronosystem. Therefore, the magnitude and the diversity of the migration challenges experienced by many refugee families span across these various contexts and their interactions; individual, familial, community, societal, and cultural factors influence how refugees frame their worldview.

The Bio-Ecological Systems Theory framework is useful for conceptualizing the refugee experience from an expanded perspective, but does not offer a specific model for service provision. However, the systemic approach known as the Prevention and Access Programs for Families (PAIF) provides a framework for developing and implementing family-focused refugee programs in the field of refugee mental health (Weine et al., 2004). Derived from over seven years of research and clinical engagement with Bosnian refugees, this framework does not focus on traditional individualized approaches to treatment, but instead addresses the family as a unit in regards to trauma, forced-migration, and cultural transition (Weine et al., 2004). PAIF specifically addresses prevention in a family-oriented way.

The PAIF framework has four assumptions. First, family is recognized as a primary social unit for refugees. The family mediates refugees' connections with immediate and extended community and social supports. Second, family is viewed as a critical component of influence in the adjustment, recovery, and health of refugees. Third, trauma and displacement in refugee families can overwhelm and challenge the strengths that reside in refugee families. Finally, support and education can help refuge families meet the demands of their host country, allowing them to acculturate, adjust, and recover over time. As highlighted by the four assumptions, the PAIF framework does not offer direct treatment of symptoms of Post Traumatic Stress Disorder (PTSD) or depression, instead it focuses on the family, family beliefs, knowledge, attitudes, communication, social networks, and access to community resources that will help families promote recovery and adjustment (Weine et al., 2004).

Problem Statement

Situated on the Horn of Africa, Somalia, officially known as the Federal Republic of Somalia, has been plagued my war, violence, and famine for over two decades. It is estimated that some 450,000 Somalis have died since the outbreak of the civil war in the 1990's and another 45.0% of the population has been displaced either to neighboring countries such as Kenya and Ethiopia or Western countries, including United States (Kemp & Rasbridge, 2004). According to the U.S. Office of Refugee Resettlement (2014), it is estimated that anywhere from 35,760 to 150,000 Somali refugees have resettled in the United States. Somali refugees represent one of the fastest growing populations seeking international amnesty (Bentley & Owens, 2008). For most Somali refugees, the process of displacement and migration is often complex, multidimensional,

and occurs across multiple stages. The first migration point, pre-migration, may include exposure to war and violence, political, social or religious instability, lack of food and shelter, and loss of family and friends experienced in their home country (Ruiz, Kabler, & Sugarman, 2011). Once refugees have escaped their homeland, the trans- migration process may last anywhere from months to years. During trans-migration, many families live in refugee camps neighboring their home country. One way families are able to resettle in the Unites States is through a lottery system. When this occurs, refugees are said to be entering their post-migration process. For many, the post-migration process brings an entirely new set of challenges and vulnerabilities, including adapting to the culture, language, and academic demands of the host country, maintaining family cohesion, enduring family separation, and being at risk for psychopathology (Smith, 2008).

In addition to the challenges associated with transition, Somali parents face numerous challenges raising their children in a Western society in which cultural ideals vary greatly from the life they left behind. These challenges include learning a new language, negotiating a new culture, juggling work demands and parenting, and navigating a foreign educational and health system (Mohamed & Yusuf, 2011). Furthermore, both the laws and the practices related to child rearing in Western countries is quite different from what Somali parents have learned in their own country, or the necessary practices that came along with life in a refugee camp (e.g., giving young children great levels of independence and responsibility). While, Somali parents seek to nurture their children into productive citizens who maintain most, if not all, of their valued traditions, they are often caught in a conflict. This conflict is due to the drastic

cultural differences between their home and host country, in that Somali parents want to maintain their traditional parenting style while their children are searching for their own identity in their new environment and host country.

It has been noted in refugee literature that displacement-related stressors exert a significant impact on refugees' psychological and physical well-being (e.g., Carswell, Blackburn, & Barker, 2011; Lincoln, Lazarevic, White, & Ellis, 2015; Miller & Rasco, 2004). The complexity and the severity of the migration challenges that refugees face, including forced migration, exposure to traumatic events, and resettlement in unfamiliar country, makes them highly vulnerable to experiencing and developing psychological distress. However, despite high levels of trauma and stress that most have experienced, the mental health trajectories of refugees are diverse. Studies have documented both significant mental health problems as well as high degrees of resilience and adaptive functioning among refugees (Ellis, Miller, Baldwin, & Abdi, 2011; Fazel, Wheeler, & Danesh, 2005; Pumariega, Rothe, & Pumariega, 2005). In fact, among samples of refugee children and adults, prevalence of Post-Traumatic Stress Disorder (PTSD) have varied significantly, with children rates ranging from 11.5 to 65.0% (Ellis, Lincoln, MacDonald, & Cabral, 2008), and 3.0% to 86.0% across refugee adults (Fazel et al., 2005).

There is limited research examining prevalence of mental illness among Somali refugees (Bentley & Owens, 2008). However, similar to other refugee groups, available research suggests inconsistencies in the prevalence and severity of psychopathology including depression, anxiety, and PTSD among Somali refugees (Kroll, Yusif, & Fujiwara, 2011). There is a Somali idiom stating, "nin madaxa laga haayo, meeli uma fyooba" that translates to "if a person has sickness or pain in their head, no other parts

will work" (Palinkas et al., 2003). For Somalis, psychological well-being is dichotomized into two categories of mentally well and mentally ill (sane or insane). For many Somalis Western understanding and treatment of mental illness is an unfamiliar concept and carries significant amount of stigma. This stigma is often associated with weak-mindedness, fear, and hopelessness and may cause them to underreport or reject receiving any form of Western treatment. Instead, it is more common for Somalis to report somatic complaints such as headaches, sleep problems, lack of energy and appetite, abdominal pain, and gross body aches (Bentley & Owens, 2008). Although, in general, mental illness would be seen as incurable in the Somali culture, spiritual and traditional healing practices are considered to be the primary source of healing (Scuglik & Alarcon, 2005).

Although not specific to the Somali population, according to Ellis et al. (2011), 92.0% of immigrants and refugees who are in need of mental health services do not obtain those services. While barriers to mental health in the refugee community are not well known, there are some key elements that have been identified. Some of the potential barriers include: a) distrust of authority, b) lack of community knowledge about the health care system, c) language and cultural differences, d) stigma related to mental health services, e) fear that treatment of PTSD will worsen symptoms, and f) resettlement stressors (Murphy, Ndegwa, Kanani, Rojas-Jaimes, & Webster, 2002; Tribe, 2002). Resettlement stressors, in particular, can pose significant barriers to Somali refugees. Challenges surrounding managing children within the U.S. context and fear that Division of Child Support (DCS) will take their children away from them for disciplining them in traditional or familiar ways, lack of transportation and child care services, as well as economic and occupational difficulties can all trump the needs of Somalis to seek mental

health services (Bentley & Owens, 2008). Therefore, Bentley and Owens (2008) suggested that initial focus on current resettlement challenges and somatic complaints rather than previous trauma exposure may be more effective in alleviating Somali refugees' concerns and situational conditions. One may conclude that mental health prevention may be a more appropriate alternative to treating refugee parents and their children rather than expecting them to access mental health services once the disorder has developed. Through prevention approaches, mental health providers may be able to enhance protective factors by improving family and community-based resources for refugees and therefore reducing the risk of mental health problems.

Rationale for the Study

According to the World Health Organization (2004) preventive programs must focus on promoting family and ecological factors that lower the risk of mental disorders and behavioral problems. If identified, these protective resources including families, social environments, schools, and communities can be linked into a network of prevention that reflects a culturally specific lens (Barrio, 2000; Tolan, Hanish, McKay, & Dickey, 2002). Therefore, in order to effectively engage with refugee families, family–focused prevention supports must achieve high levels of social and cultural specificity. Preventive programs must be based on an accurate understanding of the social and cultural interactions that are impacting refugee families (Weine, 2001). This understanding involves two primary factors: (a) attention to how social and cultural experiences change and evolve over time and (b) a consideration the how forced migration experiences interact with life in the post-resettlement country (Weine et al., 2006).

Because of the unique, ecological perspective needed to more completely address the needs of refugee families, a traditional focus on the individual is not appropriate. Therefore, programs that target programs designed for and implemented within community environments may be one avenue for incorporating familial, social, economic, and cultural dimensions of people's lives into program frameworks (Weine, 2011). Several program studies with refugee families (Weine, 2001; Weine et al., 2006) have highlighted the effectiveness of this approach and provide guidelines for incorporating key program characteristics associated with positive outcomes.

Purpose of the Study

Refugee families are multidimensional and frequently demonstrate high levels of distress upon resettlement to a host country. The daily stressors include loss of meaningful social roles, loss of community and social support, economic concerns, powerlessness, racism and discrimination, and changes to their new way of life (Goodkind & Foster-Fishman, 2002). Post-resettlement challenges may be further exacerbated by the mental health concerns often associated with high degrees of past trauma that many refugees experience prior to resettling in the United States. However, despite the high degree of stressors that refugee families' experience, the refugee community seldom seeks mental health services (Miller, 1999). Distressed refugees often do not seek mental health services because of the common stigma associated with seeking mental health services. Further, mental health clinics are not responsive to the needs of the refugee community because practitioners lack a non-Western conceptualization of mental health models. This lack of cultural fit or match can pose a significant challenge to seeking treatment. Finally, mental health services that emphasize

individual therapy are not effective without addressing the social and family needs and utilizing the resources and strengths in the community (Miller & Rasco, 2004).

In fact, supporting refugee parents is critical in addressing the needs of the whole family and may be the most effective way of preventing mental health concerns and promoting the wellbeing of refugee children. "The family is often recognized as a key context for refugees and their mental health" (Weine et al., 2008, p. 150). Other research has indicated that families may act as both a source of stress and as a resource for adjustment and coping (Voulagaridou, Papadopoulos, & Tomaras, 2006). For Somali families, the family is the ultimate source of security and identity (Putman & Noor, 1993). Despite the importance of the family unit, there are few known studies of family-focused programs (Reincke, 2011), especially that are specific to Somali refugee families. Family-focused programs that address preventive approaches and utilize family and ecological protective factors remain in many ways uncharted in research. Therefore, although current and past research recognizes the importance and the need for family-focused programs with refugee families, currently culture specific family-focused programs for Somali refugees are limited and the significance of such programs is yet to be fully understood and utilized with newly arrived Somali parents and their children.

One example of a family-focused program was developed by Weine et al. (2004) who worked with refugees from Bosnia and Kosovo. The Coffee and Family Education and Support (CAFES) program was developed to assist Bosnian families who were thought to be suffering but had not sought out mental health services. The primary goal of this program was to provide networking and social support for families, education, and a place of support and family cohesion across a 15-week period (Weine et al., 2004). The

second program, Tea and Family Education and Support (TAFES) was designed to offer similar supports in a shorter period of time (i.e., 8 weeks instead of 15). In a preliminary analysis of the data for the CAFES program, participants in these groups experienced improvements in psychiatric and mental health services utilization, knowledge and attitudes concerning trauma-related mental health, family communication, and symptoms of depression (Weine et al., 2004).

Exploring family-focused programs with refugee families is important for several reasons. First, implementing programs designed for the refugee family instead of the individual highlights family and community supports and resources. Second, family-focused programs align more appropriately with the cultural values and traditions of many refugee families, especially Somali refugees. Third, placing the focus on prevention programing may reduce future mental health concerns in refugee families. Finally, providing family-focused programs that target post-resettlement challenges may not only reduce future mental health concerns, the skills learned may also generalize to other areas of need. Therefore, this study attempted to implement a culturally-specific parent program with Somali mothers, in order to assess the process of developing and implementing a program that attempts to bridge the Western practices with non-Western practices in regards to family well-being and post-resettlement challenges.

This study focused on implementing and understanding the impact of an 8-week program designed to help Somali mothers develop a bridge between the values, beliefs, and traditions they left behind and their new lives in the United States, with a special focus on the resettlement challenges that may threaten their families' way of life and their functioning. Through the PAIF framework, the program addressed three main factors that

have been associated with refugee families' adjustment process: (a) family transition, (b) family wellbeing, and (c) community integration. It was believed that providing a culturally–specific parent support program to Somali refugee mothers would increase their level of family health knowledge, reduce emotional distress, and increase their level of community integration. Using a qualitative, phenomenological research design, I explored Somali parents' unique experiences of their family's transition process, health and wellbeing, and community integration before, during, and after their participation in the Somali Parent Program.

Guiding Questions

The following questions helped guide this study.

Q1 How do parents who participate in the Somali Parent Program make meaning of their experience?

- a. What do parents perceive to be beneficial or detrimental components of the program when interviewed during concluding interviews?
- b. How have the parents been able to apply the program in their daily life?

Q2 How do Somali parents understand and interpret their family's transition process?

Q3 How do Somali parents interpret their family health and wellbeing?

- a. How do parents perceive and understand issues surrounding their own and their children's mental health?

Q4 In what ways are Somali parents integrated into their local community?

Q5 What perceived barriers do Somali parents experience in attending the Somali Parent Program?

Definition of Terms

Acculturation. This term refers to the process whereby the attitudes and/or behaviors of individual from one culture are modified as a result of their contact with a different culture (Moyerman & Forman, 1992). In the process of acculturation, ideally the individual adapts by retaining his or her values and traditions from the home country and is able to add language and some customs from the host country (McBrien, 2005). In other words, the individual is able to move between the two cultures depending on need and situation.

Adjustment. This term refers the process by which refugee families have adapted to the post-resettlement changes upon arrival to their host country.

Cultural navigator. This term refers to an individual who acts as a cultural and language liaison between the home culture and the host culture. Cultural Navigators help refugee families navigate the host country by communicating with schools, medical facilities, employment offices about refugee needs and cultural beliefs. Cultural Navigators are critical in helping both refugee families and community members understand one another. They are also helpful in advocating and educating community and educational agencies on refugee needs and helping provide a more effective post-resettlement transition process (Bridging Refugee Youth & Children's Services [BRYCS], 2014).

Mental health. According to the World Health Organization (2007), mental health is not just the absence of a mental disorder; instead it is a "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his

community (p. 1).” Therefore, in this study the primary focus is on the general well-being of the individual and not on diagnosis and conceptualization of mental health disorders among refugee families.

Refugee family. In the process of becoming a refugee, adult caregivers may “adopt” orphaned or children of extended family members, therefore, family membership may vary from strictly nuclear families to extended families. However, within the refugee family context, all those living in the same household who have undergone the refugee experience, regardless of whether or not they are relatives, will be considered part of the refugee family (Voulagaridou et al., 2006).

The Migration Process. Refugee migration has often been divided into three stages: pre-migration, trans-migration, and post-migration (Hamilton & Moore, 2004). Pre-migration refers to refugee experience prior to leaving their home country and trans-migration refers to the process of migration that for some families may last from a few months to years depending on whether they are directly resettled to a host country or whether they stay in a refugee camp. Final stage, post-migration, refers to the life after resettling in a host country. Each stage (pre, trans, and post) represents a different set of ecologies that impact the families overall functioning and the transition process.

Trauma. According to the American Psychological Association (2014) trauma refers to an emotional response to a terrible event such as a rape, natural disaster, or an accident. Immediately after the event, the individual may be in shock or in denial, while long term reactions may include unpredictable emotions, flash backs, and physical symptoms such as headaches and nausea. Individual reactions to trauma can be dependent on the type of trauma that occurred, the age of the person at the time of the

trauma, whether it is a single traumatic event or multiple, and cultural and societal perception surrounding the incident. In this study, traumatic events are primarily associated with war-related experiences (e.g., exposure and witnessing violent acts, death of loved ones, rape.) that refugees experienced prior to resettling their host country.

Delimitations

The current study was implemented with Somali refugee mothers in a Western state in the United States. Going into this study, I recognized that there would be several challenges in implementing this type of program and interpreting the findings. First, cultural and language differences between the refugee women and myself may have increased the chances of misunderstanding and misinterpretation of data throughout the implementation of the program and during data analysis. Translation of certain phrases or terms from Somali to English may have lost the true meaning. Further, it is possible that the Somali mothers would feel guarded at times to share certain information in front of me. Although I worked with a Somali national as my co-facilitator and interpreter to help reduce these barriers, many of these challenges were still present.

CHAPTER II

REVIEW OF LITERATURE

Much of the United States has been established and shaped by the immigrants who migrated to this nation over the last hundreds of years. In fact, migration has played a major role in the growth and cultural change throughout much of the history of the United States (Griswold, 2002). Today more than ever before, this country is rapidly becoming a multiethnic and multicultural society. Since 1975, the United States has welcomed over 3 million refugee children and their families to rebuild lives, homes, and communities across all 50 states (U.S. Department of State, 2014). Although, admission rates dropped significantly after September 11, 2001, rates have since continued to increase, from 53,000 in 2004 to 70,000 in 2013 (McBrien, 2005; U.S. Department of State, 2014). Therefore, every year, nearly 40,000 to 75,000 refugees arrive to the United States dependent on presidential determination; approximately 40.0% of them are under the age of 18 (McBrien, 2005). Today, the United States is considered to be one of the largest resettlement countries in the world.

Who is a Refugee?

Historically, refugees have been admitted into the United States because of special humanitarian concern. For refugees, migration is a means of survival. The first legislation related to refugee resettlement was enacted by the U.S. Congress under the Displaced Person Act of 1948. At the time, over 400,000 displaced Europeans were admitted to the United States in the wake of World War II. Post World War II, waves of

refugees arrived from Hungary, Yugoslavia, Cuba, and Korea. Most of these groups were assisted by private religious and ethnic organizations. However, the 1975 resettlement of hundreds of Indochinese refugees prompted Congress to pass the Refugee Act of 1980, which helped standardize the resettlement services for all refugees admitted to the United States. The Refugee Act provided the legal basis for today's Refugee Admission Program (Refugee Council USA, 2014).

The Refugee Act of 1980 prompted resettlement of some 207,000 refugees in 1980, the highest recorded annual admission (Refugee Council USA, 2014). Throughout the 1980s, refugees primarily migrated from Asia, the Caribbean, and Latin America, with arrivals from this latter area forming the highest numbers (Migration Policy Institute, 2014). However, since the 1990s, refugee demographics have changed, with many arriving from third world, or war-torn countries such as Afghanistan, Somalia, Iraq, Bhutan, Burma, Eritrea, Ethiopia, Congo, and Sudan (McBrien, 2005). The United States and other leading nations allow refugees to resettle in their countries based on annual resettlement quotas established by the current president of the United States. After consulting with Congress and the appropriate agencies, each year the president determines the designated nationalities and processing priorities based on current humanitarian crises, foreign policies, and relations with other countries. According to the U.S. Department of State (2014) some of the highest refugee admissions came from Burma (16,972), Bhutan (14, 999), Iraq (9,388), and Somalia (3,161) in 2011.

Once refugees are admitted into the United States, voluntary agencies (also known as "volags") based in New York and Washington, D.C., meet with the PRM to determine the placement of refugees across the United States. PRM provides reception

and placement services for refugees for the first 30 days in the country, while the Office of Refugee Resettlement provides funds to participating states, volags, and local partners to provide assistance with housing, employment, and language instruction for the first four to eight months after arrival. Long-term assistance for refugees is offered through state social service programs as well as non-profit refugee organizations (Singer & Wilson, 2006). Although United States refugee policy is made at the federal level, volags and state refugee coordinators have an important role in determining where refugees resettle. There are a total of 10 national volags, each having a network for local partners. Some two-thirds of refugees are resettled in regions where they already have family members or there are already pre-existing ethnic communities. For these refugees, they must be resettled within 100 miles of the local volag affiliate office. The other one-third of refugees is considered to be "free" cases and are considered to have no contacts in the United States. These placements must be located within 50 miles of a local volag office. When there are no family members or pre-exiting ethnic communities, placement decisions are decided based on availability of employment, affordable housing opportunities, strengths of local volag affiliate offices, receptiveness of the local community, and availability of specialized services such as trauma centers. Some of the largest refugee resettlement areas have been metropolitan areas such as New York, Los Angeles, Chicago, Seattle, Atlanta, and Portland (Singer & Wilson, 2006).

According to the United Nations definition provided in the 1951 Geneva Convention Article 1(A)(2) relating to the Status of Refugees, a refugee is

> A person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it. (United Nations General Assembly, 1951, p. 14)

The critical component of the definition is the emphasis on finding oneself *outside the country of his former habitual residence.* Although much of the past and current literature has focused on refugees who seek safe haven in other countries, the majority of those displaced by violence do not seek or are unable to resettle in another country, instead they become "internal refugees" (Miller & Rasco, 2004). Internal refugees remain within the boundaries of their homeland, and today make up 20 to 25 million people worldwide (Norwegian Refugee Council/Internal Displacement Monitoring Centre, 2012). Therefore, although this chapter focuses on refugees who are outside their homeland, it is important to recognize that the experiences of violence, disruption, and loss are shared by not only those that resettle in countries such as the United States, but also millions of people worldwide who cannot or will not avail themselves of protection elsewhere.

Refugees are unique in the sense that they are displaced from their villages, cities, or countries without warning and may have little say in where they resettle. Before arriving to the United States, a refugee must receive official refugee status in a country of asylum in order to be considered for resettlement. The United Nation High Commissioner for Refugees (UNHCR) refers only about 1.0 % of all refugees for resettlement in a third country (McCarthy & Vickers, 2012). There are many more internal refugees who apply and are never accepted. It is only when all efforts to either help refugees return home or

settle permanently in the country of asylum have failed, does third country resettlement become an option.

Despite the unified definition of a refugee, individuals who are refugees differ greatly from one another across languages, cultures, and most importantly their adjustment process once they arrive to the host country. According to UNHCR, refugees are defined under two categories: *anticipatory* refugee and *acute* refugee. The difference in circumstance between the two was important and helped to explain why there is so much variety in refugee populations. Anticipatory refugees are able to foresee future problems in their homeland and are able to prepare for flight to another region or country. Refugees in this group tend to be financially stable and well educated. On the contrary, acute refugees are individuals who find themselves in immediate danger and have little or no time to prepare before fleeing; they are often, but not always, less educated, may have minimal vocational skills, and are more likely to have experienced a significant amount of trauma (United Nations High Commissioner for Refugees [UNHCR], 2014). It is no surprise therefore, that dependent on whether the refugee falls under the anticipatory or the acute definition, the process of adjustment in the host country may look very different and the need for additional resources may vary greatly.

Many of those who resettle in the United States are defined under the acute refugee status. One country that has experienced significant increase of refugees over the last two decades is Somalia. According to the UNHCR (2014), there are currently 1,003,465 Somali refugees (internal refugees and those living outside of Somalia). In 1991, the State of the Republic of Somalia collapsed and a civil war broke out leading to a complete disintegration of the central government (Gundel, 2002). Since this time, it is

estimated that over 400,000 Somalis have died and those that have survived have experienced gruesome trauma, including sexual violence and exposure to other forms of extreme violence, often resulting in the death of loved ones. According to UNHCR, over 65.0 % of the population has been displaced to neighboring refugee camps in Kenya. Currently, there are an estimated 35,700 to 150,000 Somali refugees resettled in the United States (UNHCR, 2014), representing two predominant Somali ethnic groups which include, the Somalis and Somali Bantus (Ellis et al., 2013). The majority of those that have resettled in the United States have resettled to Minnesota, California, Washington D.C., and Georgia.

Somali History and Culture

When discussing general cultural information, it is important to note that culture is not static, but ever-changing and expressed individually. Therefore, while the following section highlights various aspects of the Somali history, culture, language, family values and traditional healing practices, it is merely an overarching umbrella under which individual experiences take their own unique shape and meaning from one person to the next. For example, while the U.S. government may consider Somali refugees a unified group, Somali Bantus have been noted to differ both culturally and ethically from mainstream Somalis. However, less information is available in the Western literature about the Somali Bantu population, because this group has had little access to formal education and that has decreased the likelihood of a written history and culture. Therefore, the following description of the Somali history and culture focuses on the mainstream Somalis' cultural beliefs and practices.

Somalia has been characterized as one of the most homogenous countries in Africa, with over 85.0% of the population sharing a uniform language, religion, and culture. The majority of Somalis traditionally belong to the pastoral nomadic culture, herding camels, sheep, and goats. Between 60.0% and 70.0% of the population are nomadic. Much of the remainder of the population are farmers. In Somali society, clans serve as both a source of solidarity and great conflict. Clans provide a source of protection, along with political power and access to water and land. The four main clan families include the Dir, Isaaq, Hawiye, and Daarood (Putman & Noor, 1993).

Somalis are deeply rooted in the Islamic traditions, and Arabic is the second most commonly spoken language to Somali. Oral communication is at the heart of the Somali culture. In 2000, the literacy rate in Somalia was 24.0%. Islam is the primary religion in Somalia, and almost all social norms including attitudes, traditions, and gender roles among Somalis are rooted in the Islamic tradition. The five pillars of the Islamic faith define all aspects of Somali daily life. The five pillars of Islam include, Shahadah: declaring there is no god except God, and Muhammad is God's Messenger, Salat: ritual prayer five times a day, Sawm: fasting and self-control during the month of Ramadan, Zakat: giving 2.5% of one's savings to the poor and needy, and Hajj: pilgrimage to Mecca at least once in a lifetime if one is able to do so. Much of Somali culture as well as social and family values is deeply interwoven with these five pillars of the Islamic faith (Putman & Noor, 1993).

Marriage and Family

Islamic Somalis are traditionally polygymous, in accordance with the Islamic code, which allows for a maximum of four wives at any one point (Putman & Noor,

1993). The primary purpose of marriage is to produce children, especially males who will honor the father's lineage. Family provides the ultimate source of personal security and identity. The protection of family honor is very important. The often heard Somali question, *tol maa tahay?* (What is your lineage?), reflects the importance of family in the Somali culture. Somalis typically live in a nuclear family, although it is not uncommon for elders to move in with their children (Putman & Noor, 1993). Family structure is patriarchal, with women assigned to household chores, while the men graze camels (Lewis, 2008). Men are considered to be authority figures, and the eldest males are decision-makers. The oldest son holds a very important part in the family household, and female children are expected to obey male siblings (Scuglik & Alarcon, 2005). It is estimated that before their tenth birthday, 98.0% of Islamic Somali girls undergo some form of circumcision, which in Western countries is also known as female genital mutilation. Circumcision in the Somali culture is considered to be a formal right of passage for young girls; it is a source of pride and it also prepares the young girl for marriage. The average number of children in a Somali household was between four to six. Child and maternal mortality rates for Somalia are amongst the highest in the world; one out of every ten Somali children dies before their first birthday (United Nations International Children's Emergency Fund [UNICEF], 2014).

Traditional Health Beliefs and Practices

Cultural traditions along with Islamic belief system are very much embedded in the ways that Somalis understand and practice medicine. In fact there is a notion that "God . . . is the ultimate doctor. He is the one that brought down the disease. He is the one that brought down the cure" (Ciftci, Jones, & Corrigan, 2013, p. 23). In fact, illness

can be perceived as a connection to God and any affliction, especially mental illness, may be viewed as a test or a punishment from God (Abu-Ras, Gheith, & Cournos, 2008; Ciftci et al., 2013). Therefore, spiritual healing plays a powerful role in the lives of Somali people (Abu-Ras et al., 2008). To treat illness, Somalis may rely on indigenous healing methods and use extensive herbal medicine traditions or other rituals such as prayer (BRYCS, 2003). One example of using prayer as a source of healing may involve placing the Koran on the body of the individual who is ill and reading scripture from the Koran. Somalis often seek out traditional doctors or *dhaawayaal* to treat illness and injuries such as hepatitis, measles, broken bones, or other illnesses thought to be caused by spirits. It is only when all traditional forms of medicine have been exhausted that Somalis may go to a hospital to treat their illness.

Cultural and religious beliefs dictate that anything internal to the body requires prayer and the reading of the Koran, while anything external to the body requires the use of a medical doctor. The amount of exposure that Somali refugees have had to Western medicine is often dependent on geographic location. Those who live in urban settings have more exposure to Western medicine in comparison to those who live in villages or on clan land. When Somalis utilize a Western health care system, they commonly expect to receive medication for every illness. For many individuals their traditional beliefs have likely been transformed after years of life in a refugee camp where families must adjust to changes in their expected roles. For example, men were no longer able to graze livestock and women spent much of their time trying to access food and water. Therefore, many Somali refugees may present with traditional cultural beliefs that have been shaped or changed through the migration process.

The Migration Process

For refugee families and their children, the process of migration is a complicated, dynamic, and often a long, arduous journey. Migration begins when individuals or families voluntarily choose to leave their native countries or are forced to leave with little or no notice. The migration process has often been defined as occurring in three stages, including pre-migration, trans-migration and post-migration (Hamilton & Moore, 2004)

Due to individual and environmental influences, the complexity of the refugee migration experience is by no means one-dimensional and instead should be conceptualized within an ecological framework. Bronfenbrenner's (1994) Bio-Ecological Systems Theory provides a framework for viewing and interpreting the developing individual and his or her interactions with the surrounding environment or ecological system. The theory provides a lens to view the individual through an ecological, systems approach in which developing individuals mold and shape their beliefs, patterns of thinking, and decision making in the context of their immediate and extended environments. Within the Bio-Ecological Systems Theory, the environment shapes individuals and individuals also mold and shape their environments. The magnitude and the diversity of the migration challenges experienced by many refugee families span across these various contexts and the interactions between these systems; individual, familial, community, societal, and cultural factors influence how refugees frame their worldview.

Bronfenbrenner's theory provides a framework that allows one to understand the personal and the environmental experiences of refugees. It also helps to define the role that past and present experiences have on adaptation and provides a framework for

working with diverse refugee populations whose experiences and systems are often overlapping and interconnecting with one another (Hamilton & Moore, 2004). It is this interconnected web of individual and environmental contexts that highlight the uniqueness of the refugee migration process and sheds light on the incredible challenges that many refugee families experience.

Pre-Migration

It is important to note that although refugee families share overwhelming amount of similarities in their migration experience, each refugee experience is unique. As highlighted by the Bio-Ecological Systems theory, it is the interaction between the individual and his or her environment that shapes the development of the individual. Therefore, while the next several sections highlight the overarching challenges experienced by refugees, in particular Somali refugees, the migration process as well as ways in which this process occurs is distinctive for every individual.

The first migration point, pre-migration, involves the challenges experienced prior to leaving one's home country across individual and environmental influences. One common characteristic for many refugee families includes having lived in a country in which repression or political persecution has occurred over a number of years. Exposure to some form of political violence is often an underlying commonality between most refugees. Additionally, loss can be defined in multiple ways in the pre-migration stage. Material loss, including loss of a home as well as any other personal possession is very common. Financial loss, including loss of income, lack of food, and limited basic living necessities due to financial crisis is also common. Most importantly, loss of loved ones, including immediate and distant family members, friends, and neighbors impacts almost

every family. It is not uncommon for refugees to experience some form of torture, including rape, beatings, and deprivation of food and water.

During 1991 and well into 1992, southern and central Somalia were ravaged by inter-clan warfare, banditry, and widespread famine which claimed the lives of 240,000 to 280,000 Somalis. The humanitarian situation prompted the United Nations (UN) Peace Force to respond by providing food, which helped to end the famine. However, due to lack of central government, Somalia families remain vulnerable to ongoing violence, as well as lack of food and shelter. Sub-clan militia and local warlords have continued to produce a significant degree of violence and instability, which has left Somalis exposed to war and violence, political, social or religious instability, lack of food and shelter, and loss of family and friends (Ruiz et al., 2011). Most recently, the 2011-2012 famine has claimed over 260,000 lives.

In the context of an ecological framework, pre-migration stage impacts refugees across all systems. Loss of family and friends along with the disruption in immediate environments (e.g., inability to locate family or friends, increase of violence in immediate environments such as schools and neighborhoods) may all be part of the refugee pre-migration experience. Furthermore, political violence can increase distrust in authority and marginalization of various ethnic groups that can exacerbate negative stereotypes and contribute to negative schemas about an individual, a group, or even a country. These schemas can ultimately have a significant impact on psychological health as well as ways in which individuals view and interact with their immediate environment as well as with the outside world.

Trans-Migration

Trans-migration is often defined as a period after refugees have escaped their homeland and have been displaced. This process may last anywhere from months to years. In fact, due to prolonged instability and violence in Somalia, it is not uncommon for many refugee children to have been born in a refugee camp. Therefore, experiences during the trans-migration period can play a role in either increasing or decreasing risk factors depending on duration of time spent in transition camps. For many, both the amount of time spent in a refugee camp as well as the living conditions in that camp can play a significant role in the ways in which one views and interacts with their immediate and extended environment. Similar to pre-migration experiences, trans-migration can have a significant impact on one's values, belief systems, and understanding of oneself and the world around them.

Close to one million Somali children and their families live in refugee camps neighboring their home country, including Kenya, Yemen, and Ethiopia (Refugees International, 2014). Dadaab, a town located approximately 100 miles from the Kenyan-Somali border is often described as the largest refugee camp in the world. Dadaab has housed up to 439,000 refugees, despite the camps capacity of 90,000. Therefore, overcrowding is a continuous concern; a horizon of tents with wooden frames and tarps cover every inch of space. There are often high crime rates, little or no food, and sanitation is meager. Sexual violence, including rape is common in the camps, as is physical violence as a way to gain resources (e.g., stealing others' food or shelter). Due to lack of infrastructure and overcrowding, it is difficult for most to receive medical treatment. Lack of infrastructure has also impacted access to educational services.

Children and adolescents often receive disrupted or no education at all. It is not uncommon for the Somali boys to be sent to school in the camp, while the girls stay at home and help with household chores.

The horrifying conditions of camps, in which most live for years with no hope for returning home, slowly evolves into a dream of a life in the Western world because it is the only solution. Kroner (2007) describes this phenomenon of Somali culture as being called, *buufis*, meaning "the incessant urge to flee west" and has significance today because of the protracted civil war in Somalia and the view that the only salvation is resettlement abroad. Those fortunate few that escape the camp life are considered lucky by other camps residents, however many, if not most, are unprepared for the challenges that lie ahead.

Post-Migration

The post-migration process is defined as a period in which the refugee family resettles in their host country. This process brings an entirely new set of challenges and vulnerabilities which involves the intersection of all systems, including the individual, cultural, social, economic, language, and environmental factors (Hamilton & Moore, 2004). For most refugees, this process is compounded by experiences of trauma and loss, as well as multiple other stressors including culture shock, social isolation and loss of traditional support networks, language barriers, financial instability, health problems, negative racial and religious stereotypes, little or no educational experience or literacy, as well as increased risk for psychopathology (Smith, 2008). Furthermore, many families are forced to leave family members behind, which may add a significant level of stress on those that did get the chance to resettle. Therefore, despite being considered "lucky" or

fortunate for being able to resettle in a Western country, the challenges outlined above can create significant individual and family disequilibrium.

This disequilibrium is often exacerbated by the cultural and the psychosocial challenges that most refugees face once resettled in their host country. Specific to Somali refugees, the changes in cultural, linguistic, and religious expectations and practices in the United States can have a negative impact on their adjustment. Post September 11th, the negative perceptions of the Muslim culture and practices have impacted ways in which Somali refugees are viewed as well as treated. Furthermore, due to their limited educational background, both unemployment and academic challenges have posed a significant barrier for Somali success. Psychological challenges, such as coping with displacement, trauma, and loss of loved ones, social isolation, lack of meaningful activities, and decreased family cohesion can negatively affect the psychological adjustment of refugees. In fact, numerous studies have highlighted that displacement-related stressors could have a significant impact on psychological and physical wellbeing of refugees (Miller & Rasco, 2004; Teodorescu, Heir, Hauff, Wentzel-Larsen, & Lien, 2012).

The psychological distress of loss and cultural transition is often not experienced on an individual level. Instead these factors can alter family patterns of interactions, roles, and boundaries between family members. Therefore, the task of adaptation has often proved to be challenging not just for the individual, but for the entire family unit. The process of resettlement to the host country requires families to adapt to the culture and language demands of the host country, maintain family cohesion, and meet the psychosocial and social needs of family members (McBrien, 2005; Smith, 2008).

Although the three migration points occur in different contexts and times, they are critical in understanding how past and present as well as personal and environmental contexts may have impacted the overall psychological health and acculturation process of refugee families. In the case of Somali refugees resettling in the United States, the differences in socioeconomic and cultural values and norms likely influences how they make adjustments to their new environment (McGown, 1999). Furthermore, the experiences of trauma and loss during the pre- and trans-migration stages of resettlement, may continue to impact the individual and family unit, may reduce their ability to cope with new stressors, and may interfere with their ability to access personal and the environmental resources they encounter once resettled. Much of early research focused primarily on the pre-migration experiences in relation to refugee psychological health, however over the years it has become clear that the psychosocial stressors encountered by refugee families after they were displaced also can have a significant impact on their mental health (Miller & Rasco, 2004).

Family and Post-Migration

One important component of refugee resettlement is the role of the family. As refugee families resettle in their new communities, the individual stress of trauma, adjustment, and lack of access to resources can be exacerbated by the challenges that surface within families. Parents often face significant challenges in their roles as parents in a new country (BRYCS, 2014). Many refugee parents are surprised when they discover that the rules and expectations handed down through generations not only no longer apply to their life in the United States, but can also serve as barriers to success for themselves and their children (BRYCS, 2014). This discovery can bring tremendous

amount of stress and fear to parents, making them feel as if they may be losing their child to the American way of life.

Through utilization of focus groups with parents from Somalia, the Middle East, and Vietnam, Lewig, Arney, Salveron, and Barredo (2010) identified a number of challenges that refugee parents face in a new culture. The most significant challenges included: changing expectations of their children with regard to roles and responsibilities; understanding the host country's laws and norms with regard to parenting; the influence of school and police on their children's behaviors; and changes in sources and structure of social support (Lewig et al., 2010). Similarly, BRYCS (2014) identified parental authority, language barriers and role reversals, intergenerational gap, and roles in the family to be the key areas that posed significant challenges on the parents and the family unit regardless of their level of strength and resiliency.

For many parents, acceptable methods of disciplining their children in their home country may be unacceptable in the United States. As a result, some parents believe they will lose their ability to parent and may struggle to assert their authority. Children learn English quickly in schools, while parents often have a difficulty learning the language. Inability to communicate in English places many parents in a reversed role in which they have to depend on their children to act as cultural navigators and at times make important decisions on behalf of the family (BRYCS, 2014). Similarly, children tend to acculturate faster in comparison to their parents, and they may adopt various cultural traditions and values from their host country. This change can cause stress on parents, as they perceive their children becoming "Americanized," and believe they may be losing them to the host country. These various influences may significantly impact family roles and structure.

The father may no longer be the "breadwinner" because he is unable to find a job, and children may take on a leadership role by acting as interpreters and cultural navigators for their families. New roles can create significant stress on the parents and the children as they attempt to find their place in a new system (BRYCS, 2005).

While the challenges outlined above apply to many refugee populations, they are especially true for Somali refugee parents and their families. According to Mohamed and Yusuf (2011), "one of the most common issues faced by Somali immigrant and refugee families is the conflict between parents and children" (p. 165). The primary source of parent-child conflict is related to differential acculturation in relation to general roles, home expectations, and role-reversal between the parent and the child. Furthermore, past history of trauma among Somali refugees may also influence how family members interact with one another. For example, family members may try to keep their traumatic experiences a secret in an effort to protect their children. However, traumatic experiences can be transmitted trans-generationally and can have a significant impact on ways in which family members interact with one another including their ability to emotionally connect with other family members (Mohamed & Yusuf, 2011).

The Role of Acculturation

Early sociological views presented acculturation as a process of accommodation with assimilation into the dominant culture, while an anthropological perspective described acculturation as a process of interactivity between cultures (Thomson & Hoffman-Goetz, 2009). From a psychological perspective, John Berry developed an acculturation framework that focused on two separate processes, maintenance of the home culture and development of relationships within the host culture. Berry (2005)

proposed that “acculturation is the dual process of cultural and psychological change between two or more groups and their individual members” (p. 698). Berry (2005) identified four acculturation strategies, including, integration, assimilation, separation, and marginalization. Assimilation refers to entire adaptation of attitude and behaviors of the host country. Marginalization occurs when the individual does not identify with either the home culture or the host culture. Separation occurs when the person entirely rejects the host culture and maintains the home culture. Finally, integration refers to process in which the person maintains attitudes and behaviors of their home culture and also adopts behaviors and attitudes from the host country.

Based on this dual process theory, cultural and psychological change take place at both a group and individual level; on an individual level changes occur in a person’s repertoire, while on a group level change involves social structures, institutions, and in cultural practices. The cultural and psychological changes represent a long-term process, sometimes taking years, generations, or centuries. One key feature in the process of acculturation is the variability in which this process takes place (Berry, 2005). Acculturation often occurs at different rates, and with different goals. For many refugee families, the process of acculturation may lead to increases in conflict within families and higher levels of stress as they interact with the demands of the host country. For some, increased conflict and stress occur as family leaders try to counteract the influence of the host country by attempting to preserve the life they have left behind. Psychological adjustment tends to be greatest for bicultural individuals (Hamilton & Moore, 2004; Moyerman & Forman, 1992). Within this framework, refugee families are able to maintain the beliefs and attitudes of their home countries, while accepting certain

attitudes and behaviors of their host country (Moyerman & Forman, 1992). Bicultural individuals tend to have access to more community resources, greater levels of support, and strategies for increasing the physical, mental, and social wellbeing of their families.

Another important aspect of refugee acculturation is community integration. In addition to the increased stress due to cultural and linguistic barriers, refugees face additional obstacles in participating in their neighborhoods and communities. For refugees, integration into the larger community is an important component of acquiring language skills, broadening their cultural knowledge, fostering independence, and finding connections they need in order to access resources such as school, health, and employment services (Goodkind & Foster-Fishman, 2002). In a study with Hmong refugees, Goodkind and Foster-Fishman (2002) found that although Hmong refugees highly valued community participation, access to community resources was difficult due to language barriers, time constraints, and discrimination. Therefore, additional supports and services must be put into place in order to provide refugees with opportunities for community participation and integration.

Emotional Health and Wellbeing

Defining Mental Health

According to the World Health Organization (2013), mental health is not just the absence of a mental disorder; instead it is

> A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. (p. 1)

Although traumatic loss and change are marked characteristics of all refugees and there is a positive association between violence and the development of trauma symptoms, many

refugees exposed to violence do not develop psychological trauma, suggesting the presence of protective factors that may act as a buffer against psychological trauma (Lustig et al., 2004; Miller & Rasco, 2004). Furthermore, there is a high degree of variation in mental illness in refugee population (van Wyk, Schweitzer, Brough, Vromans, & Murray, 2012). It is unclear whether the differences in mental health rates are associated with low incidence of mental illness, lack of access or not seeking mental health services, or simply different definitions and understanding of mental health. Furthermore, elevated levels of traumatic stress may not necessarily imply impaired psychosocial functioning; on the contrary, many refugees may experience elevated levels of trauma, yet still manage to function well in various domains of their lives (Miller & Rasco, 2004).

The primary focus of current and past research on mental health of refugees has been on identifying patterns of psychiatric symptomatology within the framework of approaches and definitions. In fact psychotherapy and psychopharmacology are primarily a European and American phenomena that reflect a Western perspective on the ways in which psychological distress is viewed and treated. However, the majority of refugees who resettle in the United States come from non-Western societies that often have a different understanding of psychological distress and more importantly have alternative methods for treating distress in comparison to Western mental health providers (Miller & Rasco, 2004).

Although difficult to generalize, some of the major differences between Western and non-Western approaches to mental health include the use of traditional healing in non-Western cultures in comparison to professionals with formal education in Western

societies; an emphasis on religious and supernatural explanations for emotional distress in non-Western cultures in comparison to natural/scientific explanations (i.e., psychodynamic, cognitive-behavioral models) in Western cultures; and one's view of self in non-Western cultures is often embedded within the social context, roles, and interpersonal relationships, while Western cultures places more focus on individualism and autonomy (Miller & Rasco, 2004).

With that said, current conceptualizations of refugee mental health tends to focus exclusively on psychopathology and relies on Western ideology to diagnose and treat refugee families. Therefore, while these methods are important, they often fail to consider the strengths and forms of resiliency within refugee communities. Through a primarily Western lens, the following section highlights a growing body of research that examines refugee mental health and the psychological impact of migration and resettlement challenges on refugee families.

Refugee Mental Health

Muecke (1992) argues "refugees perhaps represent the maximum example of the human capacity to survive despite the greatest of losses and assaults of human identity and dignity" (p. 520). The complexity and the severity of the migration challenges that refugee parents and their children face, including forced migration, exposure to traumatic events, and resettlement in an unfamiliar country, makes them highly vulnerable to experiencing and developing psychological distress Fox & Tang, 2000). Psychological distress can be impacted by exposure to political violence as well as migration-related stressors (Miller & Rasco, 2004). Exposure to such distress may exacerbate personal

vulnerabilities (e.g., developmental level and personality traits) as well as external factors such as degree of trauma exposure and acculturation stress.

Living through horrors of war and other forms of political violence clearly takes a toll on one's psychological well-being, however the degree to which refugees develop traumatic symptoms is often dependent on the traumatic nature of exposure to violence, political or otherwise. In addition exposure to violence, numerous studies have found migration related stressors also have a profound impact on the refugees' psychological and physical well-being (Miller, Worthington, Muzarovic, Tipping, & Goldman, 2002). In particular, the psychological stressors associated with post-resettlement related to multiple losses and changes resulting to life in new and unfamiliar settings can result in poorer mental health outcomes. These mental health outcomes include mental disorders, substance abuse disorders, negative behavioral outcomes, early pregnancy, and risk behaviors for HIV/AIDS (McBrien, 2005; Weine, 2011). Current data clearly shows a strong link between ongoing stressors and the development of depression as well as forms of anxiety (Miller & Rasco, 2004). Furthermore, post-resettlement factors appear to be one of the strongest explanatory factors underlying high levels of depression found in refuge studies (Miller & Rasco, 2004).

A growing body of literature has focused on the mental health needs of refugee parents and their children (del Valle, 2002; Ellis et al., 2008; Heptinstall, Setha, & Taylor, 2004; Papageorgiou et al., 2000). Surprisingly, despite the significant distress and trauma that most refugee children and their families experience, there is a great deal of variability in the reported rates of mental illness in both refugee children and adults

(Fazel et al., 2005). Furthermore, of those who may be in need of mental health services, many do not seek services or have little access to them (Ellis et al., 2011).

Most commonly, the symptoms of traumatic stress among refugees have been assessed using the diagnostic criteria of Post-Traumatic Stress Disorder (PTSD). Although PTSD symptoms have been documented in numerous studies of refugees from diverse national ethnic backgrounds, PTSD does not adequately capture the totality of the trauma experience, nor does it negate the possibility that culturally specific expressions of trauma may exist that have little resemblance to the Western diagnostic criteria of PTSD. The migration experience outlined in the previous section, highlights the complexity of the individual as well as community experiences. Psychological trauma should not be understood as an individual phenomenon and instead should be viewed as a psychosocial phenomenon that affects entire communities and their underlying ideology (Miller & Rasco, 2004). Therefore, it is more appropriate to consider PTSD as a construct that exists across different cultures that consists of a set of highly inter-correlated symptoms of distress that may develop in the wake of a traumatic experience over which refugees have little or no control.

With that said, studies have found elevated levels of PTSD, which though variable, are often alarming in comparison to the non-refugee populations (Miller & Rasco, 2004). Among samples of refugee children and adolescents, PTSD rates range from 11.5% to 65.0% (Ellis et al., 2008). Studies of refugee children have shown greater variability of PTSD levels, with a critical factor appearing to be the degree to which children are exposed to acts of violence before becoming displaced (Smith, Perrin, Yule, Hacam, & Stuvland, 2002). Thabet and Vostanis (2000) described these correlations as

reflecting a “dose relationships” phenomenon, in which there is a positive relationship between the number of traumatic events children experience (i.e., high doses of war-related violence) and the severity of their PTSD symptomatology.

One of the most cited studies on the effects of political violence and the migration experience was by Kinzie, Sack, Angell, Clarke, and Ben (1989) who worked with Cambodian refugees in the United States. In their community study of 46 Cambodian youth, 50.0% of the study participants were identified with PTSD at the time of the initial study, 4 years after their departure from Cambodia. More importantly, in a 3-year follow-up study, Kinzie et al. (1989) found nearly identical prevalence of PTSD among these Cambodian refugee youth. In a cross-sectional survey of 364 internally displaced 6- to 12-year-old children and their families from Bosnia, Goldstein, Wampler, and Wise (1997) found that 94.0% of the children met criteria for PTSD. Children with greater symptoms had witnessed death, injury, or torture of a member of their nuclear family, were often older, and came from a larger city in Bosnia. Other studies reported lower rates of PTSD among similar populations. For example, Smith et al. (2002) examined the mental health of 3,000 Bosnian refugee children and estimated the prevalence of PTSD to be 52.0% of the sample.

Similarly, among refugee adults including Somalis, prevalence rates of PTSD have been reported to range from 3.0% to 86.0%, with a similar range (3.0%-80.0%) reported for major depression (Fazel et al., 2005). Similar rates have also been reported for depression in the adult refugee population, with rates ranging from 11.0% to 47.0% (Papageorgiou et al., 2000). Because refugees often experience multiple traumas over a prolonged period of time, there is a greater complexity in the mental health issues

experienced by refugees and there symptoms may be easily exacerbated for years to come (van Wyk et al., 2012). The high prevalence rates of psychological distress and mental illness among refugee populations, as well as the limited access to care, suggests the need for more systemic and culturally appropriate approaches for providing support.

Attitudes and Expression of Emotional Distress Among Somalis

Expression of psychological wellbeing is a socially constructed concept that relies on cultural, religious, and social practices of specific nationalities or ethnic groups. In Somali culture, the concepts of "mental health" and "behavioral health" do not exist (Schuchman McGraw, & McDonald, 2004). Mental illness is viewed as a condition that is present or not; people are often considered "crazy" if they display symptoms of mental illness. Furthermore, it is not uncommon for Somalis to deny a problem when in fact it may be really bothering them.

Somatic symptoms tend to be more common such as headaches, stomachaches, muscle aches, decreased appetite and weight loss or tiredness in comparison to sharing concerns about mental distress (Schuchman McGraw & McDonald, 2004). In addition to the somatic symptoms, flashbacks, cognitive problems such as low concentration, rumination, and poor memory have also been reported. Due to religious beliefs, thoughts of suicide or death wishes may be denied and instead a fatalistic view is taken in which whatever happens is "God's will." Because the family name and lineage carries a tremendous amount pride for the Somali people, the label of "mental illness" may bring great shame to the family and therefore it is avoided and denied under most circumstances (Scuglik, Alarcon, Lapeyre, Williams, & Logan, 2007). The stigma that is often associated with mental illness brings high degree of social isolation to the

individual who is suffering. This isolation can be particularly difficult due to the communal and family-oriented nature of the Somali culture and therefore can worsen the mental health problems (Schuchman McGraw & McDonald, 2004).

When Somalis exhibit mental health symptoms, family members often provide the primary care. They may also seek help from traditional healers, elders, and religious leaders. Seeking assistance from resources outside of the Somali community is considered to be shameful on the person and their family (Schuchman McGraw & McDonald, 2004; Scuglik et al., 2007). Instead, beliefs in supernatural healing, along with Sheik healer, or traditional types of healers known as *minga* or *waddad*, can carry more weight in the Somali culture in comparison to Western forms of medicine, as well as scientific or technological advances (Scuglik et al., 2007). The level of education as well as the past geographical location (e.g., urban or rural setting) of the refugee in Somalia significantly impacts their understanding of the traditional Western view and treatment of psychological distress. For example, those who have lived in more urbanized settings, such as Mogadishu, tend to have a more open view of mental health and have had exposure to medical facilities in comparison to those who lived in tribal villages and refugee camps and have had little contact with Western medicine, more importantly any form of psychiatry.

Coping and Community Supports

Despite the need for mental health services, refugee families may experience significant barriers to accessing those services. These barriers are two-fold because they may be linked to both the personal and institutional migration process and subsequent experiences with institutions. For example, some of the primary reasons that refugees

have not accessed mental health care include fear and mistrust of the system, language differences, pre-occupation and anxieties about immigration status and housing, shame and stigma surrounding mental health care, and lack of collaboration among service providers (Palmer, 2006; Wynaden et al., 2005). Alternatively, others have proposed that the greatest barrier to accessing mental health care can be attributed to one's cultural conceptualization of mental health (e.g., Sheikh & Furnham, 2000).

Health and manifestation of illness are culturally constructed experiences. In fact, Sheikh and Furnham (2000) have argued that the way that people conceptualize their mental health is related to their cultural belief systems. Beliefs in more traditional cultures are often deep rooted and somewhat restricted with religion often playing a significant role in the understanding and treatment of mental illness as compared to a more Western view of mental health. Furthermore, mental health is not understood on a continuum, instead an individual is viewed as either well or "crazy," and there may be limited words to describe mental illness (Ellis et al., 2011). Thus, while refugees are not a homogenous group, and vary in nationality, religious practices, ethnicity, as well as socio-background and culture, many of the groups, especially refugees from East Africa and Southeast Asia, have negative perceptions associated with mental illness (Palmer, 2006; Wynaden et al., 2005). As a result, individuals from these cultural backgrounds tend to demonstrate lower levels of service use and higher rate of morbidity. For some families, ostracism and stigma from community members can bring significant shame to the whole family. In fact, the shame they receive can be viewed as more damaging than not receiving mental health services. For many, seeking mental health services is often

considered the last resort, and many turn to religious or spiritual programs as the primary form of treatment (Ellis et al, 2011; Palmer, 2006).

Parental experiences of adversity and trauma affect children's psychological functioning. In particular, some types of parent traumatic exposure are more strongly associated with children's mental health concerns than are children's own exposure, especially if parents were tortured (Fazel, Reed, Panter-Brick, & Stein, 2012). Therefore, parents' physical and psychological distress can have a strong effect on refugee children's well-being. For example, Mayan refugee girls' symptoms of depression were associated with their mothers' reports of psychological distress (Miller, 1996). Furthermore, refugee parents with poor mental health may also treat their children more negatively as was noted in one study of Cambodian refugees who directed feelings of anger towards their children (Hinton, Rasmussen, Leakhena, Pollack, & Good, 2009). Evidence also suggests that higher levels of vulnerability persist for the next generation; children born to refugee parents are at increased risk of developing psychotic disorders in comparison to the native population (Fazel et al., 2012).

Conversely, social support and higher rates of parent well-being have been identified as important protective factors for refugee children (Lustig et al., 2004). In fact, it has been suggested that "the single best way to promote psychosocial well-being of children is to support their families" (Ogata, 1994, p. 15). However, parent support can be threatened by the many post-resettlement challenges experienced by most refugee families. Many refugee parents develop feelings of losing their children in America. Refugees are often surprised that the rules, values, and expectations passed down from generations in their own culture no longer apply to their life in United States. Children

learn English quickly in schools and tend to acculturate faster to their new way of life. As they are immersed in school settings each day, they tend to adopt American social practices, while their parents tend to retain their traditional values and beliefs. As a result, their parents may experience painful role reversal and may be forced to depend on their children for translation as well as all other cultural bridging. These changes can often disturb the family's cultural bonds and patterns of authority (BRYCS, 2014).

The resettlement challenges experienced by refugee families can impact their coping styles and more importantly their family bonds. Furthermore, as suggested in previous sections, coping styles can also be threatened by the degree of psychological distress and post-resettlement challenges families' experience. Barriers in accessing mental health services may prevent families from developing adaptive ways of addressing acculturation challenges as well dealing with their past experiences of trauma. Due to these barriers, lack of treatment may have significant negative long-term effects on the wellbeing of refugees including their physical and psychological health. Furthermore, refugee children may be at increased risk of negative outcomes, including psychopathology and academic failure (de Anstiss & Ziaian, 2010). These negative effects can expand beyond the individual by increasing risk of family stress, school problems, and delinquent behaviors (Fazel & Stein, 2002).

Bridging the Gap

As practitioners, we may know the science behind Western practices, however if we want to reach out to the Somali refugee community, the Western way of addressing mental health promotion and treatment may not be the best solution. It appears that clinic-based services are not especially efficient for reaching refugee populations, nor

well matched to the worldviews of the population we intend to serve. This does not imply that therapy and medication have no place in treating distressed refugees. Instead, it suggests that a more comprehensive, flexible model that bridges different cultural ideals must be adopted to adequately respond to the mental health needs of refugee populations.

Disconnect Between Current Practices in Treating Refugees

When describing the refugee family experience, Morland, Duncan, Hoebing, Kirschke, and Schmidt (2005) note, that there is

> Potential for tragic consequences to newcomer refugee families when cultural differences, misunderstandings, language barriers, and lack of cooperation exist between public child welfare, newcomer refugee families, and refugee serving agencies. (p. 793)

The disconnect between a Western understanding of mental health and illness in many ways could not be further from the Somali practice of reliance on religious and cultural practices. Given the broad exposure to trauma and post-resettlement stressors in the lives of refugees, treatments beyond those offered by traditional clinic-based mental health services are needed. For example, according to Miller and Rasco (2004) these services may include development of social networks that may decrease the risk of isolation; identification of new social roles that may aid in providing new meaning in people's lives; enhancement of skills and resources that may increase access to health services, access to education, employment, and legal status; and increasing social ties to communities that have been overshadowed by fear, mistrust, and violence.

Miller and Rasco (2004) have argued that there may be a strong link between mental health and ability to effectively address post-resettlement challenges. Therefore, refugee mental health services require a broader, a more holistic approach rather than a

narrow approach that only focuses on the individual. According to Birman et al. (2008), refugee mental health services should be addressed within the context of acculturation and resettlement with families, schools, and other settings that refugees interact with on a daily basis. Therefore, resourcing out to the family unit and community where refugees work and live may be an important component of treating the individual. It is in the community where one may work to build a bridge between the two cultures and promote psychological wellbeing as well as understanding and treating psychological distress. Furthermore, it is in a community setting that mental health professionals can begin to provide family outreach and address the distress experienced by refugees from an ecological framework. Within this framework, the refugee experience is not viewed as a single event, but a constellation of challenges that include loss, significant change, and potentially trauma based experiences that may be either exacerbated or ameliorated by social supports and access to community services. Furthermore, the family unit represents the key social support and bridge to other community services.

Culturally Sensitive and Adapted Programs

Challenges experienced by refugee families and their children who may be suffering, but are not seeking mental health services, calls for building preventive approaches for refugee mental health. According to World Health Organization (2004) mental health prevention aims at

> Reducing incidence, prevalence, recurrence of mental health 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. (p. 17)

Utilizing prevention approaches with the refugee population may enhance protective family and community resources that can stop, lessen, or delay mental health concerns in individuals and families.

Therefore, preventative mental health approaches must address issues across the range of challenging environments including family and ecological factors faced my refugee children and their families. According to Birman et al. (2008), "a coordinated comprehensive treatment model is more likely to meet the diverse needs of refugee children and families and to be more acceptable to them" (p. 123). A comprehensive treatment model that is multicultural in nature may be particularly appealing to refugee families due to their prioritization of survival and economic challenges over psychological concerns (Birman et al., 2008). The World Health Organization (2004) notes that effective prevention programs build upon existing protective resources that are associated with the family as well as their surrounding community.

A common element in various prevention and treatment approaches with traumatized refugee populations has been psychoeducation (Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004). Lukens and McFarlane (2004) define psychoeducation as a treatment modality that integrates both psychotherapeutic and educational programs within a holistic and competence-based approach. Psychoeducation is typically strength based and is considered among the most effective evidenced-based practices that have emerged out of clinical trials and community settings (Lukens & McFarlane, 2004). The goal of psychoeducation is to help individuals understand difficult and emotionally loaded information and to help the individuals be able to use that information in a proactive manner (Lukens & MacFarlane, 2004). In other words, psychoeducational

techniques help individuals understand mental health concepts or experiences in relation to other systems (e.g., family, school, health care providers). This approach is especially important for the refugee community in which community resources are an essential component of their everyday functioning and there may be stigma associated with addressing mental health concerns directly.

Psychoeduational groups have been used with other refugee populations to address a variety of psychological concerns and to promote wellbeing. For example, Akinsulure-Smith (2009) studied the outcomes of delivering support through a psychoeducational group with refugees between the ages of 17 to 21 from Sierra Leone, Haiti, Bosnia, Guinea Bissau, Albania, and Colombia to address re-traumatization of these students after the September 11th, 2011 tragic event in New York City. The goal of this group was to provide coping skills and emphasize resiliency and social support. Although no formal assessments were utilized, participants reported learning simple coping strategies for emotional and behavioral relief in the group. They also reported that the group helped them manage their psychological distress more effectively (Akinsulure-Smith, 2009). In another study, Uitterhaegen (2005) described a psychoeducation and psychosocial support program in Netherlands for adult refugees and asylum seekers. Refugees who were trained in the native language and culture of the refugee community facilitated the program with a professional coach from a local mental health institute. The goal of the group was to provide psychoeducation, psychosocial support, and empowerment while raising awareness of topics such as trauma, acculturation, mourning and loss, stress, feelings of guilt, as well as alcohol and drug abuse. Participants in the program reported feeling “lighter” after their session and noted feeling a sense of relief

that others were experiencing similar challenges, and they described themselves as less agitated and more trusting of other people. Furthermore, participants reported that they gained more knowledge of psychological problems and reported less stigma surrounding mental illness and the Dutch health care system (Uitterhaegen, 2005).

Therefore, providing prevention based services with a focus on psychoeducation in a community-based setting that addresses the post resettlement challenges experienced by most refugee families may be one avenue of addressing family social support, increasing knowledge and attitudes concerning trauma and mental health, and increasing families' access to community engagement and service utilization. Community-based settings, such as refugee community organizations which are established and organized around various minority groups are often considered to be the voice of its community and to be representative of the its refugee members (Hopkins, 2006). Refugee community organizations are often considered to be a trusted place for many refugees. Therefore, providing preventive services with a focus on psychoeducation in a community-based setting such as a refugee center may help reduce refugee families' negative perceptions surrounding mental illness and increase the likelihood of their completing such a program.

For Somali refugees, utilizing a psychoeducational approach may be a way to allow Somali parents to develop a bicultural understanding of emotional wellbeing and health, in which they can find a balance between Somali cultural norms and values as well as understand Western approaches to mental health and sources of support in their communities. Furthermore, providing psychoeducation may also help in reducing mental health stigma in the Somali community and more importantly increasing treatment

outreach for refugee children and their families who may desperately need mental health services.

While there are numerous studies that have examined effectiveness of prevention programs with refugee children across various settings (Barrett, Moore, & Sonderegger, 2000 Rousseau & Guzder, 2008), there has been less focus on prevention approaches and effective practices when working with refugee families (Lewig et al., 2010; Weine, 2011). Studies that have examined family-focused prevention programming have addressed post-resettlement and acculturation challenges through a strength-based approach. For example, the Coffee and Family Education and Support (CAFES) program was developed for Bosnian refugee families who had family members who were suffering but had not sought out mental health services. This program was designed to offer support and education that served three primary functions: helping families find support from other families, facilitating family-group cohesion and supports, and helping families build knowledge and skills as a means for strengthening them (Miller & Rasco, 2004; Weine et al., 2006). According to Weine et al. (2008), the CAFES multifamily program was effective in increasing families' access to mental health services. Another multifamily-focused program, Tea and Family Education and Support (TAFES) was designed for refugees from Kosovo with a goal to help families with issues of family cohesiveness, adjustment, and dealing with life-transition (Weine et al., 2003).

Designed specifically for African refugee parents, the African Migrant Parenting Program in Australia identified its goals such as enhancing effective parenting and relationship skills in order to help parents understand their children's needs as they move through various developmental stages in new social, cultural, and education environment

(Renzaho & Vignjevic, 2011). Participants included refugee parents from Democratic Republic of Congo, Burundi, Liberia, and Sierra Leone. Utilizing a "Parenting in a New Culture Guide" parents attended eight culturally competent parenting skill sessions. Authors used the Adult-Adolescent Parenting Inventory (AAPI-2) to assess the effectiveness of the program. The program was found to be effective across all four parenting areas assessed, including, parent expectations, empathy, styles of punishment, and parenting role (Renzaho & Vignjevic, 2011).

Furthermore, Bridging Refugee Youth & Children's Service (BRYCS, 2005) released a report in which they interviewed the directors of 28 parent-strengthening programs across 13 states. The report outlined parent challenges, the role of parent services, the role of evaluation, and resources that were helpful in carrying out an effective refugee parent education program. Although the programs varied greatly, there were several consistent themes across each of the parent strengthening-programs. Most programs appeared to be culturally specific (i.e., providing services for a specific ethnic group) to the refugee group, and the themes addressed included helping develop parenting skills, providing information about child abuse laws and the school system, and providing ELL classes.

The primary factors that have been addressed in prevention studies with refugee families tend to include parental social support, knowledge and skills of parents, communication patterns between the parents and their children, links between family members and mental health organizations, and links between families and service providers, including schools (Weine, 2009). Furthermore, spanning over 20 years of research with families from Bosnia, Liberia, Burundi, Kosovo, and Somalia, Weine

(2011) has found that ethnicity, culture, and social context all play important roles in developing family-focused programs with refugee families. Further, an earlier BRYCS (2005) report proposed that effective programs with refugee parents share the following characteristics: (a) parents are involved in the development and implementation of the program; (b) community leaders are engaged in the early phases of development; (c) potential barriers to attendance are addressed; (d) culturally competent practices are implemented that start with "where the client is;" (e) concrete and experiential methods are used to teach about parenting in the United States; (f) parental authority is reinforced; and (g) the program is strength-based and helps decrease the acculturation gap.

Developing and disseminating family-focused programs with refugee families is essential to ensure that refugee families are receiving adequate supports and care. There are key program characteristics that should be considered when developing these types of programs. Weine (2011), identified eight key program characteristics that seem to be consistent across several refugee studies, these include, feasibility, acceptability, prosaicness (i.e., whether the refugee parents able to comprehend the program), culturally tailored, multilevel (i.e., the program addresses multiple family needs), time focused, effectiveness, and adaptability. The program proposed in this research will utilize many of these characteristics including, feasibility, acceptability, prosaicness, culturally tailored, time-focused, and multilevel.

The culturally tailored characteristic is especially critical in implementing programs with refugee families. Birman et al. (2008) echoed the importance of understanding the specific cultural and social needs of refugees. She argued that we first have to understand refugees' mental health and the challenges in providing refugee

services, in order to accurately reflect the cultural and contextual factors that may be impacting them (Birman et al., 2008). With that said, there is a significant need for culturally-specific parenting programs with refugee parents (Weine, 2011).

Only a few parenting programs have addressed the specific needs of Somali parents (Reincke, 2011). Those that have been implemented have primarily provided psychoeducation around parenting techniques and the acculturation gaps that can develop between parents and their children. While these are vital components of parent or family-focused programs, little focus has been directed toward incorporating more of a mental health awareness component with Somali refugee parents. More specifically, there is little understanding about how implementing parenting psychoeducation, acculturation, and mental health awareness with refugee parents may impact parents' awareness of mental health needs, family cohesion, and access to social supports and community resources. Using an ecological framework, a Somali parent-training program may help to assist Somali parents in bridging the gap between Western and non-Western understandings of family health, family transition to the host country, and community integration.

Conclusion

Refugees have been described as "normal people living under abnormal circumstance" (Papadopoulos, 1999, p. 111). They are forced to leave their home and begin a new life in an unfamiliar place with new laws, traditions, and language. For Somali refugees living in the United States, the history of trauma, including living in refugee camps for years, separation or loss of loved ones, exposure to violence, and loss of food and shelter is exacerbated by the challenges they face once they resettle in a host

country. These challenges include employment, acculturation, access to resources, and understanding the new dynamics of the family unit. For Somali families, one of the most common issues post-resettlement is conflict between parents and children (Mohamed & Yusuf, 2011). For many parents, their identity as parents may not have the same clarity as it once did. Stress of parental authority, language barriers and role-reversal, acculturation gaps, and changes in the structure of the family, can provide significant disequilibrium with the family unit and can cause tension and anxiety for both parents and their children (BRYCS, 2014). As a result, the challenges of post-migration can add more stress and anxiety to the trauma experiences they left behind.

Unfortunately, Somali refugee families do not tend to seek outside services or supports due to a lack of adequate services for the refugee community, cultural barriers, problems with accessibility, and the high degree of stigma that is placed on mental health problems within the Somali culture (Bentley & Owens, 2008). Because of the gap between Western notions of mental health and that of the non-Western world, current practices with refugee communities are beginning to shift toward more community-based preventive approaches with refugee families that enhance individual and community protective resources through a culturally specific lens. By promoting family functioning and addressing supports across broad systems (e.g., family, peers, and community), the goal is to reduce the risk of mental disorders and behavioral problems in children, and help families address their resettlement challenges.

Culturally specific programs designed for Somali parents are limited and those that have been developed have focused exclusively on parenting skills and acculturation. There has been little or no emphasis on helping parents understand and navigate the

psychosocial challenges experienced by both themselves and their children, nor has there been a focus on ways of accessing mental health services when necessary. Therefore, through the use of psychoeducation the current study attempted to build a bridge between traditions, beliefs, and values of the Somali parent community with those of their host community in relation to family transition, family health, and community integration.

CHAPTER III

RESEARCH METHODOLOGY

The current study utilized qualitative methodology to explore the experiences of refugee Somali parents throughout an 8 week Somali Parent Program. According to Denzin and Lincoln (2011),

> Qualitative research involves an interpretive, naturalistic, approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them. (p. 3)

In essence, qualitative researchers explore ways in which people make sense of their world and their experiences. In fact, qualitative methodology emerged by asking people questions about their lives and their social and cultural contexts. It is rooted in social and behavioral sciences including anthropology, sociology, and psychology (Merriam, 2009).

Most researchers who study the experiences of refugee populations have utilized qualitative approaches (Khawaja, White, Schweitzer, & Greenslade, 2008; Warfa et al., 2006). Qualitative methods provide richness and detail that allows for an understanding of how people interpret their experiences, how they construct their worlds, and what meaning they may attribute to those experiences (Merriam, 2009). Qualitative methods encompass multiple philosophical orientations and approaches including positivist and postpositivism; social constructivism; critical theory; and postmodern or poststructural orientation (Merriam, 2009). For this study, I chose the social constructivist framework because it assumes that there are multiple realities and interpretations for every single

event. Furthermore, it assumes that researchers do not find knowledge but instead construct it through others' experiences (Merriam, 2009).

Multiple philosophical orientations, perspectives, and disciplines have contributed to the array of interpretations and understandings of qualitative design. However, Merriam (2009) outlined several characteristics that were key to understanding the nature of qualitative research. First, there is a focus on meaning and understanding. The primary goal is to understand the phenomenon from the participants' perspective in order to gain insight into how they interpret their experience, how they construct their worlds, and what meaning they attribute to their experiences. Second, the researcher is considered to be the primary instrument for collecting and analyzing data. Third, the qualitative process is inductive. In qualitative research, the researcher builds towards a theory through observations, interviews, or documents to generate larger themes. Finally, the product of qualitative inquiry is rich with descriptions.

Because qualitative methods are used in a variety of fields and disciplines there is need for different types of qualitative research. In fact, there are over sixteen different theoretical traditions identified in qualitative research, but the most commonly used approaches in the social sciences and applied fields of practice include narrative research, phenomenology, grounded theory, ethnography, and case study (Creswell, 2013). Narrative research allows the researcher to analyze individual's stories, phenomenology focuses on the exploration of one's experience, ethnography attempts to capture the culture of a particular group, case study analyzes a single bounded system, and grounded theory seeks to develop a theory. Each of the theoretical approaches could be used to highlight a different aspect of the Somali Parent Program. However, in order to fully

capture the essence of Somali parents' experiences in the program, I chose phenomenology as the theoretical approach for this study in order to develop a deeper understanding of member's experiences within their communities as well as within this context.

Rationale for Study Design

Phenomenology is a "study of people's conscious experience of their life-world that is their everyday life and social action" (Merriam, 2009, p. 25). From a phenomenological perspective, the experiences of different individuals are analyzed and compared to examine the essence of the phenomenon. As highlighted in Chapter 2, refugee experiences span across the person, the family, the community, and broader social-political contexts. Therefore, a phenomenological approach highlights the salient experiences of refugees that may otherwise be overlooked. Psychological phenomenology explores "what" the participants have experienced, and "how" they have experienced it (Creswell, 2013; Moustakas, 1994).

Given the cultural and language differences that exist between Somali refugee parents and the United States culture, it was especially important that I captured the process of implementing this support program as well as Somali refugees' experiences of participating in the parent program and incorporating their perspectives and voice. Furthermore, Somali culture focuses on storytelling, in which the sharing of stories from one generation to the next brings a significant amount of pride to Somali families (Putman & Noor, 1993). Therefore, utilizing the phenomenological perspective to explore "what" the Somali parents experienced by being part of the Somali Parent Program (SPP) as well as "how" they experienced being a member of the group seemed

the most natural, culturally congruent way of capturing the meaning of each family's experience. Therefore, this phenomenological approach focused on exploring Somali parents' experiences in attending the group in relation to family transition, family wellbeing, and community integration.

Researcher Stance

Although much of my research experience has been devoted to understanding the acculturation process of refugee children and their families, my understanding and commitment to this population resonates much deeper. I am a refugee myself, who moved from the war-torn country of Bosnia & Herzegovina at the age of 10. Although my story may differ from those of the Somali women, I have learned that we often share similar highs, similar lows, and most importantly, myself and my family understand what it feels to leave everything we have ever known to start over in a new place, new culture, and to begin a new way of life. Over the last 18 years, I have watched my parents overcome tremendous challenges in order to provide a better life for their children. My brave parents are the reason I am here today. Through my work with refugee families as well as my own bond with my family, I have witnessed time and again the degree to which family protective factors such as family cohesion and support can facilitate healing and overall adjustment. Therefore, I genuinely believe that if we can work to empower refugee parents, we can help them to support their children and lead to positive outcomes for both themselves and their children. I am passionate about working with refugee families because it gives me energy and hope, in knowing that I can help make a positive change in the lives of those who have been robbed of everything but their spirit to live.

As a refugee myself, I held certain assumptions and biases that I brought to this study. First, my own refugee migration experience may have influenced how I perceived and understood others' experiences. Second, although I am a refugee myself, I view and understand the world through a western lens in comparison to the refugee mothers who participated in this study. Furthermore, my values, traditions, and cultural and religious beliefs are very different from the mothers who attended the group. Finally, I came to United States as a refugee child not a refugee parent and a mother, therefore my understanding of the resettlement challenges are from the child's view and not one of a parent. Throughout the implementation of this program, it was very important for me to share and to build trust with these women without placing my own views, biases, and assumptions on their experiences.

Finally, it is important to note that at the time that the study was conducted, I sat on the Board of Directors for the World Refugee Center (WRC; the name used in this study is a pseudonym in order to protect the identity of the participants and the center). This was the organization where the participants for this study were recruited and where the program was implemented. As a Board Member, I recognized that my position could have been perceived as one of authority and therefore it was important for me to separate my role as a Board Member, from that of a researcher in this study. In other words, at no point in this study, did I use my position to coerce participants to participate in the study, or to suggest that they would receive more or less support from the center. Furthermore, because of my position, I needed to be aware of how participants might have perceived me throughout the process of implementing the study and collecting data.

Program Interpreter

Farha Abed (pseudonym), a cultural-navigator at the local World Refugee Center (WRC), was recruited to act as a co-facilitator for the SPP, an interpreter, and a cultural-broker throughout the implementation of the program. Ms. Abed is Somali and is 18 years old. Ms. Abed moved to the United States from Somali when she was a little girl and is proficient in both Somali and English. She was a wonderful fit for this position because she identifies herself as Somali, but has been immersed in the culture of the United States and this specific community for over five years. Due to her age and experiences, Ms. Abed provided important input on the experience of Somali children growing up in a host country, including their relationship with their parents.

Context and Participants

All participants in this study were recruited through the WRC. The WRC is located in a small city in a western state. According to U. S. Census Bureau (2010) the current estimated population of this community is slightly less than 100,000. Although the majority culture identified as White (79.0%), the rest of the population was comprised of 1.7% African American, 1.2% Native American, 1.3% Asian American, and 3.4% were from 2 or more races. Hispanic or Latino of any race made up 36.0% of the population. The community median household income is $44, 226 and 23.5% of the population is considered to be below poverty level.

The WRC is a nonprofit agency that serves refugee populations in the local community. Five members of the East African community first established the World Refugee Center in 2008. Although it was known under a different name at that time, its purpose was to address the challenges refugee newcomers faced in adapting to their new

life in the United States. This organization was also established to help educate the receiving community about refugees and their new role in the community. As the refugee community grew, the center realized that they were no longer serving just members of the East African community, but newcomers from over 20 different countries. In 2011, the center's directors adopted a new name (WRC) to better reflect the populations that were being served. Today this organization provides classes for English as a Second Language (ESL), GED, and Citizenship for refugee adults. They also provide case management, employment assistance, women's health classes, and provide healthcare referrals. For children, the center offers a day care services for refugee families who attend the ESL classes at the center. Currently, there are over 2,600 refugees living in the community. In 2014, 806 refugees accessed the WRC from 30 different countries including approximately 35.0% from Somalia, 17.0% from Burma, 17.0% from Mexico, 9.0% from Eretria, and 8.0% from Ethiopia. Services have also been provided to a smaller number of individuals who come from Sudan, Tanzania, Thailand, Guatemala, Afghanistan, Kenya, and Libya.

Purposeful sampling was used as a way to select information-rich cases that would provide great detail and depth to the parent group. According to Creswell (2013), these are individuals who are selected because they can provide an understanding of the research problem and the phenomena being studied. The criteria to be a participant included that the participant have (a) a refugee status, (b) Somali ethnic background, even though they may have lived in a refugee camp in other countries for most of their life, and (c) have children or are considered to be a caregiver for a child or children. No restrictions were made on the age of their children or the number of children.

Furthermore, each family unit or household was counted as one participant. Therefore, if both a mother and father had attended the parent program, they would have been considered a single participant because they came from the same family unit.

Participants in this study included 10 Somali refugee mothers between the ages of 29 and 55. After completing the initial interview, one of the participants dropped out of the study because she was pregnant and gave birth shortly after the initial interviews were completed. This participant did not attend any of the program sessions and was not included in data analysis. Because they were recruited from the WRC, all of the participants were considered refugees under the federal definition. Participants were not required to show any additional paperwork to prove their immigration status. Additionally, while I hoped to recruit a diverse group of participants based on the amount of time they have lived in the United States, membership was open to anyone who met the criteria outlined above. Most of the participants had received some type of service through this agency (e.g., language classes, employment support, referral to health care). Each participant was compensated up to $80.00 for attending the Somali Parent Program. For each session that the participant attended, they received a $10.00 gift card at the completion of the program.

Data Collection

Data were gathered through initial and concluding interviews with program participants, videorecordings of the sessions, and other sources of information gathered throughout the study (e.g., field journal, co-facilitator interview, artifacts). Additionally, a brief demographic questionnaire was completed prior to the start of the SPP. The initial interview and demographic questionnaire were only administered to the original group of

participants who expressed interest in the program, and not to individuals who began attending the group at a later date.

Interviews (Initial and Concluding Interviews)

The initial interviews focused on participants' current family resettlement experiences as they transitioned to the United States with specific emphasis given to the topics of family wellbeing and family connections to community social supports and resources (see Appendix A). The information collected during this interview was used to inform program sessions as well as the data collected during the focus groups and interviews after the completion of the program. Each interview lasted approximately 30 minutes and was conducted by myself with the assistance of an interpreter (i.e., Ms. Abed).

Concluding interview questions (see Appendix B) were developed to help participants reflect on their experience in SPP, including the aspects of the program that they found to be important. This interview focused on the role of SPP in helping members understand their emotional health, family relationships, and community involvement. Questions such as, "What aspects of the program stood out for you?" "When you think about how you were with your children prior to the group, how have things changed after the group?" and "How might you describe this program to other Somali parents?" were asked. Data collected throughout the program implementation including artifacts, facilitator journal, and each session video recordings were also used to create additional questions to be used during the concluding focus groups.

Demographic Information

Prior to the start of the group, a brief demographic questionnaire was completed (see Appendices C and D). Participants were asked to provide demographic information about their age, gender, ethnicity, religious background, highest education attained, date of arrival to the United States, primary language spoken, length of time in a refugee camp, as well as number and age of their children. This demographic survey was provided to the original group members and not to those who joined the group after it had officially started.

Video Recordings

With the permission of the participants, video recordings of each group session were recorded throughout the 8-week program. In order to capture all of the participants during each of the recordings, the camera was placed in the front corner of the room. For each session, the recording started during check-ins and after each participant had come into the room, got their food, and sat down. The recordings were stopped after each session's closing remarks. These video recordings were reviewed after each session as a way for the researcher to consider particular comments, discussions, or behaviors that occurred during the session to look for any emerging and interacting themes. Due to technical difficulties, the first session was not recorded, however all other session were recorded resulting in a total of 14 hours of recording.

Artifacts

Artifacts included both attendance sheets as well as any tangible material that the participants created during the parent group sessions. Collecting data on attendance ensured that I had accurate information about how many participants attended each of the

sessions. In addition, it helped to generate trends on who attended and how many times in relation to their participation in the group and overall experiences in the group. Other artifacts included tangible materials such as the family tree, parent mask, community genogram, and photolanguage cards. Photolanguage cards are a set of 130 black and white photographs that represent various aspects of the human condition (i.e., happiness, grief, sorrow, anger, content, etc.). These cards were used at the end of the program to elicit discussion about the participants' experiences throughout the 8-week period. Participants could take the artifacts that were developed during each session home after photographs of each of them were obtained at the end of sessions to use for data analysis.

Facilitator Journal

A facilitator's journal was used to record aspects of the program implementation and participants' responses to various activities and topics. The primary purpose of the facilitator journal was to summarize my impressions of each of the group sessions. This summary focused on providing an overview of the session (i.e., material covered and overall review of the session); observation of participants' verbal and physical responses during group discussions, level of engagement, and general mood throughout the session. Additionally, an overall assessment of the session and the participants' responses to the topic and activity was noted. The facilitator journal was completed immediately after each group session. The facilitator journal was used to generate common themes across the sessions and included the following elements: (a) a highlight or overview of the session including a summary, (b) observation participants' verbal and physical responses, and (c) a general assessment of the session.

Co-facilitator Interview

The program interpreter, Ms. Abed, was an integral part of the development and implementation of the program. She was present for every interview and program session as well as served as a cultural navigator throughout the program implementation. During each session, Ms. Abed provided consecutive interpretation in which she would stop the participants or myself every 1 to 5 minutes or at the completion of a thought to render what was said into English or Somali depending on who was speaking. At times she jotted a few notes down in order to remember what was being said. At the beginning of the program she often had to stop the participants in order to have the opportunity to interpret, however over time the participants grew more aware of her presence and her role. After the completion of the program, I interviewed Ms. Abed to gain a better understanding of her experience in the program. The interview questions focused on her program expectations prior to the start of the program, challenges that she experienced as an interpreter, and what she enjoyed the most about the program.

Procedure

Prior to data collection, approval from the University of Northern Colorado's Institutional Review Board (IRB, see Appendix E) was obtained as well as from the directors of the WRC. Once this approval was obtained, recruitment of participants was initiated. The study consent form (see Appendices F and G), along with the demographic survey and any other information distributed to the participants throughout the parent program were translated from English to Somali. Using a forward-backward translation method, all documentation was first translated into Somali and then back translated into English (without seeing the original). The back-translation was compared with the

original English measure and any discrepancies between the translated and the original version were resolved between the two translators. The translators who examined the survey and consent form were Somali community members who were employed by the WRC to translate immigration, employment, and health documents.

Potential participants were invited to take part in this project in collaboration with Mohammad Ali (pseudonym), co-director of the WRC. Mr. Ali acted as a cultural broker in helping the participants understand the purpose of the study. He answered any questions they had and explained aspects of the project in a culturally relevant manner. Ms. Abed also assisted in recruiting participants and serving as an interpreter for all data collection and the program sessions.

The program was originally conceptualized to be delivered to both parents (mothers and fathers). However, after reviewing the program's goals and the topics that would be discussed during the 8-week period with Mr. Ali and Ms. Abed, it was determined that a mother's group only was more culturally appropriate for this Somali community. Both Mr. Ali and Ms. Abed believed that a mother's only group would elicit richer discussions, in which the mother's would feel more comfortable to share personal stories as well as ask questions. As such, Somali mothers were invited to participate in the SPP during their English Language classes at the WRC. With Mr. Ali and Ms. Abed acting as interpreters, I visited three English classrooms (classes that represented different levels of English proficiency) and shared about the program and asked if any individuals were interested in participating. Mr. Ali and Ms. Abed acted as the primary interpreters during these presentations. For those individuals who expressed interest, I wrote down their names and contact information. A type of snowballing procedure was used in which

class attendees were asked whether they knew of others who might be interested in attending the SPP. Furthermore, Mr. Ali and Ms. Abed also helped to find eligible participants through conversations with Somali community members who had expressed a desire to be a part of a parent program in the past and were not present in the English classes I attended.

Once a sufficient number of potential participants was identified ($N = 10$), interviews were scheduled with each individual who expressed interest in participating. Although, the original plan was to complete the interviews in the participants' homes, it was later determined that completing the interviews at the WRC would be easier for the participants. These interviews were scheduled across multiple days to coincide with participants' English classes. Due to scheduling conflicts and participants' comfort level, some of the interviews were completed in small groups of 2-3 participants rather than individually. Ms. Abed assisted in scheduling the interviews and served as the primary interpreter with potential participants. During this meeting, I shared the goals of the program, worked to establish rapport with the mothers, assessed family barriers to participation, and invited the mothers to attend the SPP. If the mothers agreed, they were asked to provide verbal consent and Ms. Abed administered the demographic survey.

Following the administration of the demographic survey, a semi-structured interview was conducted with each participant to gather information related to the family's transition process to the United States, their beliefs surrounding health and wellbeing of their family, and the social and community supports and resources that they currently utilize. These interviews lasted between 15 to 30 minutes and were audio recorded if the participant agreed. All participants consented to audiotaping and this

helped to ensure that all information was represented in the most accurate way possible despite the language differences.

Once the group of participants was established and all consents and interviews were collected, the meeting times and dates were scheduled based on participant availability and distributed to all identified participants. The group met on a designated day, once a week, for two hours at the WRC. The group meeting was scheduled from 11:30 a.m. to 1:30 p.m., after the English Language instruction period was finished. Because some participants were not English language proficient, a Somali Cultural Navigator, Ms. Abed, co-facilitated the program. In addition to providing interpretation, Ms. Abed helped facilitate the groups and helped ensure that the content was culturally sensitive and appropriate for the Somali refugee mothers.

Approximately two weeks after the completion of the program, participants were asked to participate in concluding focus groups at the same site as the groups (WRC). These interviews were provided in both group and individual formats and lasted between 45 to 60 minutes. All program participants were invited to be interviewed and several focus group times were scheduled to accommodate as many participants as possible. Three focus groups and two interviews were held to examine participants' experiences in the group and reflect on their family's transition process, family well- being, and level of community integration. Six out of the ten original participants who completed the initial interviews also completed concluding interviews. Additionally, three other participants who joined the program after the completion of the initial interviews were also interviewed. Ms. Abed and myself facilitated the three focus groups and the two

interviews. In order to increase participation in the focus groups, participants were contacted by phone to remind them of the meeting.

The Program: The Somali Parent Program

The SPP was designed as a preventive program that utilized two primary conceptual frameworks, the bio-ecological systems framework and the Prevention and Access Program Framework (PAIF). The bio-ecological systems framework helps to organize the Somali refugee migration and resettlement experience from an ecological perspective in which the individual and the environment interact and have influence on one another. This was an important component of the program because many of the discussions throughout each session focused on parents' interactions across various systems, including their family and community system.

The PAIF model developed by Weine, Kulenovic, Pavkovic, and Gibbons (1998) was the second framework used in this study. PAIF draws upon the family as resource and in using this model the the program was designed to address three primary areas of refugee family resettlement: family transition, family wellbeing, and community integration. Below is a more detailed description of each of the three program components along with the Somali Parent Program Curriculum Outline in Table 1. Additionally, Appendix H provides a detailed lesson plan for each of the eight program sessions.

Table 1

Somali Parent Program Curriculum Outline

Session	Session Content	Session Activity
Initial-Engagement	- Describe the program - Assess barriers to participation - Invite family to the first meeting - Provide verbal consent - Collect pre-treatment assessments	
1. Defining the Family	- Outline structure of the program - Define family - Family story	The Family Tree
2. Family & Transition	- Family post resettlement - Family stressors	Collage
3. Parenting in the Host Country	- Define parent discipline - Culture & discipline - Parent discipline laws	Parent Mask
4. Marriage & Parenting	- Define marriage roles - Program review	
5. Stages of Social-Emotional Development	- Define & discuss stages of social-emotional development	Timeline and Tree of Life
6. Family Health & Wellbeing	- Emotional health & culture - Feeling identification and expression	Vignettes
7. Family Resources	- Define and identify community resources - Set goals for the family	Community Genogram
8. Celebration	- Lessons learned discussion and reflections - Celebrate with food, music and certificates of completion	Photolanguage Cards
Concluding-Engagement	- Collect concluding interviews data	

Family Transition

This component of the program was broken down into four individual sessions. The first session, *Defining the Family focused* on establishing group norms, defining what constitutes a family, and allowing group members to share their family story. The

second, third, and fourth sessions utilized components of the *Parenting in a New Culture: A Guide for Arabic Speaking Parents* program, which has previously been used with refugee parents from Africa (Renzaho & Vignjevic, 2011). Specifically, the second session, *Family and Transition* focused on resettlement challenges within the family context as well as exploring where the group members saw themselves in the family resettlement cycle. To facilitate this session, the "Managing Family Stress" section in the Parents in a New Culture program (Renzaho & Vignjevic, 2011) was adapted and used. In session three, once the parents had identified family stressors, the topic focused on how to discipline children and the laws surrounding discipline in United States. Finally, during the fourth session, the impact of post-resettlement on marriage and spousal roles within the family context was discussed.

Family Well-Being

This component of the program was broken down into two individual sessions. During session five, *Stages of Social-Emotional Development* the participants were introduced to Erikson's (1950) Stages of Social-Emotional Development. In this session, the participants defined and discussed similarities and differences between development in Somalia and western culture. This session was followed up by a lesson on *Family Health and Wellbeing* in which the participants were asked to define emotional and physical health and encouraged to explore attitudes and beliefs surrounding emotional health as it relates to their family units. Participants had an opportunity to compare and contrast similarities and differences between Somali culture and western ideas of emotional health. The specific focus of this lesson was on emotional health as it related to

parent-child interactions. For example, one of the discussions centered on exploring ways to communicate feelings with children.

Community Integration

This lesson centered on exploring Somali mothers understanding and beliefs around the role of communities and their level of community involvement in the United States. More specifically, during the *Family Resources* lesson, the participants defined what constitutes a community and described similarities and differences between their community in Somalia and their community in the United States. Following this discussion, the participants created their own community genograms in which they identified various community supports and resources including their children's school, place of worship, medical and health centers, local police centers, employment offices, and refugee resource centers. Once they identified various community resources, the participants were asked to identify the type of relationship they had with each of those resources including, positive supports, problematic supports, and distant supports. The community genogram activity facilitated a rich discussion about community resources that the participants found helpful and those that they found challenging.

Celebration

In the final session, participants had an opportunity to reflect on the lessons learned throughout each of the sessions. Somali culture highlights the importance of oral storytelling and poetry is a primary source of storytelling in the Somali culture. Therefore, it was originally planned that during the final session, participants would be asked to reflect on a lesson and share some aspect of their learning that they would like to pass on to other refugee families. Each participant's feedback was to be recorded and

transformed into a poem encompassing the lessons of all program participants. However, it was later decided that photo language cards might be more useful to help participants reflect on their experiences in the program. Photo language cards are 130 black and white photographs that are designed to facilitate personal expression and communication through vivid images that exemplify various aspects of the human experience that represent both positive and negative emotions. Participants was asked to choose two photos, one that represented them prior to the start of the group and one that represented them at the completion of the program. Each participant shared their images with the rest of the group. In addition to the poem, certificates of completion were also distributed to each of the group participants.

Each session was divided into four components. The first component was the entry phase that included an initial check-in time in which participants were welcomed and attendance was taken. During this time, group members treated themselves to Somali food, they joined the group circle (i.e., chairs were set up in a circular format), and chose a feeling card that represented how they were feeling that day. After each participant shared their feeling card with the group, the second component included a psychoeducation presentation or topic that was intertwined throughout and primarily focused on addressing the main points for the session. For example, during the family wellbeing and health session, participants were taught ways to express emotion to their children. The third component was an experiential piece that reflected the psychoeducation lesson. The experiential activity encouraged participants to express themselves through art, music, or storytelling. For example, during the *Parenting in the Host Country* session, parents were asked to draw on a mask how they believed their

children viewed them and how they viewed themselves as a parent. The fourth and final component was a closing discussion in which participants were asked to come together as a group and reflect on the topic or the activity reviewed during that specific session.

Data Analysis

The session video recordings were not transcribed, however each session was reviewed for session content as well as participants' interaction and engagement for each individual session as well as overtime. Additionally, 5 hours and 15 minutes of initial and concluding interviews were collected. Each initial and concluding interview and focus group was transcribed. The resulting 67 pages of transcripts were coded for units of general meaning by two coders, including the group facilitator and an independent coder who was trained in qualitative research. Process notes were also transcribed and reviewed, resulting in an additional 14 pages of transcripts. Finally, artifacts collected during each session provided a richer context for understanding individual members' experiences within a given session.

Phenomenological research means capturing "rich descriptions of the phenomenon and their setting" through a descriptive account of the person's experience (Kensit, 2000, p. 144). For this study, it meant examining individual experiences of each participant and capturing the meaning and the common features of their experience in SPP. Phenomenological researchers argue that in comparison to other methodologies, the phenomenology approach "cannot be reduced to a 'cookbook' set of instructions" (Keen, 1975, p. 41). Instead, data analysis must be receptive to the phenomenon being studied (Hycner, 1985). As such, I chose to adhere to the data analysis guidelines promoted by Hycner (1985) because it allowed me to follow phenomenology principals while also

staying true to the phenomenon being studied. These guidelines involved a 15-step approach, including transcription, bracketing and phenomenological reduction, listening to the interview for a sense of the whole, delineating units of general meaning, delineating units of meaning relevant to the guiding questions, training an independent judge to verify the units of relevant meaning, eliminating redundancies, clustering units of relevant meaning, determining themes from clusters of meaning, writing a summary for each individual interview, return to the participant with the summary and themes, modify themes and summary, identifying general and unique themes for all the interviews, contextualizing of themes, and composite summary (Hycner, 1985). This process is outlined in Appendix I.

As noted earlier in this section, the first step (*transcription)* of the data analysis process involved transcribing all of the pre and post program interviews. The second step (*bracketing and phenomenological reduction*) required myself as a researcher to bracket out my own biases, theoretical concepts, and interpretations so as not to interfere with the themes based on the participants' unique experiences. I listened to the audio recordings from the interviews and the focus groups as well as watched the video recordings of sessions in order to become familiar with the words of the participants and to be able to capture their unique perspectives. I also read all of the interview transcripts and attempted to enter the unique perspective of each of the study participants. After bracketing my interpretations and meaning, I implemented Step 3 (*listening to the interview for the sense of the whole*), which required me to listen and read through the interviews again to capture the sense of the whole. To accomplish this step, I listened and re-read the interviews several times to gain a better sense of the whole interview.

After transcribing the interviews and reviewing them several times for bracketing and gaining a sense of the whole, in Step 4 (*delineating units of general meaning),* I reviewed each word, phrase, sentence in the transcript to capture the essence of the meaning expressed by the participant, while trying to stay close to the literal data. For example, the statement "My experience was like, at the beginning I didn't know and I was in distress and all the things I was going through and the culture shock" was delineated in the following units, my experience was like (unit 1), at the beginning I did not know and (unit 2), I was in distress (unit 3) and all the things I was going through (unit 4) and the culture shock (unit 5). After delineating units of general meaning for each transcript, in Step 5, I delineated units of meaning relevant to each research question. During this step, units of general meaning were grouped based on relevance to the research question. In other words, I examined the each of the units to determine whether what the participant said appears to correspond to the research question. For example, units, "females coming together and eating food and laughing, the sense of belonging, if I need somebody or if I need a ride I can call (participant name), support, people coming together," were all relevant units of meaning.

In Step 6 (*training independent judges to verify the units of relevant meaning),* I hired a graduate student who had training in qualitative research to independently code Steps 1 through 5 and verify the present findings. There was 81.0% agreement between the second coder and myself for the units of general meaning codes for the initial interviews. There was 83.0% agreement between the second coder and myself for the units of general meaning codes for the concluding interviews. According to Hycner (1985) because each researcher brings a different perspective into the coding process,

differences between coders are to be expected. I reviewed the minor differences that were found between the second coder and myself and we were able to come to an agreement for both pre and post program codes. Furthermore, the second coder also reviewed the summary outline for each interview and was in agreement with the generated clusters and emerging themes for both pre and post program interviews.

During Step 7 (*eliminating redundancies*), I reviewed the units of relevant meaning and eliminated any redundancies in these data. After reviewing the transcripts I chose not to eliminate any units because while two units may have been similar, they carried a different context. However, this step also allowed me to review how many times a relevant meaning was listed within a given interview as well as across the interviews, indicating the importance of that particular issue. For example, during pre-interviews, language challenges were noted 29 times across the 10 interviews. Following the removal of any redundancies in Step 8 (*clustering units of relevant meaning),* I reexamined the units of meaning captured and grouped those units to make clusters of themes within the holistic context. Because there is often overlap between the clusters, extracting the meaning of different clusters helped to pull out central themes and express the essence of each cluster as well as clusters as a whole. For example, one cluster that emerged was related to females coming together which included units such as, "females coming together and eating food and laughing, before we came together we would see each other or you know in school or something, now I can say that we can come together and support each other." Once I identified all the clusters of meaning in Step 9 (*determining themes from clusters of meaning*), I reviewed the clusters to determine whether any of clusters fit together and whether these clusters created a common theme. For example,

one theme that emerged was *Support and Belonging*. The clusters for this them included, sharing, one of us, gratitude, belonging, and support.

After creating central themes in Step 10 (*writing a summary for each individual interview*), I created a summary outline for each of the interviews. Each outline provided a richer context for the emerging themes. While Step 11 (*return to the participant with the summary of themes: conducting a second interview*) required me to review the written summary with each participant, I chose not to complete this step due to the cultural background of the study participants. I believe that the participants in this study would have been confused by my request and in order to support and please me, they would have agreed with the findings. Instead, the pre and post interviews, as well as the other data collected (i.e., video recordings, field journals, and artifacts) provided strong support for the themes. Since I did not complete Step 11, I also did not complete Step 12 (*modify themes and summary*) because I did not have any new data to review in order to modify the themes and the summary.

Once all of the themes were identified for each individual interview, in Step 13 (*identifying general and unique themes for all of the interviews*) I reviewed each of the themes and compared them across all of the interviews to determine if each of the themes was common to all or most of the interviews. During this step, it was evident that the themes generated during the initial interviews significantly differed from the themes generated during the concluding focus groups. In other words, themes generated during the initial interviews emphasized the participants' transition and post-migration challenges, while the post-interviews provided rich data on the participants experience in SPP. After reviewing for general and unique themes, in Step 14 (*contextualizing of*

themes) it was important to place the theme back in the context from which the theme emerged. This process allowed me to better understand the phenomenon and its impact within a given story shared by the participant. Finally, in Step 15 (composite summary), I created a composite summary that described each of themes as related to individual participants as well as the group as a whole. These summaries were included in the results of this study.

Conclusion

It is important to note that despite the rigorous data collection and analysis process outlined above, maintaining trustworthiness in this study was difficult because some of the meaning may have been lost through the translation process. Furthermore, cultural differences between participants and myself may have impacted how the meaning was extracted from each of the sources of data. During the data collection process, I regularly checked in with the participants in order to ensure that I was accurately interpreting their experiences during each of the sessions. Additionally, after each session, I reviewed and processed each of the sessions with the SPP interpreter Ms. Abed. As such, through the process of bracketing and engaging in constant dialogue with the Ms. Abed as well as a Mr. Ali the cultural navigator, I hope that their unique perspectives are highlighted and their experiences are represented. Furthermore, I hope to have captured the meaning and the essence of their experience in SPP.

CHAPTER IV

FINDINGS

This chapter provides a detailed description of the group members in the Somali Parent program and their stories as shared through interviews, group participation, work projects, and observations. I realized as I was writing their stories that I know longer thought of them as study participants, but that they were group members and mothers. As such, I have changed to referring to these women as group members, mothers, or by their pseudonyms. All data were analyzed using qualitative analysis methods that allowed for the identification and description of central themes unique to these Somali mothers across the three phases of their involvement: pre-group, during group sessions, and post-group program. Before introducing the themes, I have provided a brief introduction of each group member and a general overview of the group process.

Description: The Somali Mothers

The members of the Somali Parent Program (SPP) included 10 Somali women who frequently attend the local community refugee center to attend English classes as well as access other community resources (e.g., employment help, immigration and medical documentation supports). Their ages ranged from 29 years to 55 years of age, although it is likely that these are estimates because many refugees were born in homes rather than hospitals, most without birth certificates or other records of their age. I estimated their average age to be about 40 years. Although all of the group members were born in Somalia, they were forced to leave their homeland after the war erupted to

resettle in countries such as Kenya (eight members), Ethiopia (one member), or even as far as Malaysia (one member). Nine out of the ten group members had resettled in refugee camps in these countries.

Based on responses to the pre-interviews, they lived in refugee camps between 3 to 22 years, with 18 years representing the average length of stay. There was a tremendous amount of diversity across the members in their resettlement experiences to the United States. Prior to joining the program, 40.0% of the participants had lived in the United States less than a year, while the rest had been in the United States between four to seven years. The average length of stay across the 10 members was just less than four years (3 years and 11 months). This community was not their first resettlement location; all of the women had resettled in neighboring cities or states prior to resettling in their current local community. In fact, the average length of time that members had resided in their local community was 2 years and 8 months. All group members were unemployed at the start of the program.

Because of the emphasis on enhancing the health of the family unit, all members of SPP had to be mothers. The number of children reported by each member varied from two to nine children. The age of the children varied from 3 to 30 years of age. Two of the 10 members were pregnant during their participation in the program. Not all of the members were living with their children; six reported being separated from at least one of their children who were still living in various parts of Africa, including a refugee camp. All women described their country of origin as Somalia and their first language as Somali. Half of the group members were widows and identified as single mothers, while the other five were currently married. Table 2 provides a more detailed description of

each of SPP members, the number of group sessions attended, and whether they completed the concluding interviews. The table also includes a list of mothers who joined the program after the initial interviews were completed. This information was gathered from the demographic survey that each group member completed prior to the start of the program. Although the primary emphasis of this study was on the group process, this section provides a brief description of each mother, presented with a pseudonym to protect the privacy of all group members.

Qani

Qani was a 29-year-old woman who moved to the United States from Kenya about seven years ago. She was the only participant who did not live in a refugee camp prior to resettling in the United States. Qani is married and has two boys, a 5-year-old and a 2-year-old. She was pregnant with her third child when she completed the initial interview to participate in the program and gave birth soon after the start of the SPP. As a result, Qani did not participate in the program and did not attend any program sessions.

Ayana

Ayana was a 44-year-old woman who lived in a Kenyan refugee camp for 20 years prior to resettling to the United States 4 years ago. Ayana is married and has 5 children aged 19, 13, 12, 10, and an 8 year old. Ayana has a son (age 12) with significant mental health needs. Ayana is separated from four of her children who are still living in Kenya. Ayana was extremely committed to SPP as evident by her perfect attendance. She came to every session with a smile on her face, always eager to learn and share.

Table 2

Demographic Information of Participants

Participant	Age	Refugee Camp	Years in the U.S.	Year in Local Community	Number of Children	Total Sessions Attended	Completed Concluding Interviews
Core Program Participants (initial interviews completed)							
Ayana	44	20 years	4 years	3 years	5	8	Yes
Basra	43	3 years	4 years	3 years	6	7	Yes
Dawo	49	22 years	8 months	8 months	8	6	No
Amal	42	22 years	6 months	6 months	7	4	No
Samiira	55	22 years	6 months	2 months	9	5	Yes
Hodan	42	20 years	5 years	3 years	9	7	Yes
Nadifo	30	18 years	5 years	1 year	6	3	No
Hibo	38	20 years	6 months	4 months	7	6	Yes
Mako	30	18 years	4 years	4 years	2	6	Yes
Additional Program Participants (initial interviews were not completed)							
Shamso	-	-	-	-	-	6	Yes
Caadil	-	-	-	-	-	4	Yes
Khaalid	-	-	-	-	-	3	Yes
Abshir	-	-	-	-	-	5	No
Amaani	-	-	-	-	-	4	No
Galaal	-	-	-	-	-	2	No
Geedi	-	-	-	-	-	1	No

Note. All names are pseudonyms

Basra

Basra was a 43-year-old single mother who lived in Malaysia prior to resettling in the United States four years ago. She also lived in a refugee camp slightly less than three years. Basra has six children who ranged in age from 8 to 14 years. Basra had significant medical concerns due the beating she sustained by soldiers in Somalia. Despite her challenges, Basra attended 7 out of 8 program sessions and was an informal leader of the Somali Parent Program. Prior to the start of each group, she walked the halls of the refugee center and reminded the women that group was about to begin. If she could not find certain members, she would call them until she reached them. It was noted that she engaged in every session, but tended to listen to others before giving her opinion or asking a question. Like Ayana, Basra always seemed to carry a smile on her face.

Dawo

Dawo was a 49-year-old single mother who lived in a Kenyan refugee camp for 22 years prior to resettling to the United States. She had only been in the United States for eight months prior to the start of SPP. Dawo is a widow with eight children between the ages of 12 and 30 (i.e., 30, 28, 26, 24, 22, 18, 15, and 12). Two of these children still live in Kenya. Dawo attended 6 out of the programs 8 sessions. Although she stayed quiet throughout most of the sessions, she always seemed engaged in the programs activities and attended the program fairly regularly.

Amal

Amal was a 42 year-old single mother who, like Dawo, lived in a Kenyan refugee camp for 22 years prior to resettling to the United States. However, she was even newer to the United States having arrived only 6 months prior to the start of SPP. Amal is a

widow with seven children, 27, 25, 24, 21, 20, 18, and a 15 year old. Amal is separated from four of her children who still live in Kenya. Amal was only able to attend half of the sessions.

Samiira

Samiira was a 55-year-old woman who had also lived in a Kenya refugee camp for 22 years prior to resettling to the United States. She had been in her new host country a similar amount of time as Amal, six months. Samiira is married and has nine children, two of whom are still living in Kenya. The exact ages of Samiira's children was not available, but she attended five of the eight SPP sessions.

Hodan

Hodan was a 42-year-old mother who lived in a Kenyan refugee camp for 20 years prior to resettling in the United States. Unlike some of the other members, Hodan, who arrived 5 years ago, is literate and semi-fluent in English. Hodan is married and has 9 children, aged 24, 22, 19, 17, 15, 12, 9, 6, and 3 years old. Hodan attended most sessions, missing only one. In the beginning, Hodan was hesitant about the purpose of the group but over time she became a leader for the other group members. Hodan was always engaged during the sessions and was incredibly outspoken and inquisitive.

Nadifo

Nadifo was a 30-year-old mother who lived in the refugee camp for 18 years prior to resettling in the United States 5 years ago. She is a single mother with 6 children, ages 11, 10, 7, 6, 5, and 3 years old. Nadifo attended only three of the programs eight sessions. Due to her status as a single mother with fairly young children, it was very difficult for Nadifo to attend the program consistently.

Hibo

Hibo was a 38-year-old mother who lived in the Kenyan refugee camp for 20 years prior to resettling to the United States just six months ago. She is married with seven children, who range in age from 7 to 19 (19, 18, 14, 13, 12, 9, and 7). Hibo attended six of the eight SPP sessions. Hibo became employed after the sixth session so she was not able to attend the last two sessions. However, throughout the earlier sessions, Hibo was engaged and very inquisitive. She always seemed open to sharing her experiences as a parent in a foreign country and eager to learn from others in the group as well as the group facilitators.

Mako

Mako was a 30-year-old single mother who lived in an Ethiopian refugee camp for 15 year prior to resettling to the United States five years ago. She has 2 children, ages 13 and 9 years old. Mako attended six out of the eight sessions.

Although these 10 members were recruited prior to the start of the Somali Parent Program, the group had an open door policy. As such, seven additional participants attended the program at some point during 8-week period of the group. Initial interviews or demographic data were not completed on these participants; however, three out of the seven participants completed the concluding interviews. These seven participants attended anywhere from one to six sessions.

Additional Program Participants

Shamso, who attended 6 of the 8 sessions, was both the oldest participant in the program (early 60s) and was from a different region of Somalia. She brought a unique dynamic to the program as a female elder because others were inclined to listen to her.

Furthermore, many of her views, specifically related to the rights of women, were controversial in the eyes of many other participants.

Abshir attended 5 out of the 8 sessions and was also one of the older group members (mid-50s). Although Abshir rarely spoke, her engagement in the program was present in her body language as she intently listened and tracked other members as they expressed their opinions.

Caadil attended four of the eight sessions. Caadil was in her mid-30s and was pregnant throughout the program. Although she attended only half of the sessions, she was very outspoken when present. She was particularly vocal during our Celebration session, in which she expressed tremendous gratitude for SPP and stated that she wished she had come to more sessions.

Amaani also attended four out of the eight sessions. Amaani came early in the program as well as the last session. Amaani was in her 40s and had multiple children. Although Amaani also rarely spoke during the sessions, at the end of the program she expressed great appreciation for the Marriage and Parenting session. According to Amaani, this session was particular helpful for her family including her relationship with her husband.

Khaalid attended three out of the eight program sessions. She was in her 30s and has multiple children. Similarly, Galaal attended two out of the eight program sessions and Geedi attended one program session. Despite not completing the program, all seven of these group members made a significant contribution to the program and the group process through their openness, engagement, and inquisitive nature.

The Group Process

At the start of the Somali Parent Program, it was unclear how members would evolve as a group throughout the eight sessions, especially with the flexible group membership. Further, it was not known how consistent their group attendance would be, how much and in what ways would they contribute to group discussions (group contribution), and how they would relate to group facilitators as well as each other (group interaction). These dimensions of group engagement (i.e., attendance, contribution, and interaction) are represented on the Group Engagement Measure (GEM; Macgowan, 2006) a measure developed to assess engagement in group work among adult group members. The GEM includes seven dimensions including, attendance, contributing, relating to worker, relating to other group members, contracting, working on own problems, and working on other members' problems. For this study, I used GEM as a framework for exploring various aspects of the group process. Therefore, I chose to focus on three dimensions of GEM, which included attendance, interaction, and contribution. I chose these three dimensions because they seemed clinically and culturally appropriate for the SPP group members. More specifically I combined several of the dimensions including relating to worker, relating with members, and contracting to create the group interaction dimension because these dimensions reflected the participants interaction with other group members as well as the facilitator. Similarly, I also combined contributing, working on own problems and working in other members problems to create a group contribution dimension. I used the three dimensions (attendance, interaction, and contribution) as an organizing framework to describe group process across sessions and did not collect any quantitative data on these dimensions. In the following paragraphs,

group attendance, interaction, and contribution are discussed as related to the members' process in the SPP. The actual themes developed during the course of the group are described later in this chapter.

Group Attendance

Group attendance appeared to be impacted by several factors, many of which were related to external circumstances including scheduling, external stressors, and access to community resources such as transportation. For the first three weeks of the program, attendance remained steady for eight out of the ten group members. During the fourth week, the refugee center was closed for Spring break, which negatively impacted program attendance (i.e., only four out of the ten core members attended this session). Similarly, the program also saw a decline in attendance during Weeks 5 and 6, a time in which the world news had reported that the refugee camp in Dadaab, Kenya would be closing due to a terrorist attack that had occurred in another part of Kenya. This closure meant that outside contact and monetary funds were shut off and the refugees living in the camp had 90 days to evacuate and return to Somalia. Many of the group members had family, including their children, living in this camp. Such news brought a tremendous amount of anxiety and fear to many of the participants who preferred to stay at home and monitor the news and their phones instead of attending any community programs including the SPP.

During this same time frame, two local factories began hiring new employees and Hibo who had attended regularly stopped coming. As such, this also impacted the attendance of the program. For other group members, childcare and transportation continued to be a barrier to attending the weekly program. Despite these barriers, six out

of the ten original members, plus Shamso (the group member who joined the program after the pre-interviews were completed) attended six or more sessions. Although many of the members experienced barriers similar to the other group members (e.g., the proposed closing of Dadaab, issues with childcare or transportation), they appeared to hold one another accountable. For example, some group members would call other group member if they were not present at the group meeting. Others reported finding comfort in attending the program and being able to talk about their present stressors. For example, when the news of the Kenyan refugee camp closure was broadcast, the members who attended the group that week reported that although they too had family members in Kenya, they found comfort in attending the group, being able to express how they were feeling, and supporting one another.

Group Interaction

Although many of the group members knew one another from attending English classes at the refugee center, many others were only general acquaintances. Some of the members had encountered the group facilitator at various events at the community refugee center, but they did not know each other personally. As such, although the group members would speak with one another throughout the sessions, during the early sessions there was little interaction between the members and the group facilitator. Group members tended to direct their comments and questions towards the interpreter/co-facilitator (Ms. Abed) or to each other. Similarly, early on in the program, the interaction between the members appeared limited and superficial. They would check in with one another, but conversation was kept to a fairly limited level and members did not share personal information. For example, the group members discussed events that happened

during their English class or grievances related to community needs or resources. It almost seemed as if they perceived this group as more of an interview rather than an opportunity to share and interact. This response was not without reason as recently I had conducted focus groups to learn about community needs.

However, as the sessions continued and group members were asked to participate in more personal discussions (e.g., their resettlement journey, marriage dynamics, and parenting in a host country), they began to engage more with one another. For example, as one mother (Basra) shared her journey of giving birth while running away from soldiers, others listened and provided comfort as she described her ordeal. They also began to share their own journeys and hardships. Similarly, as I posed deeper questions and allowed myself to be vulnerable (e.g., sharing personal information) during the group discussions, the participants appeared to respond with openness and honesty. During one particular discussion on marriage and the female role within marriage, the members wanted to know how women were treated in the United States. More specifically, they wondered whether I had a partner and what my experience was like as a female. Many of the members shared that they had never discussed this topic before, even amongst other Somali women because it was considered very "taboo" within the community. As such, this question required a willingness to be open and vulnerable from the group members as well as from myself as the group facilitator.

It is also important to note that the group members who joined the group after it had started did not appear to disrupt the group dynamics and interactions. Many of these new group members were often friends of other members who had brought them to the group. Additionally, the core group members such as Ayana, Basra, Dawo, Hodan, and

Shamso seemed to act as models for others on how to engage with one another. For example, it was during our third session and as we were getting ready to begin group, some men came into the room asking if they could join. Before I had the opportunity to respond, several of the women, including the ones listed above, approached the men and noted that this was a "women's group only." It was evident that they had taken ownership of the group and were protecting their time and one another.

Group Contribution

Group contribution was evident through members' level of participation in the discussions, activities, and the members' body language including facial expressions, body movements, and voice tone. I found this aspect of the group process be the most difficult to establish. Although the participants were aware of the purpose of the program, many also appeared wary of the intentions or the usefulness of the group. For example during the Session 1 discussion on their transition to the United States, many reported feeling "hopeless" that this group could help them. They were tired of retelling their stories and believed no one was doing anything to support them. Furthermore, as they completed the "Tree of Life" activity during this same session, in which they were asked to reflect on their past, present, and future, many were resistant to sharing memories from the past and reported that they had "worked really hard to try not to think about the past." Similar resistance was evident during the second session as many of the group members spoke about lacking a "voice" in their local community. They could not see how a group such as this one could help them when so many other people had made them feel "invisible."

However despite their hesitation and lack of hope in the early sessions, over time their participation and contribution to the group increased. One example of this growing engagement became evident during session check-ins. Each week, members began group by identifying a feeling card and reporting why they chose that card. Early on, the whole group would choose the "happy" card without being able to elaborate why they had selected this feeling. However, during the 3rd or 4th session, they began to select different cards, including those representing negative emotions. They also began to elaborate on why they were feeling a certain way. For example, Shamso reported feeling "sad and in prayer" one week because her mother, who was still back in Somalia, was sick and Shamso could not be with her. Their body language also began to change over time. They became more expressive with their emotions and engaged in discussions. During the early sessions, some of the group members answered their phones during the session or walked out of the session before it was over. However, they started to turn off their phones at the beginning of the session or silence it if it rang. They would face each other and listen when others were speaking and waited until the group was finished before leaving the room.

As the sessions continued, instead of hesitating to discuss specific topics, they became inquisitive and wanted to learn more. They were curious about women's rights in the United States, how mental health was viewed and treated, and ways in which they could improve themselves as mothers and community members. They also wanted to share their culture and traditions with each other and me. As we approached our last session, in which we were to reflect on the program and celebrate the group members, they were adamant that they wanted to prepare all the food for this special event. Their

commitment to the group was evident. Just as they had told a group of men that this was a "women's group only," they had taken pride in their group and no longer seemed to feel as voiceless and invisible.

Contextualization of Themes

In order to capture group members' experiences in the SPP and how they experienced the program over time, themes were grouped across three phases of the program, initial, during, and concluding. Additionally, several overarching central themes emerged across all three time frames. Although all of the themes are interconnected, they are also unique in their own way and capture a different component of the members' experiences. Therefore, each theme is discussed within the context (i.e., initial, during, and concluding interviews) from which the themes emerged.

Initial Interview Themes

Prior to the start of the SPP, the 10 original group members completed demographic surveys and initial interviews. During their interviews, group members shared their experiences related to their resettlement journey and adjustment to life in the United States, their family health and well-being, perspectives on parenting in the United States, current sources of support, and what they hoped to gain from attending the SPP. The themes that emerged from the initial interviews included fear, confusion, and loneliness, shifts in family dynamics, sources of safety and security, and navigating systems.

Fear, confusion, and loneliness. This was one of the most salient themes across all of the members regardless of how long each individual had been living in the United States and their level of social support. The journey to the United States and the

challenges associated with adapting to a new way of life brought a tremendous amount of fear, confusion, and social isolation for all the group members. Not only were they overwhelmed by the adjustment and acculturation challenges of resettling in an unfamiliar place, they often had few social supports to meet those demands. Their sources of stress included their first plane ride, their initial arrival to the United States, the shock of encountering a different culture, the struggle to find affordable housing, lack of social supports, and being a parent in a foreign country. Due to their limited understanding of United States laws, many of the mothers lived in fear that their children could be taken away. While the sources of stress and confusion were different, they appeared to manifest in similar ways. The mothers reported isolating from their families and experiencing physical pain (e.g., headaches). In particular, fear, confusion, and loneliness were the most often voiced emotions and often had a significant negative impact on the mothers' physical and emotional health and wellbeing.

For most group members, their arrival to the United States was often described as a stressful experience. Many spoke extensively about traveling on a plane for the first time and feeling confused, overwhelmed, and often scared. Dawo describes her family's experience below.

> The problem that I faced and my family faces is when we were coming to America we had to take the plane which I didn't know or the language, so understanding you know switching from plane to plane so that was difficult, so we didn't know. So one time when we landed in Dubai they told us to sit there for 6 hours, but no one came to get us, so we sat there for 6 hours and the plane left and we didn't know and after that they told us that there won't be a plane until tomorrow at 10:00. We had to go to a hotel, which was freezing and we didn't know what food to eat, my kids didn't even drink so we stayed there until the morning and the IOM (International Organization for Migration) came to get us and after that we took the plane and we arrived to America.

As outlined above, their feelings of confusion were often related to navigating airports, connecting from one flight to the next, and being left at airports without any supports or resources. These worries were further exacerbated by their initial culture shock. Culture shock was defined as being surrounded by individuals who did not resemble them and more importantly did not reflect their traditions and cultural beliefs. Hodan noted, "The culture shock was really hard, we have never seen the not sort of naked but people were not fully dressed like we were."

Finding housing was another source of significant stress that caused feelings of fear and worry. Once they arrived to the United States, many were not given their own housing right away. Instead, they had to live in motels or even in strangers' homes until housing was available for their family. For some families, finding permanent housing lasted for only a few days and for others, weeks. Unfortunately, early arrival stressors were only the of their feelings of confusion and anxiety related to the "unknown" these would persist as they began to rebuild their lives. In particular, many of the women such as Nadifo below, who came as widows or single mothers had to navigate the transition process on their own which brought even more challenges.

> Without a father, there was no one that could help us. So there were many challenges that I faced that I can't even describe them, but the main problem was me and the kids and living in America and not knowing anything and not being able to get the help that I need.

For many of the mothers both single and married, navigating the transitional challenges also carried feelings of loneliness and social isolation from the outside world. Not only did they feel as if they did not "know anything" they also felt as if they did not have anyone to share their grief with in order to reduce their feelings of confusion and fear. " The main problem is loneliness." These words were echoed over and over again as

I asked the group members about how they were doing emotionally. Prior to resettling in the United States, they described living in communities in which they were surrounded by family and friends. “Back in Africa, everyone was a community.” However, life in the United States left many of the mothers feeling isolated, lost, and trapped in their homes with little access to the outside world. Due to the lack of transportation, many were forced to stay in their homes with nothing to do and no one to talk to. Their feelings of loneliness were rooted in the absence of social contact, connection, and supports. Dawo described her experience.

> The main problem is loneliness. I used to have high blood sugar and at home back in Africa it wasn’t that high but when I came to America, it got high all the time. Now I am always checking my blood pressure and its always really high due to that because I am alone at the house all of the time when the kids leave, I don’t see anyone so the anxiety and the loneliness and the confusion is the main problem. So I don’t see our people, anyone I can talk to or anyone I can communicate with so that is creating more of a problem with my health because I don’t see anybody so I feel like I am alone in one place and I can’t have anybody that I can talk to or associate with, because back home in Africa, everyone was a community so we would walk together and do activities but here I just stay in the house and not do anything and no one to talk to so that’s the main problem that I am facing.

Another source of stress and anxiety and one of the most critical components of navigating their transition included being a parent in a foreign country. As mothers, they knew they had a great responsibility to keep their children safe and also felt tremendous fear that their children would be taken away. There was a lot anxiety and confusion based on the belief that if they “don’t do a good job” of parenting, they would be at risk for losing their children.

These stressors, the general confusion about life in the United States, and feeling overwhelmed by the expectations brought on by living in a new place left these mothers feeling overwhelmed by the demands of their host country. The culmination of these

different pressures and worries were taking a significant emotional and physical toll on them. Although many of the women identified having "emotional stress," they were unable to identify the reasons for their feelings or more importantly how to treat or reduce their symptoms. As such, many described having physical reactions to their emotional stress. They spoke about their countless visits to the ER that resulted in the mothers being told by doctors "there was nothing wrong with them." This cycle often left them feeling more confused and hopeless. Samiir described how her experiences were affecting her relationships within her family.

> My kids now make fun of me all of the time because either I am sick or like I have a blanket over me all of the time. So during the day I am kind of okay because I come to the school (English class) and I try to see my friends, but at night either they think I am faking sick, either I am sick or something is wrong with me. Like I have a blanket all of the time and I don't talk to anyone, I isolate myself from them, I just stay by myself and think about things and my whole life and I have so much stress and anxiety and confusion. And every time they take me to the ER, they tell me exactly the same thing everyday, there is nothing and they check my blood, everything they check there is nothing wrong. So now my kids even joke around that they are not going to take me to the doctor but I always ask them to take me to the ER and every time there is nothing wrong and I really don't know and maybe it's the stress that is causing it. I just don't know.

Shifts in the family system. Much of the discussion during the initial interviews focused on the family unit. Mothers spoke extensively about how their transition to the United States impacted their family system, roles within the family, and changes in parenting dynamics. They also discussed how parenting practices in their home country contradicted "the America way" of parenting. Parenting in Somalia often involved community support including neighbors and family members. This arrangement meant that children were free to play outside and that the community would look after them and in some ways raise them. For many of the mothers, having these supportive adults around them brought an added sense of comfort, because they felt that they were not alone in

raising their children. They disagreed with the United States perspective on when children should be considered independent, allowed to make their own decisions and be responsible for the consequences to their decisions. In Somalia, children are thought to be responsible for themselves at a younger age, about 11 or 12. Therefore, lack of community support as well as differing expectations of child autonomy often caused the mothers to feel a lot of pressure to raise their children in ways that would accommodate the "American system."

> You are too responsible here, you have to care about not getting them in trouble, discipline is a big thing because they go to school and they may have a conflict with a peer and then they call us and tell us, hey your kid was not disciplined enough . . . back home our kids are everybody's community kids and now you can't leave them at home by themselves until a certain age, you have to make sure they get up in the morning and go to school. Basically you are doing everything . . . back home when you reach a certain age, 11 or 12 . . . you are not responsible (the parent). The other thing is we have to be in control of the kids and tell them not to do things . . . we have to accommodate with the American parent or the American system. We can't discipline the way we want to.

Consistent with Dawo's perspective in the above quote, some described feelings of frustration and resentment. Many believed that the United States expectations of parenting were unfair and that it was too difficult for them to "control" their children. In this context, their definition of control was being responsible for children until age 18, including cooking for them, insuring that they had clothes and school supplies, and reporting to the school when they did something wrong in school. Their living situations (mostly apartments) required that their children remain quiet during certain times. For their older children, they now had to find a way to encourage and motivate them to do what was needed (e.g., go to school), whereas before, it would have been the adolescent's responsibility. Adjusting to western styles of discipline also brought a new set of challenges. Sadly, they believed that if they did not abide by these principles, their

children might be taken away from them. As such, Somali mothers were experiencing a greater responsibility to discipline their children, however they lacked traditional ways of parenting including community and social supports they had in Somalia.

For many of the group members, they perceived that their children were now in control of the family system. Their children acculturated faster, they rapidly learned the language, and understood how to navigate the school and other community resources. This reversal in roles made some of the parents feel powerless and vulnerable in the eyes of their children. They believed that their children were in control and they had to do what their children wanted in fear that if they did not, they would lose them to the authorities. In some instances, it meant that their children were making adult decisions around discipline and rules for the home. According to Samiir, "I feel like the kids are in control rather then me in control of the kids . . . I have to do everything for them because if I don't, I might lose my kid."

Their loss of control and the change in their family dynamics seemed to be reinforced because of their language differences. As children became fluent in English faster, parents had to rely on children in their interactions with the broader community. For example, without access to an interpreter, they were forced to find their own way to translate important documents. If their children were old enough, they performed this function. Further, if there was not an interpreter available when going to a doctor's appointment or their children's school, they were dependent on one of their children to act as an interpreter. As such, both the parents and children were placed in uncomfortable situations. Furthermore, they often had to pull their children from school in order to attend an important appointment to serve as translators for their parents.

As children started to learn their new language they started to speak English in the home. For many Somali families, this had significant implications because the children could now communicate with one another in a language that their mothers did not understand. For many of the mothers, they felt that they communicated less with their children and had fewer interactions with them. Furthermore, this lack of communication between the children and their parents created a certain degree of mistrust. According to Ayana, "they have a conversation in English and I don't understand them and what they are talking about. . . . When they are hiding something, they just speak in English."

Navigating systems. The process of adjustment and acculturation also required mothers to learn how to access resources in their communities. However they often encountered significant barriers to accessing services due to language and transportation barriers. Even when they did have access to these resources, many were unclear about what services were available to them and more importantly, experienced difficulty understanding and engaging in those systems. One of the most prominent examples discussed by the mothers in relation to community resources included understanding and engaging in their children's schools. More specifically, many of the mothers expressed confusion regarding their role within their child's school as well as general understanding about how schools in the United States function. They were also uncertain about how to engage with their child's teachers due to barriers such as language and transportation.

Although many of the mothers expressed interest in engaging in their communities, one of their greatest barriers was related to language. In fact, language was the number one barrier identified by the mothers. "My biggest challenge is the language," according to Hodan. Not being able to read, write, or speak in English, combined with the

lack of available interpreters proved to be a daily barrier for communicating and accessing the outside world. For many of the women, not being able to speak for themselves had greater implications than accessing services; being unable to communicate meant that they were dependent on others. It also left many of them feeling invisible in their homes and in their communities. Below Dawo describes the impact of language on her and other mothers.

> Let's say we went to a doctor's appointment, we don't have an interpreter that can translate for us so either way we can't even go. Even if we take the bus, we get there and there is no one (they miss the appointment because the bus was running late). We have to ask other people to take us and translate for us and you can't keep asking that same person every time that you have a doctor or something. So lack of language barrier, lack of interpreters that are available is the problem. We can't even get our voice heard because we don't have anyone that could talk on behalf of us or could translate on behalf of us.

As noted by Dawo, another significant barrier was lack of access to adequate transportation. If they did not own or know how to operate a vehicle, or have a husband who did, they were fully dependent on either public transportation or others. Unfortunately, the public transportation system in their community is not reliable, and many described waiting at bus stops for two or more hours before the bus arrived. They also described confusion around how the bus system operated. Therefore, they were often dependent on others to take them to places such as English classes, the grocery store, and medical appointments. They also reported that they missed important meetings at their children's schools because they were not able to access adequate transportation. For many of the mothers, like Amal below, this was their daily reality.

> The lack of transportation for my family or myself is the problem. For me to get to this school (the refugee center) is a hassle. I have to take a bus, which I don't know where the bus is and no one has shown me. . . . When I get here (the refugee center), I don't know how to go back . . . yesterday I was there for two hours in the snow and I didn't know what to do, so finally I called someone and he came to get us.

Along with the challenges presented by language barriers and poor transportation resources, many of the mothers also described not being able to understand the system and the resources that were offered to them. Attending medical appointments, reporting to their child's school, or learning how to access resources in their community were constant stressors for many of the families. They desperately wanted to engage in their communities, especially their children's school, but often found themselves unable to navigate the nuances of these various systems. This left many of the mothers feelings frustrated and overwhelmed. More importantly, many of the mothers felt disconnected from their communities.

Sources of safety and security. Despite their arduous journey to the United States and the countless barriers that they had encountered upon arrival, for most of the mothers, living in their new country meant that their families were safe, they were together, and they were living in peace. As Ayana noted, "I don't worry for my safety. I don't worry that anyone is going to shoot me, rob me, or rape me . . . we have peace." This sense of safety gave them immense gratitude. It also gave them hope for their family's future, which included opportunities to get an education and to be happy. For many of the mothers, they were relieved to finally be free from the dangers they experienced living in war and refugee camps. Thus, feelings of safety and living in peace were often interchangeable.

Women who were able to come with their entire immediate family expressed feelings of gratitude because they recognized that for many of the refugee families, this was not the case. In addition to feeling safe and united as a family, many of the mothers expressed appreciation for being able to receive basic needs, such as food, shelter, and medical services. These were often described in the form of receiving food stamps, finding a safe place to live, and being able to receive Medicaid for their children and themselves. Some also discussed the importance of having access to water and electricity.

Although many of the participants found it difficult to articulate what they wanted to gain from the parenting program, one thing that was consistent was a need for education. “I want to be able to go to school and get education,” Hibo expressed. For many of the group members, an opportunity to receive an education for themselves and their children was an important part of living in the United States. They felt grateful for the opportunity to have an education, an opportunity they may not have had before. For many, an education meant learning the language and learning to read and write. It also meant gaining a new skill set such as learning to use a computer as well as learning hands on skills.

The central themes of Fear, Confusion, and Loneliness, Changes in Family Dynamics, Navigating Systems, and Sources of Safety and Security while distinct also emphasized the shared transitional or post-resettlement experiences of these ten mothers. Their stories highlighted significant stressors related to their transitional experiences such as their fears associated with navigating a new culture and a new community, their loss of control within the family, and lack of understanding and access to adequate resources. More importantly, their stories also highlighted their remarkable resiliency, gratitude for

being given the opportunity to be live in peace, and hope for a better future for their family.

During: The Somali Parent Program

In order to capture the group members experience throughout our eight weeks together, the following section provides a snapshot of each of the eight sessions. More specifically, I have attempted to outline the participants' evolution over time as captured through video-recorded sessions, participants' artifacts, and my own process notes.

Session I: Defining the family. This session had three primary goals: (a) introduce SPP including group norms, (b) explore the group members' definitions of their families, and (c) invite the members to reflect on their past, present, and future through the use of the Tree of Life activity. While most of the group members appeared reserved in the early part of the session, the dynamics quickly changed when they were asked about their family's worries. Many of the mothers spoke passionately about the cultural challenges of living in a foreign country. Many experienced difficulty in balancing their native culture with the American culture and expressed great concern that their children were losing their native culture and traditions. During the Tree of Life activity, three major themes emerged across the stages of discussing their past, present, and future. When discussing their past, many shared their memories of war, violence, and loss. In the present stage, the major theme seemed to be "trying to make a better life for our family," through education and good health. In the future, many expressed a desire to go back to Somali to help others. They also hoped that their children would get a good education and find employment. Although many were resistant to share their past because they "worked really hard to try not to think about the past," the Tree of Life sheets below (Figure 1) by

Basra and Shamso provide a glimpse into some of their narratives. The bottom of the tree, the roots, represents their past, the middle, or trunk, their present, and the branches, their future.

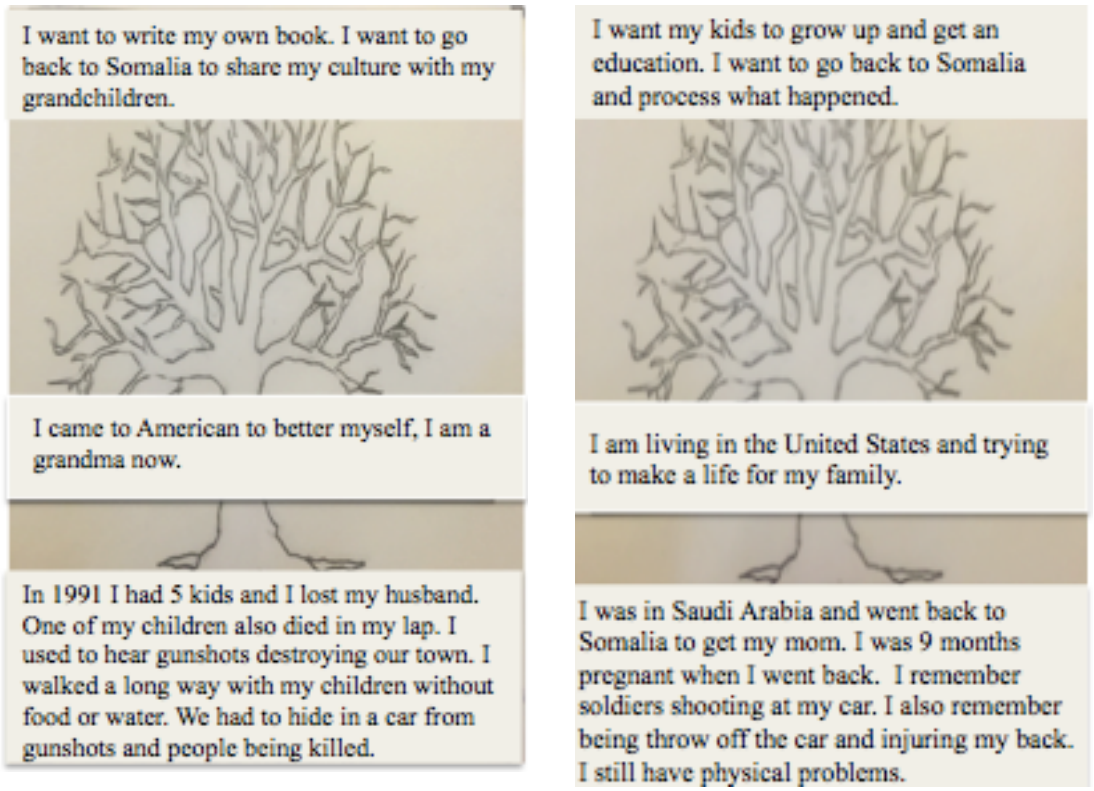

Figure 1. The Tree of Life. This activity describes the participants past (tree roots), present (trunk), and future (tree branches) experiences. The original responses were handwritten at the time, but were later typed to enhance readability.

Session II: Family and transition. The primary goal of this session was to use the contextual framework provided by Bronfenbrenner's Bio-Ecological Systems model as a guide to explore the participants' migration journey (pre-, trans-, and post-) with emphasis on the post-resettlement process. As shown on the video-recordings, during the discussion, many of the group members emphasized how "invisible" and "unsupported" they felt in their community across all the systems (micro, meso, exo, and macro). Due to

language barriers, many believed that they could not effectively advocate for their families, especially their children. For example, they wanted their children to be able to pray in school or for their daughters to wear a hijab without being ostracized. They desperately wanted their children to maintain their religion, culture, and language, but believed this was impossible because of how invalidated they felt by their community.

After the discussion, the group members were asked to create their Family Transition Collage that depicted their family's resettlement story. Although wary of the collage activity at first, many started to enjoy looking through the National Geographic magazines, cutting out different images, and sharing their clippings with the group. Their collages depicted images of loss (i.e., mass grave sites) as well as images of gatherings, farming, and cultural traditions that highlighted their life in their home countries. The two Family Transition collages can be found in Figures 2 and 3.

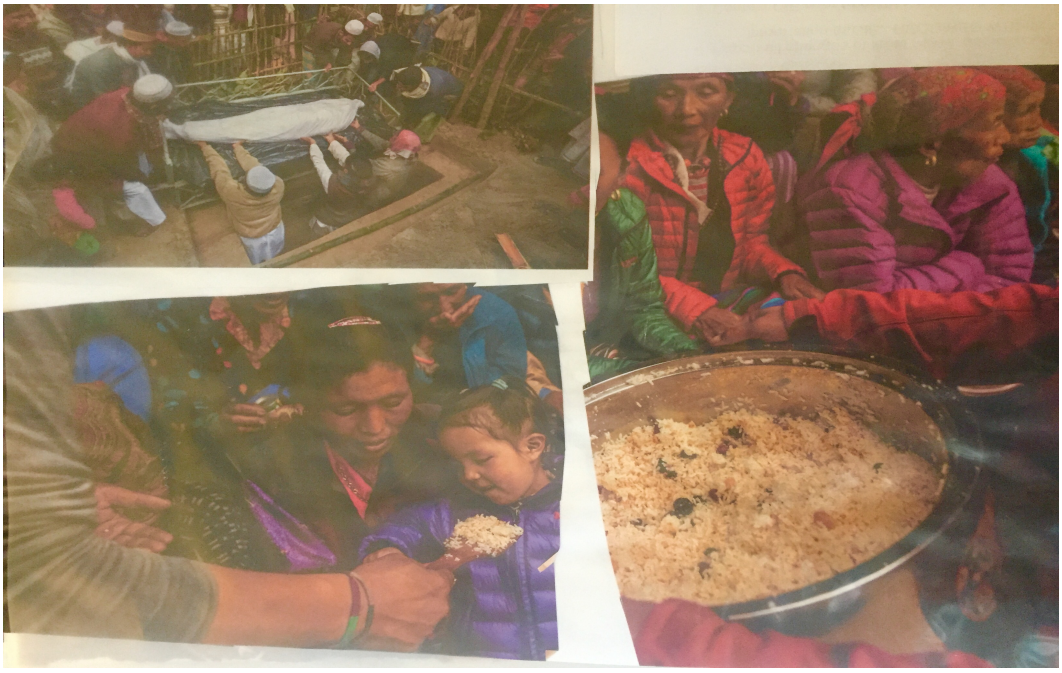

Figure 2. Family Transition Collage created by Basra. This collage depicts the participants' resettlement story utilizing images cut out from magazines.

Figure 3. Family Transition Collage created by Hodan. This collage depicts the participants' resettlement story utilizing images cut out from magazines.

Session III: Parenting in the host country. This session focused on exploring the group members' parenting experiences during pre- and post-resettlement. As they began exploring parenting roles, many of them had difficulty describing a mother's role vs. that of a father. They did not identify mother and father to be co-parents. Instead they identified father as the one who "gave the child life, "the decision maker for the family", and "the financial supporter," while the mother fulfilled all other parenting roles (i.e., taking care of the children, fulfilling domestic duties, supporting children emotionally, and the one who "brings the family together"). However, many of the families had to readjust these roles after resettling in the United States. Some of the group members were single mothers who had to meet all of the parenting roles, while others were now the main financial supporters or spoke English more fluently than their husbands, which required a large shift in previous roles and expectations. In order to express their relationship with their children, the group members were asked to create a mask that reflected how they want to be viewed by their children and how they believed their children viewed them (Figure 4). It seemed that the group members enjoyed the activity but became so involved with the art materials (e.g., paint, glitter, feathers), that they may have lost sight of the theme. However, the activity did allow for the mothers to bond as mothers and as parents. As they decorated their masks, they exchanged stories about their children and laughed together. The activity helped the mothers recognize that every mother in the program experienced similar parenting highs and lows and that they were not alone.

Figure 4. Parent Mask. This activity was designed to reflect how the participants perceive their parent-child relationship, including how they view their children and how they think their children view them.

Session IV: Marriage and parenting. This session was originally going to be cancelled because the refugee center was on spring break, however in order to maintain the routine and flow of the program, we decided to have the group. To my surprise, seven mothers (four core members and three additional) came to the session. The original purpose of the session was to review how group members felt about the progress of the group as well as to continue the discussion on the impact of family transition in the context of parenting roles. There was no planned activity for this session. However, as the session progressed, group members wanted to discuss how their transition to the United States was impacting their marriage. Unexpectedly, we began exploring their views on intimacy in relation to female genital mutilation. As mothers, they were questioning whether female genital mutilation was appropriate for their daughters now

that they were living in a place that did not support those practices. They were curious and eager to learn what "marriage and intimacy" was like in the United States and wanted to find a way to allow themselves as women to explore their sexuality while respecting their cultural and religious traditions and values. This was by far, was the most intimate and vulnerable session for the group members and myself and I wrote about it extensively in my process notes.

Session V: Stages of social-emotional development. The primary goal of this session was to explore the group members understanding of social and emotional development in children, adolescents, and adults using Erikson's Psychosocial Stages. However, before we began our lesson for the day, many of the group members expressed feelings of worry and sadness during check in. I quickly learned that Kenyan authorities were threatening to close the Kenyan refugee camp (Dadaab) where many group members still had family, including their children. The Kenyan government was demanding that all Somali refugees be evacuated from the camp and sent back to Somalia. This event created a great deal of stress for the women and they feared for their families' lives. Despite their worries and sadness, they believed the SPP provided a place in which they could express those feelings. Although I invited them to spend the entire session processing their current difficulties, they wanted to continue on with the lesson and "distract" their minds.

As part of this session, I asked the group members to walk me through how they viewed stages of human development including expectations and roles at these different points. I followed their framework by introducing Erikson's Psychosocial model of human development. Although their stages emphasized cultural norms (i.e., girls

responsible for domestic duties at a very young age, boys play outside), we (the group members, myself, and Ms. Abed) were surprised to learn how much each of our stages of development aligned. I was also impressed by the members' level of insight and their ability to express developmental differences across various stages. Below is the model of social-emotional development that was created by the group members (Figure 5).

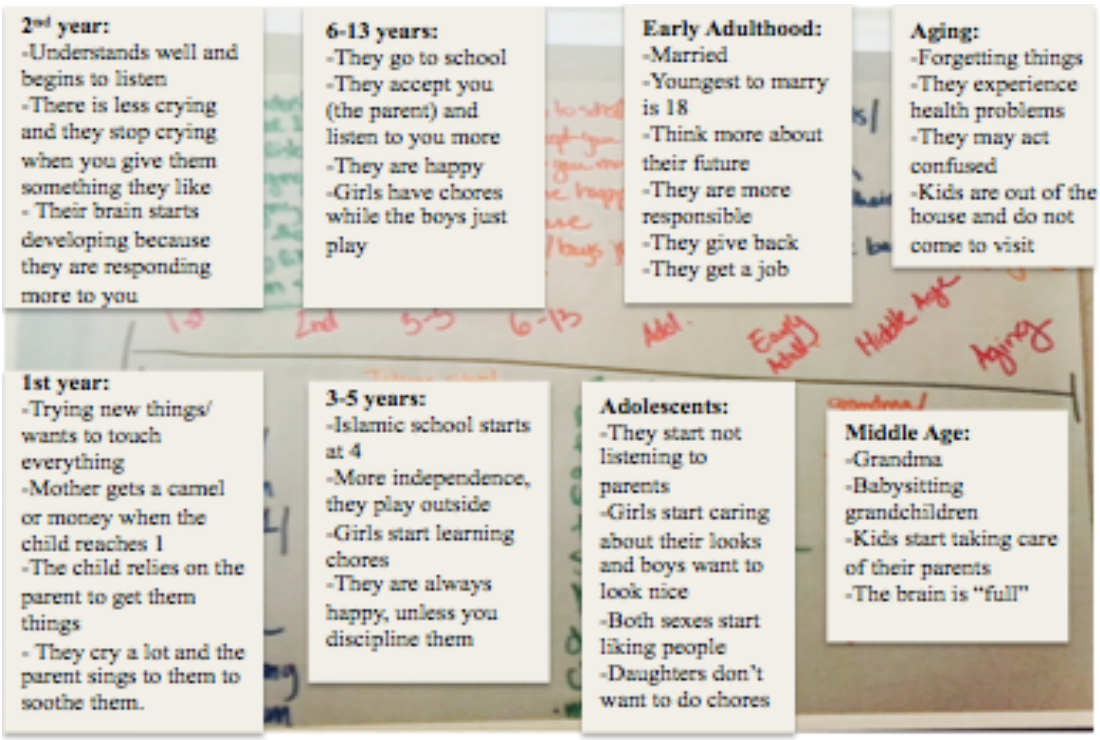

Figure 5. Stages of Social-Emotional Development. This model depicts each stage of development through the participants' cultural perspective. The original responses were handwritten at the time, but were later typed to enhance readability.

Session VI: Family health and well-being. The primary goal of this session was to explore the group members understanding of health and wellbeing with primary emphasis on mental health. Using Erikson's Psychosocial model, group members discussed how they would make meaning if a person was not meeting the expectations of

a specific developmental stage. One mother in particular, Ayana, spoke about her experience in raising a child with a disability. She shared her stress and confusion around her son's diagnosis. She also shared her grief and blame that she placed on herself for his diagnosis. Due to stigma related to behavioral health, this was the first time Ayana felt safe enough to share her story with a group of other refugee women. Ayana's testimony became the catalyst for other mothers to share their own stories. The discussion quickly turned to other family members who suffered from mental illness and the participants' desire to help them. Many of the family members they discussed still lived in Somalia or Kenya. As such, they lacked adequate supports and were often shunned from society due to stigma placed on mental illness. As they shared their pain they also wanted to know how behavioral health was viewed in the United States and the ways to treat individuals who were struggling emotionally. Ayana's brave testimony seemed to break the cultural barriers related to behavioral health and allowed for a powerful discussion on health and wellbeing. The activity during this session encouraged the mothers to create their family's stages of social and emotional development. They used an outline of a tree and various colors of leaves (each color represented a different stage) to represent different development stages among their children, their husband, and themselves. The activity provided an opportunity for the mothers to share stories about their children and explore family dynamics within their family system.

Session VII: Community integration and resources. The primary goal of this session was to define the role of social and community supports and help the group members develop their own community genograms that highlighted their current family resources. On the video recording, when describing what community meant to them, they

used words such as, “support system, being connected, sharing, and celebrations.” They also explored similarities and differences between their communities in Somalia and here in the United States. They described their Somali communities as focused on religion, culture, love, support for one another, and celebration. In the United States, they saw their Somali community coming together regardless of their tribal affiliations, to help one another. However, the group members shared that in Somalia they could come together any time, but in the United States they often felt alone and separated from one another. During the second part of the session, the group members were asked to create their own community genograms. They identified some community supports that they would like to improve (e.g., their relationship with their children’s school, local police), but they were also open to discussing how they could better integrate into their communities. This conversation was quite a contrast to our earlier discussions and the pre-interviews in which many described themselves as invisible and hopeless that their community could offer any meaningful support to their families. It seemed clear that they were becoming more open to reaching out and integrating into their communities. Below is a sample community genogram created by Samiira that identified what type of community relationship (i.e., supportive [two straight lines], problematic [zigzag line], or distant [broken line]) a person has with different community sectors (Figure 6).

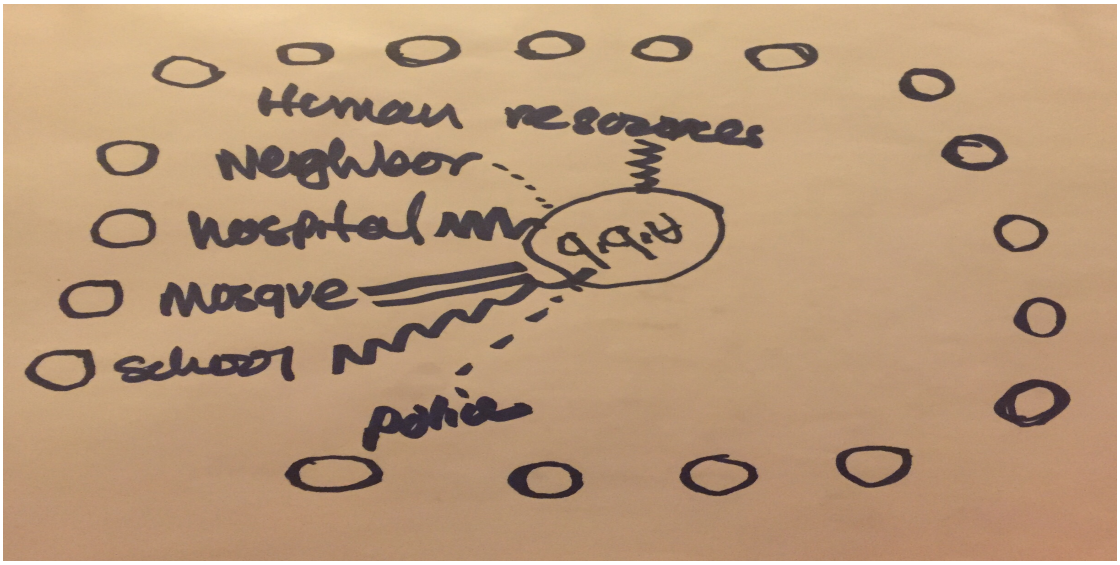

Figure 6. Community Genogram. This genogram represents the participants' relationship with the local community. A supportive relationship is represented with two straight lines, a problematic relationship is represented with a zigzag line, and a distant relationship is represented with a broken line. Samiira created the Community Genogram above.

Session VIII: Celebration. This was the final session of SPP and my favorite session. The primary goal of the session was to review, reflect, and celebrate our eight weeks together through food, music, and certificates of program completion. For this session, the group members wanted to prepare their own food as a way to honor our time together. Using photo language cards, the group members were asked to reflect on their experiences in the program. More specifically they were asked two choose two cards, one that represented them at the beginning of the program and one that represented them at the of the program. As they shared their cards, many described how much they had learned from the program and each other. For example, when sharing her cards Hodan noted, "Support and community coming together and learning about the culture. I used to be someone who didn't know anything . . . now I am in the light." Hodan's photo language cards can be found in Figure 7. The opportunity to learn and come together

seemed to give them a newfound confidence and a sense of empowerment. Shamso echoed this thought beautifully, “I learned education. My kids are walking with me, instead of in front of me. I became a teacher.” They also discussed becoming more fulfilled and happier since being part of the program. Ayana noted, “Now I learned a lot, stress has been relieved from us coming together,” and Basra noted, “Now I am happy and dancing!” Their testimonials were inspiring and a beautiful way to bring our program to a close.

Figure 7. Photo Language. This activity depicts the participants’ reflections on their time in the program including one photo that represents the participant at the beginning of the program (the card on the left) and one photo that represents them at the end of the program (the card on the right). Hodan picked out the photo language cards above.

Concluding Interview Themes

Two weeks after the completion of SPP, concluding interviews were completed. Although all group members were contacted to participate, six out of the ten group members who completed the initial interviews also completed the post-interviews. I tried

to contact the group members who attended more frequently as well as those who attended less often in order to better understand the potential barriers. Ayana (eight sessions), Basra (seven sessions), Samiira (five sessions), Hodan (seven sessions), Hibo (six sessions), and Mako (six sessions) completed the concluding interviews. Additionally, three other group members who joined the program after the completion of the initial interviews were also interviewed. These three group members included, Shamso (six sessions), Caadil (three sessions), and Khaadil (two sessions). Concluding interviews focused on the group members' experiences in the SPP. Group members were asked to explore how their experiences in the program impacted their relationship with their children, understanding of their family's emotional health, and access to social supports and community resources. The central themes that emerged from their interviews included, understanding culture, feeling identification and expression, parent-child relationship, community engagement, and empowerment.

Understanding culture. This was one of the most salient themes across all concluding interviews. They discussed "understanding culture" in the context of what they would take away from the group as well as how they would describe the group to another Somali parent. The discussions focused on overcoming cultural barriers by learning how to balance their Somali culture with U.S. culture. Prior to the start of the group, many of the mothers reported feeling conflicted by the two cultures. This conflict was not only impacting them personally, it was also impacted their relationship with their family, more specifically their children, as well as the surrounding community. Therefore, for these mothers "understanding culture," meant that the program allowed

them to explore these cultural differences as well as begin to navigate and balance the two cultures in hope of increasing their understanding and appreciation for diversity.

As discussed during the initial interviews, culture shock can be one of the most challenging aspects of the refugee family's adjustment to life in the United States. Prior to the start of the program, Mako noted, "I didn't know to handle the culture differences." However, during the concluding interviews, many of the mothers reflected on how the parent program helped them learn how to "balance the Somali culture with the American culture." Many reported feeling conflicted prior to the start of the program and believed that they had to choose between the two cultures. This was especially true when discussing their relationship with their children, in which they often worried that their children would lose their Somali culture, including their language and traditions. According to the mothers, participation in the SPP encouraged them to engage in cultural discussions with their children. Shamso echoed this theme, "Let's have a family talk about our culture, our religion and then let's understand this culture too and this religion. And just balancing both cultures." By engaging in these discussions, they reported learning how to maintain their "strong Somali culture" with their children by upholding their religion, language, and traditions while also being able to talk to their children about the American culture.

For many of the group members, there was a new appreciation for more of a bi-cultural model of living in the United States. Not only were they engaging in these discussions with their family members, they had a different perspective on how to communicate with others in their communities. It allowed the group members to view their community through a different lens. It allowed them to be more open to

"understanding and connecting with other people," including those who were different from them.

Feeling identification and expression. Prior to the start of the SPP and during the early sessions, many of the mothers expressed resistance to sharing their past experiences with one another. Similarly, they were also very resistant to expressing any negative feelings. For example, during weekly check in, in the early sessions, many of the mothers only reported positive emotions such as happy and excited. Some of the members shared that they were resistant to discussing their past because they did not want to relive it and believed that it would make them feel worse. However, during the concluding interviews many reported that prior to the SPP, they had never had an opportunity to express themselves and share their feelings or events from their past. "Before I was shy and I was to myself and I didn't know how to express myself and my pain," Mako shared. The opportunity to describe their experiences brought a certain sense of relief for many of these mothers.

One of the mothers in particular, Ayana, discussed how important it was for her to understand expression and sharing of feelings in the context of mental health. During the session on psychosocial stages of development, Ayana disclosed that she has a son with a disability and shared her own difficult journey of raising this son as single mother. For many years, Ayana had blamed herself for his diagnosis and desperately wanted to find a medical cure for his difficulties. However during the concluding interviews, Ayana had a different perspective on what it meant to learn about emotional health and wellbeing. "I didn't know before what it was about or the cause or if it was something it was done to that person but now I know that it wasn't on his ability, or he didn't bring it to himself, it

was just the way he was born." For Ayana, learning how to express her feelings allowed her to forgive herself and her son. "The first time that I shared about my son, I became relieved of the stress and to know that I came to get away but I learned how to deal with it." SPP gave Ayana the confidence to treat her son like her other children and give him similar opportunities.

> Before I used to keep him in the house and not let him go anywhere, but now after we talked about what it is or the resources that are out there for him, now I take him to the mall or we go swimming or go play ball, like I go with him but before I used to keep him in the house and not let him out but now I know after you talked to me, after school I make him busy playing ball or go swimming or go to the mall. He is becoming happier than he was before. Before I used to say, stay at the house but now he likes it more when we go outside and do something.

For many of the mothers the opportunity to express themselves and their feelings also meant they felt better emotionally. Many of the mother expressed that being part of the parent program made them feel "happier," and increased their mood overall. Additionally, they seemed to be experiencing less stress. As noted by one group member in describing how she felt after group, "Happy and relieved of stress. And I liked saying good morning to you, that makes me happy." Not only were they feeling happier, they were also learning to be happy with their children and their family.

Parent-Child relationship. Many of the mothers highlighted that their increased knowledge about the parent-child relationship was one of the most valuable things they would take away from the SPP. Hibo noted, "The connection between the children and the families and then the connection between the mother and the children" was one of the most valuable aspects of the program. Similarly, other mothers reported gaining a new sense of understanding and appreciation for communicating, connecting, and understanding their children. They reflected on how much their communication with their

children had increased since they started the program because they now valued the importance of communication with their children and took the time to sit and talk with them. It appeared that prior to the start of the program many of the women felt detached from their children and they lacked family cohesion and support. Now they understood that they could create opportunities to engage with their children whether it was asking them about school or providing emotional support to them. Many of the mothers also spoke about taking the time for "family talks" and "family gatherings." They also described changing how they communicated with their children. Instead of raising their voice or arguing, they were more open to listening to them and engaging in adaptive and healthy communication styles. Below Basra shares the impact SPP has had on her family.

> Before, like the emotion of the family, we never shared anything. We didn't talk about anything at all, it was just individuals doing individual things, but now with this group, have helped me deal with everybody talking about what's going on and talking about the family or individual. We sit and we share what happened or what's going on with them daily. Just that emotional support that we are giving each other and just talking to each other.

In addition to communication, many of the women spoke extensively about how the program helped them understand their children better. In particular, the value of learning about social-emotional stages of development and how learning about the stages helped them understand the development of their own children better. They believed they were able to better understand their children's needs and wants. For some of the mothers, it also meant taking the time to ask their children about school, their friends, and provide emotional support for their children.

Community outreach. Many of the mothers discussed how being part of the program helped them become more aware of their surrounding community. In particular, many of the mothers discussed having a greater awareness of community resources that

would be useful for them and their families. For Ayana, “Now I know what resources to call for the support and how to find something.” Some of these community resources included learning how to access their children’s school, finding a safe playground or park for their children, and learning about various medical resources in their communities.

Another important resource that many of the mothers reported accessing after the completion of the group was their children’s school. Many of the mothers reported recognizing the importance of having a relationship with their children’s school. Furthermore, they seemed more comfortable to contact their children’s school, as well as attend school functions. As such, it appears that as they grew more confident in themselves (i.e., gained a sense of autonomy), they also felt more integrated in their community and more confidant to reach out and access available resources needed for their family.

Support, belonging, and empowerment. Phrases such as, **“**females coming together, talking, sharing, belonging, and supporting one another” echoed over and over again as many of the mothers described what they would take away from the parent program. In particular, many of the mothers discussed how prior to the start of the parent program there was little cohesion amongst the Somali women in the community. Although many attended English classes together, they described saying hello to each other in class but never connecting with one another once class had ended. Being part of the SPP provided a safe place in which the mothers could come together, share with one another, and support each other. “What I gained was you know the sense of belonging,” Mako shared. This sense of belonging seemed to give them a voice and a sense of empowerment.

As discussed during the initial interviews many of the women described a great deal of social isolation, which resulted in feelings of loneliness. Attending the SPP brought the women together and provided them a place of belonging. In the words of Basra, the program provided a place for "females coming together and eating food and laughing." Previously, many of the mothers felt that they were outsiders in their own communities and in some ways, their own families. They did not feel valued and more importantly they did not feel like they belonged. Many of the women described how important it was for them to have a place where they could share, listen, and be heard by other group members. They described the value of listening to each other's experience and learning from each other. Many of the mothers felt that no one could understand their pain and their challenges. However by sharing and listening to one another, they realized that they were not alone. This brought joy and happiness to many of the group members and more importantly made them feel more connected to one another.

In addition to having the opportunity to share with each other, they also expressed gratitude toward me, as the facilitator who had brought these women together. "We've never had a female come in and want to work with us and bring us together," Shamso shared. Many of the women found themselves surprised that another female and an "outsider" cared to listen to their stories and was able to bring them together. Prior to the start of the program, many of the mothers felt that our "differences" were too strong. Hodan explained, "We used to think that you were a white person, but now you know our story. So basically don't judge people by the way they look, they might have a different story. Now you are one of us." They were surprised that they were able to connect with me and feel safe to learn and share. They appreciated having a safe space in which they

could ask questions, and a space where I was equally open and honest with them as they were with me. For many of the women, I became "one of them."

One of the most powerful moments during the concluding interviews occurred when Hodan asked me if I would be able to pick her out of a crowd. Beyond being able to identify someone based on their physical appearance, Hodan wanted to know if she was "just another face in the crowd, or if she was someone who mattered." Hodan was not alone when she asked this question, every mother in the program wanted to be seen as someone who was important and visible to others.

Hodan: If you saw a lot of people, would you be able to pick us out and say Hodan, Hodan! Like can you tell us from other people?
Vanja: Oh, absolutely! (I would recognize) All of the women in our program.
Hodan: So if there were a lot of females, like a lot of Somali people, would you be like, oh that's Hodan.
Vanja: Yes, absolutely.
Hodan: And same here, if they bring a lot of white people, or similar (laughing) people like you, I would be able to pick you out.

For Hodan even though our exterior may be different (i.e., racial differences) we were able to look past those differences. The dialogue above highlights Hodan's realization that despite our differences, there could be a bridge across racial, cultural, and religious divides where we are connected on a more personal level because we took to time to look past our exterior. The Somali mothers also expressed gratitude for having the opportunity to learn. "I never had a chance to have a meeting with or support group with a lot of females and that has given me more knowledge and more power," Hibo, shared. Many expressed how "very little" they knew when they entered the program and how they knew more now. Beyond gaining new skills, they gained confidence in themselves. By recognizing that they were not alone and that their voice mattered, they felt empowered. For example, many of the women expressed that by being part of SPP, they

learned to speak up for themselves, to express their opinions, and they learned to have their own voice.

In addition to what they gained from being in the group, some of the mothers believed so strongly in the value of the program, that they expressed the need to continue this program on their own. “We would love to try, now you showed us how and what to do,” Basra shared. These were the same mothers that several months ago believed that they had little to contribute to one another and to their community. Now, they wanted to continue providing support to one another and meet regularly. They valued their time together and wanted to maintain their newly forged relationships with one another. As the facilitator, this seemed like a dream come true and an ultimate definition of empowerment.

The five central themes outlined above provide a lens into the Somali mothers' experiences in SPP. They are reflective of not only what they learned from the program, but also what they learned from each other. As a whole, these themes capture the group members’ vulnerability to share and engage with one another and with me, as well as their openness to experience the unknown. This story would not be complete without also describing the learning that occurred for the interpreter (Ms. Abed) as well as myself.

The Interpreter Experience

The SPP interpreter was a significant part of the program experience. Not only was she present for every interview and every session, she was also involved in the development of the program and served as a cultural navigator on several occasions throughout the program. As such, at the end of the parent program, I completed a closing interview with the interpreter in order to gain a better understanding of her experience in

SPP. More specifically, the interview questions focused on her program expectations prior to the start of the program, challenges that she experienced as an interpreter, and what she enjoyed the most about the program.

It was interesting to learn that the interpreter had very low expectations for the parent program and anticipated that the program would be a "disaster." According to Ms. Abed, "I didn't think anyone was going to show!" More specifically, she did not believe that we would be able to engage the group members enough for them to attend all eight sessions. She also did not think that the group members would be willing to share anything personal throughout the program or that they would allow themselves to be open and vulnerable. Now looking back, she described herself as "being ignorant" in not giving the mothers a chance and having such low expectations for them as well as me.

She described the challenges of being an interpreter in this program and a young member of the refugee community. Because of her youth and her lack of status in the refugee community she often felt that the group members were not taking her seriously during the early sessions. For example, they would talk over her or not consider her opinion to be of importance. Also early in the program, some of the group members believed that what she was interpreting for me were her questions and discussion points rather than mine. At times, this was upsetting for some of the group members, because they believed that at her young age, it was inappropriate for her to be discussing such topics (e.g., husband and wife relationships, female genital mutilation) with community elders.

Finally, she spoke extensively about how much she learned from the group members by being part of the parent program. According to Ms. Abed, "For me this was

eye opening . . . I feel like I learned something about my culture." She further noted, "I have gained more knowledge and understanding . . . I feel like I understand more about myself." She had come to the United States at a very young age and her mother never spoke about the past. Ms. Abed explained, "I didn't know what life was like in the war, what they went through." Therefore, being a part of the parent program gave her the opportunity to hear about the experiences of other Somali women. Although difficult at times, hearing the other women share their stories gave her new insight into her own past and Somali history. She also enjoyed engaging in conversations about the balance of two cultures. As a young Somali woman herself, she is going though similar experiences and having the opportunity to engage in cultural dialogue with other Somali women, gave her a new perspective. Finally, and most importantly, she expressed that being part of the parent program taught her patience and increased her trust and confidence in the Somali women in her community.

The Researcher Experience

As the facilitator, and sometimes member, of the SPP, it is only fair that I also share my own experience. The most appropriate way to capture my experience and to introduce this section is to include the closing paragraph of my last Process Note.

> As I reflect on the last 8 weeks, I feel eternally grateful for the opportunity to get to know all 17 women that opened their hearts and gave our program a chance. Their rawness and vulnerability is humbling, and their strength and bravery amidst some of life's greatest adversity is inspiring. They are some of the kindest, most thoughtful women I have ever met. I have learned so much about the Somali culture and traditions, parenting and motherhood. I have a new perspective on the refugee journey. More importantly, I have a new perspective on the power of the human spirit. My hope and dream for what the Somali Parent Program could be, was only a fraction of the beautiful reality that it is today. What a journey it has been. I will cherish our time together for the rest of my life.

Indeed, what a journey it has been. No matter how much I prepared, I knew that little was going to be in my control once the program started. I came into this process naively focusing only on what the program could teach the Somali mothers about family transition, family well-being, and community integration. Although I had planned for group discussions as I prepared the weekly lesson plans, the focus was more on the teaching and less on listening, reflecting, and being present. As such, I came to the first session filled with anxiety. From worries about food and our space being ready on time, to how many Somali mothers would attend our sessions, and more importantly, how many of them would decide to stay and even come back the following week. These worries were all I could think about. However, as they shared their "Tree of Life" activity and reflected on their past, present, and future, "their stories of insurmountable loss and pain engulfed the room," and I quickly realized the importance of listening first and teaching second.

That would only be one of many lessons to come. As our time continued, their stories became richer and more personal, as the bond between us grew stronger. They invited me to family celebrations and offered prayers for my health and happiness. Our connection went beyond the words relayed through the interpreter; instead we connected through a gaze, a comforting hug, and a warm smile. I began to see them beyond the label of "Somali, refugee, and my study participants," instead they were women, wives, and mothers. As my awareness grew, so did my anger and my sadness. They had so much to offer to their refugee and broader community, yet their names and faces were unknown to most. For the first time, I was able to recognize what they meant when they spoke about being invisible and voiceless in their communities. I had worked in the refugee

community for several years prior to the start of this project and I too did not "see" them until now.

As our time came to a close, I became overwhelmed by their gratitude for what the program meant to all of the mothers, their families, as well as myself. While I had hoped that our time together would provide insight and skills related to family transition, family well-being, and community integration, what I did not anticipate was the emerging sense of empowerment, hope, and friendship that grew out of our eight weeks together. I was thrilled that they gained new skills, but I was inspired by their newfound zest and hope for themselves, their families, and each other. Similarly, I was also overwhelmed by the impact each one of the mothers had on me. While I had hoped that the mothers would take away something useful from this group, I did not realize how much I would learn from them both professionally and personally. Professionally, I grew more confident as a qualitative researcher. I also learned to navigate cultural awareness and acceptance while maintaining clinical and research rigor. Personally, they taught me patience, humility, and tolerance. More importantly, they gave me strength.

Conclusion

The purpose of this chapter was to gain a descriptive account of the group members experience in SPP on both an individual as well as group level. In order to better understand the group members' evolvement in the program over time, the study data were divided into three phases, initial, during, and concluding program phase. Initial program data reflected the group members' experiences prior to the start of the program, with emphasis on their resettlement journey and transition to the United States. The descriptions during the program phase focused on their weekly experiences in SPP.

While the concluding program data allowed the group members to reflect on various aspects of the program as well as their overall impressions and experiences. As such, overarching themes were generated for initial and concluding program phases, while the program delivery phase provided further detail and individual experiences as related to the overarching themes. Although the overarching themes were generally interconnected, they also had some distinct aspects and provided a powerful narrative on how the SPP impacted the members' across time.

CHAPTER V

DISCUSSION

As the number of refugees continues to grow, host communities must find effective ways to support their transition and integration into their new homes. Implementing family-focused programs that are designed for the family unit highlight family and community strengths, supports, and resources. Furthermore, family-focused programs align well with the cultural values and traditions of many refugee families, especially those who are Somali. This study explored the experiences of Somali mothers in a culturally-specific, 8-week Somali Parent Program (SPP) designed to explore three main factors associated with refugee families' adjustment process including family transition, family wellbeing, and community integration. Using a phenomenological approach, initial and concluding interview transcripts, video recordings of each program session, artifacts created throughout the program, and my own process notes were analyzed to capture the Somali mothers' experiences in the SPP.

My main goal for this study was to understand how Somali mothers make meaning of their adjustment process and their involvement in SPP. The initial interviews highlighted the Somali mothers' transition and integration experience. Common themes emerged related to emotional distress, shifts in family dynamics, navigating systems, and sources of safety and security. Somali mothers reveled that being part of SPP provided a source of belonging, support, and empowerment for the mothers. Other emerging themes highlighted the importance of sharing one's story, understanding of cultures and

biculturalism, parent-child relationships, and understanding of community supports and resources. The theme map below (Figure 8) provides a visual model for the pre and post program emerging themes.

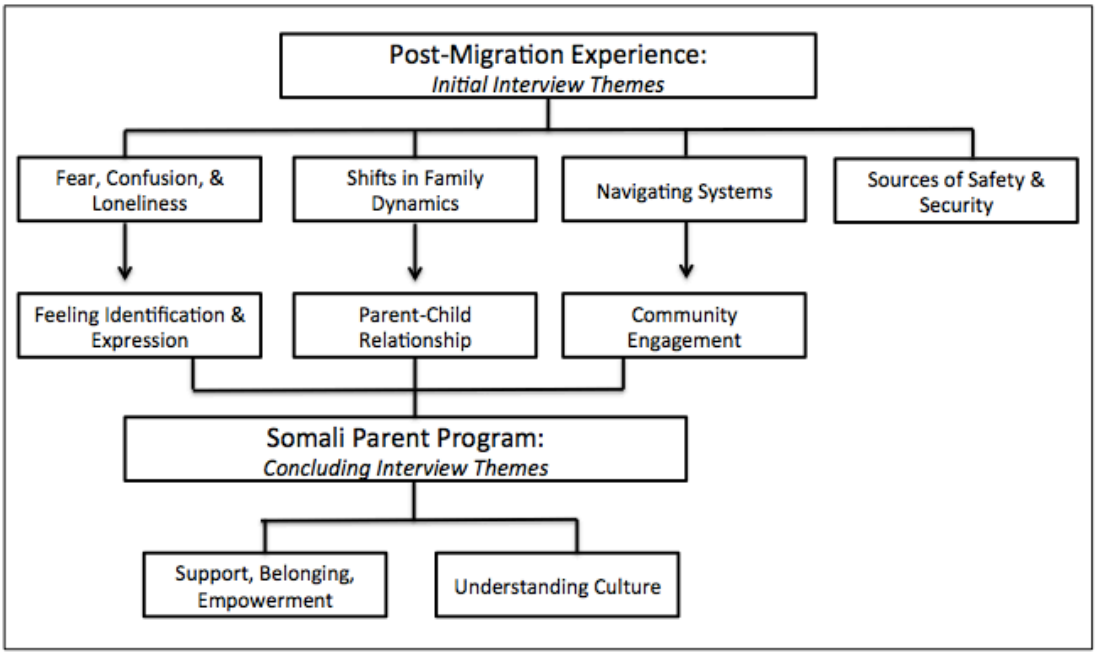

Figure 8. Theme Map. This map depicts the emerging initial interviews themes related to the post migration experience (top of the diagram) and the emerging concluding interview themes related to the group members' experience in the Somali Parent Program (bottom of the diagram).

Guiding Questions

My main goal for this study was to understand how parents make meaning of their experience in SPP, including questions of what they found beneficial or detrimental, as well as whether they were applying the concepts in their daily lives. Despite barriers related to transportation, medical appointments, and employment, the core group attended SPP 65.0% of the time. While there are several emerging themes that reflect the Somali

mothers experience in SPP, the most salient theme that emerged was an increase in social support and the significance of the shared experience. More specifically, words such as "females coming together, talking, sharing, belonging, support," were echoed by many of the mothers as they reflected on their experience in the program. Prior to the start of the program, although they lived in the same community and attended English classes together, many felt isolated from their cultural group as well as the broader community. SPP provided a safe place in which they could share, listen, and support one another. The program's emphasis on sharing and reflection allowed the group members to identify common threads of the refugee experience that united them as Somalis, women, and mothers. Many found a great sense of comfort in knowing that other women in the Somali community shared their pre and post-resettlement challenges. Their commonalities and shared experience in the program connected the mothers and provided a new found sense of belonging. As Basra suggested to a group of men, "this was a women's group only," indicating the pride she had in the special space that they had created.

Social support is a critical factor in decreasing isolation and loneliness and increasing belonging and life fulfillment in refugee communities as individuals integrate into their host communities (Jordan, Matheson, & Anismna, 2009; Simich, Beiser, & Mawani, 2003; Stewart et al., 2010). Furthermore, social support can help to ameliorate acculturation difficulties that many refugees experience during post-resettlement (Stewart et al., 2010). For example, Stewart et al. (2011) found in their support program that refugee group members reported that the sessions offered a sense of relief as they reconnected with their cultural and ethnic community. Similar to the findings indicated in

SPP, this group program resulted in increased social integration and decreased loneliness among the refugee participants (Stewart et al., 2011). Similar findings were also noted in the Tea and Family Education and Support (TAFES) multi-family group program for Kosovar refugees (Weine et al., 2003), in which the program had a positive impact on participants' social support and sense of belonging. Thus, community-based programs like SPP help to promote information exchange, emotional support, and opportunities to connect with one's ethnic community and may serve as a beneficial approach for enhancing social support and belonging among refugees.

In addition to increased social support, Somali mothers identified that being able to share their stories and be heard was one of the most beneficial aspects of SPP. More specifically, Somali mothers reported that SPP allowed them to "talk about our past and our current situation," as well as learn "how to express myself and my pain." This was an interesting finding considering that there was much resistance during the initial interviews and early sessions to idea of discussing past trauma and identifying feelings. This resistance was not unusual, Jimale et al. (2002) suggested that, "Somalis tend to say everything is fine even when things are bad." For many Somalis, expression of emotional distress is often shown through somatic symptoms such as headaches, body aches, and tiredness (Scuglik et al., 2007). It is also not uncommon for refugees to avoid discussing traumatic memories because many fear that talking about memories brings physical and emotional pain (Weine et al., 2004). However, with time and a growing sense of connection and safety, the Somali mothers began to express their feelings (both positive and negative) during weekly session check-ins and to share their past experiences. Although it may have been painful initially, it also seemed to bring a sense of relief. As

noted by Basra, “Expressing my past and for the first time I talked about it, the relief that I got after talking about what happened to me in the past.”

Just as emotional expression brought a sense of relief, learning and understanding culture and cultural differences brought a sense of acceptance for the Somali mothers. For the mothers this meant a greater understanding of cultural differences and learning how to balance their own culture with that of the host country. Much has been written about the acculturation and adjustment aspects of the refugee experience (Birman, 2006; McGown, 1999; Moyerman & Forman, 1992) and for many families maintaining their religious, ethnic, and cultural values can be one of the most challenging aspects of the resettlement process. Furthermore, many families experience acculturation gaps as their children learn the language and adapt to the host culture while refugee parents tend to retain their native language and culture (Birman, 2006). However these Somali mothers reported that the program taught them how to maintain their “strong Somali culture” with their children by sharing about and upholding their religion, language, and traditions. However, they were also more willing to talk to their children about American culture. Although the program did not focus on specific cultural training, it did promote cultural exchange through Somali food, weekly lessons, discussions, and sharing my own experiences. Each lesson included a Somali way of understanding a specific topic (i.e., social-emotional development) followed by an introduction to a Western perspective on that same topic. As such, this form of cultural exchange and comparison may have increased Somali mothers’ awareness, understanding, and acceptance of cultural differences.

Two primary examples of how the Somali mothers were able to apply SPP in their daily life was through their parent-child relationships and community integration. Through the program content and discussion, these mothers seemed to gain a new sense of value for connecting, communicating, and understanding their children. Many refugee parents and children experience significant family distress as a result of changes in family roles, functions, and responsibilities (Lewig et al., 2010). As such, there is often disconnect between the needs of refugee parents and the needs of their children, which may result in parent-child conflict (Mohamed &Yusuf, 2011). According to the Somali mothers in the program, their increased efforts toward connecting and communicating with their children resulted in increased family engagement through "sharing, family talks, and family gatherings." They reported speaking more openly with their children and having more patience with them.

In addition to becoming more engaged with their children, Somali mothers also reported feeling more integrated in their local community. First they reported having greater awareness of community resources, such as accessing medical supports or activities for their children. They also reporting accessing their children's school more often and feeling more comfortable to contact their child's teacher and attending school functions. For many refugee families, integrating into their community can be one of the most challenging aspects of their post-resettlement journey due to lack of access to resources as well as language and transportation barriers and cultural differences (Goodkind & Foster-Fishman, 2002). For the mothers in SPP participating in this program seemed to give them a sense of agency and confidence to access community resources.

The second research question explored how Somali parents understand and interpret their family's transition process. Somali mothers identified three central themes when exploring their transitional process and experience. Regardless of how long they had been living in the United States, every mother experienced emotional distress related to their transition. They emphasized, "thinking a lot" throughout their transition process. In fact, the phrase "thinking a lot" has often been identified as the key complaint across many cultures and many refugee groups as a sign of emotional distress (Hinton, Reis, & de Jong, 2015). For the Somali mothers in SPP, their thoughts resulted in feelings of confusion, fear, and loneliness. More specifically, confusion and fear related to reflecting on their past and experiencing new stressors in the present. Somali mothers described spending their time "thinking" about their past, including traumatic memories, fear for relatives and family and friends back home, and trying to make meaning of their traumatic experience. They also experienced confusion and fear associated with integrating into their new community, including adapting to the culture, norms, and values as well as experiencing language challenges and deterioration of their family system. Their transition process also brought feelings of loneliness and social isolation from their family and their community. Many felt disconnected not only from their social networks and supports, but also from their immediate family members.

The family disconnect echoed by the Somali mothers was often the result of acculturation stressors during their transition and post-resettlement process. Family difficulties have been identified as one of the key factors in the refugee acculturation and transition experience (Renzaho & Vignjevic, 2011; Scuglik et al. 2007; Weine et al., 2004). For the Somali mothers, their transition experience had a direct negative impact on

their family system, with significant distress related to the parent-child relationships being the primary concern. First, they lacked the guidance and support from extended family and community that they once had in Somalia to raise their children "the Somali way." They also experienced significant discomfort and ambiguity in raising their children the "American way." They feared the American system of parenting threatened their Somali traditions and that their children were at risk for losing their native language, cultural identity, and religious values. Despite their own desire to maintain their culture, they often gave into their children's demands because they feared that their children would be "take away" otherwise. Their children acculturated faster, learned English, and were better equipped to navigate these new systems and as a result, these mothers experienced a type of loss in their place in the family. Many families experienced a breakdown in the family system and a significant shift in family structure and dynamics, which caused significant discomfort for the Somali mothers.

Finally, despite all the identified challenges that the families experienced during their transition, their new communities also brought a new sense of safety and security that they did not have in the past. These included access to food, housing, medical supports, education, and opportunities for employment. Similarly, they also felt safe from the dangers that they experienced while living in Somalia and the refugee camps. Thus, feelings of safety and living in peace were often interchangeable. They also valued having their family together and safe. As such, many identified feeling "happy" because their basic needs were being met. Interestingly enough, no matter how long the Somali mothers had been living in the United States prior to start of SPP, they did not take their safety for granted.

The third research question explored how the Somali mothers interpret their family health and wellbeing as well as how they perceive and understand issues surrounding their own and their children's mental health. Due to the adverse experiences that most refugees have experienced, as well as the significant stress that occurs in their transition to the United States (Kroll et al., 2011), family health and wellbeing is a critical component of refugee families' adjustment experience. For these Somali mothers, health and wellbeing is a complex issue. Although most of the mothers reported that their families (i.e., their children) were currently "happy" and "doing well," the mothers themselves had a different experience. According to the SPP mothers, their health and wellbeing was impacted by both experiences from the past as well as their present post-resettlement challenges. These challenges were manifested in two ways, feelings of significant emotional distress and ongoing somatic complaints.

As outlined in the previous section, they described their emotional distress as feeling stressed, overwhelmed, and spending their days "thinking a lot" about the past, including their own trauma experiences and their post-resettlement challenges. These stresses were further exacerbated due to lack of social supports in their present communities. A feeling of loneliness was one of the most common complaints reported by SPP mothers. They felt socially isolated from both their communities and their families. Similarly, SPP mothers also reported ongoing somatic symptoms (e.g., body aches, difficulty sleeping, headaches) that often resulted in multiple visits to the emergency room. Physical complaints are frequently reported by Somali refugees (McGraw-Shuchman, 2004). For the mothers in SPP, most were not diagnosed with a medical condition during those hospital visits and instead were told that their symptoms

were related to stress. While they recognized that they were experiencing both physical and emotional symptoms, they had difficulty relating these symptoms to their medical providers. They also experienced difficulty interpreting what these symptoms meant and more importantly how to treat them. As such, not having a clear diagnosis and clear recommendations on how to treat their symptoms created further feelings of frustration which resulted in higher levels of emotional distress and negatively impacted their physical and emotional health and wellbeing.

The fourth research question explored group members' community involvement and integration. Regardless of how long the Somali mothers had been living in the United States, all of them expressed minimal integration in their local community prior to the start of SPP. In fact, all of the mothers identified navigating and integrating into their local community to be a stressful experience. In particular, the SPP mothers identified three barriers that impacted their community integration and engagement, which included, language, transportation, and system differences. Language was a daily barrier for communicating and accessing the outside world. From accessing community resources such as medical and employment services to attending school functions for their children, lack of interpreters in their community made it difficult to be aware of community supports and engage in community functions. Most of the mothers did not drive and found the public transportation system to be unreliable. As such, this significantly limited their ability to access resources in their local community. Even when they were able to overcome language and transportation barriers, they experienced great distress because they did not know what community resources were available to them or

how to access those resources. Many of the mothers expressed trying to integrate into their community, but not being successful at doing so.

After the completion of SPP, Somali mothers had a different perspective on community integration. While language and transportation remained significant barriers, being part of SPP helped them become more aware of their community and the resources that were available for their families. They had a greater sense of the supports that were available and they grew more comfortable in accessing organizations within their community (e.g., their children's schools). One of the most exciting aspects for me as a school psychologist was that Somali mothers reported increased interest in engaging in their children's schools. They described feeling more comfortable attending school functions such as parent-teacher conferences for their children. In addition to learning about community supports, the Somali mothers also started to rely on one another as way of integrating into their community. For example, they provided transportation for one another for different appointments and community events.

Practice Implications

Culturally Specific Family-focused Program

Although current and past research has identified the importance and the need for community programs with refugee families, culturally specific family-focused programs for Somali refugees are limited (Lightfoot, Blevins, Lum, & Dube, 2016). Therefore, the significance of such programs is yet to be fully understood and utilized with newly arrived Somali parents and their children. SPP was a culturally specific program for Somali mothers that emphasized family transition, family wellbeing, and community integration. Every aspect of SPP incorporated Somali culture and traditions into the

program. Somali food and music was an essential component of every session and each program lesson and discussion emphasized cultural dialogue. For example, when discussing Erikson's stages of social emotional development, the Somali mothers were first asked to review stages of development from a Somali perspective, followed by review of Erikson's stages. This method of sharing invited rich dialogue between the group members and provided these women the opportunity to consider how they could integrate both cultures into their daily lives. Although the program was originally designed for both male and female parents, it was determined that having an all female group was the most culturally and spiritually appropriate for this specific program. In this type of setting, the mothers felt more comfortable to share and ask questions.

The Somali mothers experience in SPP highlights the need for and the importance of cultural relevant programs with refugee families as an indicator of refugee engagement as well as cultural adaptation. Ibraki and Nagayma Hall (2014) found that only half of ethnically diverse individuals will attend more than one counseling session, while 70 percent of whites will attend more than one session. These data represent college students so it was likely that the percentages among less acculturated, ethnically diverse individuals were even lower. However, SPP group attendance serves as an indicator of treatment engagement among the Somali mothers in this program. The SPP median attendance across the original 10 group members was 6 and the mean was 5.2, suggesting high group engagement among group members. Only 1 woman out of a total of 10 women did not attend any of the sessions after completing the initial interviews due to giving birth shortly after. All other group members attended at least 3 or more sessions. Although there was an ethnic mismatch between the group members and myself,

emphasis on cultural responsiveness within every aspect of SPP may have contributed to the high group engagement. In consideration of the imbalance between ethnically diverse behavioral health professionals and the needs of ethically diverse populations including refugee populations (DeCarlo Santiago & Miranda, 2002), promotion of culturally relevant and specific programs may reduce disparities in behavioral health care among ethnic minorities, including engagement in treatment.

Additionally, cultural understanding was one of the most salient themes across all concluding interviews. Not only did the Somali mothers report gaining a greater understanding of the United States culture, they expressed their heightened awareness and knowledge of how to integrate their traditions, beliefs, and values with the expectations of their host community. Cultural adaptation has been found to be one of the most difficult aspects of Somali integration (Jordan et al., 2009). Therefore, culturally specific programing that allows refugees to maintain their ethnic identity while integrating into the host culture, may be a critical component of reducing stress associated with refugee acculturation and adjustment and increasing positive well-being.

Somali Parent Program as a Source of Social Support

Positive refugee acculturation, adjustment, and recovery requires social and ethnic community supports (Jasinkaja-Lahti, Liebkind, Jaakkola, & Reuter, 2006). For the Somali mothers in SPP, social isolation and loneliness was identified as one of the key stressors of the refugee transition and adaptation process prior to start of SPP. Despite living in the same community and in some cases, attending the same English classes, most of the mothers identified they had encountered nonsupportive interactions (i.e., they were not able to find social support when they sought it out) within their ethnic

community as well as the host society. It is difficult to say why these women had not naturally grouped together to support one another during their interactions at the refugee center, but it is likely that their daily stressors and responsibilities took precedence over reaching out to support one another. The SPP offered them a special time and a place for these types of interactions. However, concluding interviews found that support and belonging was one of the most meaningful aspects of Somali mothers experience in SPP. According to the Somali mothers, SPP brought cohesion amongst the group members and a sense of shared meaning about their past and present experiences. SPP allowed them to develop an interpersonal support network that went beyond the 8 weeks spent in the program.

Increased social support has been found to be a positive factor in individually well-being and adjustment (Jasinkaja-Lahti et al., 2006). In particular, Schweitzer, Melville, Steel, and Lacherez (2006) found social support be to a salient psychosocial factor in determining psychological wellbeing and may impact feelings of belonging and isolation. However, for many refugee families, the availability of interpersonal support and ethnic networks within the host society may vary and is often identified as one of the primary post-resettlement challenges (Stewart, et al., 2008). The experiences of the Somali mothers in SPP are promising and suggest that culturally relevant community programs can help to increase social support and strengthen ethnic networks within specific refugee communities. Furthermore, such community programs may also provide a buffer against acculturation stress and foster psychological health and wellbeing among refugees.

Somali Parent Program as a Source of Empowerment

One of the most unexpected outcomes of SPP was that the Somali mothers reported a sense of agency, identity, and meaning that grew out being part of SPP. The pre-, trans-, and post-migration experience disrupts one's family and cultural system (Schweitzer et al., 2006). The differences and demands of the culture and language of the host country further challenge one's sense of identity and belonging. Prior to the start of SPP, the Somali mothers reported feeling invisible and voiceless in their community. More importantly, Somali mothers felt that their cultural and religious principles were at risk. However, being part of SPP gave them a renewed sense of knowledge and power. The program helped these Somali mothers to feel empowered not only on an individual level but also as women and members of the Somali community.

Many refugees experience displacement, exposure to extreme violence and loss, as well as political and ethnic persecution. Somalis have lived under these conditions for over two decades with over 1 million displaced from their homes (Betancourt et al., 2015). Pre-migration experiences are compounded with post resettlement and acculturation challenges such as language difficulties, un- or under-employment, confusion navigating systems and integrating into the community, lack of social supports and networks, and disrupted family dynamics (Stewart et al., 2008). Although most refugees are incredibly resilient, these stressors and others often strip them of their cultural and ethnic identity leaving them feeling disenfranchised and highly vulnerable to psychological distress. Providing refugee families with the knowledge and tools to understand their transition experience, to enhance their own emotional health and well-being, and assist them with community integration can have a significant positive impact

on their self-concept and psychological health and well-being. This type of preventive, community-based programming is incredibly important considering the stigma associated with accessing mental health services in the Somali community (Ciftci et al., 2013). As such, family-focused programs such as SPP can help ameliorate psychological distress associated with pre- and post-migration experiences by helping refugee families develop protective psychosocial factors that will enhance their overall sense of self and wellbeing.

Promotion and Prevention in Behavioral Health

As noted, the complexity and the severity of the migration challenges impacting refugee families makes them highly vulnerable to experiencing and developing psychological distress (Fox & Tang, 2000). However, despite the high degree of stressors that refugee families experience, the refugee community seldom seeks behavioral health services (Miller, 1999). Within the Somali community, the label of "mental illness" may bring significant distress and shame on the family and is often avoided and denied under most circumstance (Scuglik et al., 2007). There is a different conceptualization of emotional distress and appropriate treatment, which often includes religious, cultural, and traditional healing practices. Even though their pre-migration experiences may have been quite traumatic, many refugees place more emphasis on post-resettlement stressors and rebuilding social contexts instead of those that occurred during pre-migration (Savic, Chur-Hansen, Mahmood, & Moore, 2016).

Therefore, rather than focusing on the past, emphasis should be placed on helping families within their communities as they encounter system-wide challenges in their post-resettlement transitions. This can be done through development and implementation of community programs that promote prevention and wellbeing. Community programs align

well with the refugee social and cultural traditions (e.g., bringing communities together, sharing, food) and promote social networks and community supports. Although most refugees have experienced a high degree of distress in their lifetime including a history of trauma, not every refugee needs to tell their trauma narrative and receive intensive behavioral health services. As such, community programs that foster culturally specificity, learning and skill building, as well as opportunities for expression and open dialogue may be better suited to meet refugee needs. One of the primary goals of a program like SPP was to promote positive wellbeing and help reduce to the risk of developing behavioral health concerns in the future. For refugees who are experiencing significant distress, community programs such as SPP may serve as a screen for identifying behavioral health concerns and assisting these individuals in accessing needed care. In SPP, no group members were identified as needing more intensive behavioral health services. However, had there been concerns, this group setting would have been an ideal venue for connecting the group member to appropriate services because of the safe, supportive, culturally sensitive atmosphere that had been developed. As a testament to this possibility, it was in this setting that one mother chose to tell about her struggles with her son who had serious mental health challenges.

The Need for Community Programs and Supports

The experiences of Somali mothers in SPP highlight the need for expansion of refugee community programs that build on the strengths of refugee families and emphasize post-migration experiences. In a study exploring positive factors associated with positive adjustment of Somali refugee families, Betancourt et al. (2015) found that "religious faith, healthy family communication, support networks, and peer support," (p.

114) were considered primary individual, family, and community strengths by Somali families. As such, developing community programing that integrate cultural and spiritual factors, family systems, and social supports is a key to promoting healthy adjustment among refugee families. For example, Somali mothers in SPP identified a desire to maintain their religion, culture, and language with their children. One possible way to integrate the factors outlined above and address acculturation challenges could occur through the creation of a family-based program in which parents can teach about and celebrate their culture (e.g., music, dance, story telling) and language with their children. Such family-based programs may be one way in which the parents can keep their culture alive while engaging with their children.

Somali Parent Program also highlights the importance and the value of collaborating between programs and community organizations. Implementing SPP at a local refugee center where many of the group members had attended English classes and accessed other resources significantly contributed to the success of SPP (e.g., high group attendance, group engagement, etc.). Similarly, collaborating with local community resources such as health centers, transportation, housing, community colleges, workforce agencies, immigration offices, and schools may help reduce challenges related to navigating community systems as well as to enhance family access to these necessary community resources.

The Role of Schools and School Psychologists

One of the most important and challenging community services identified by the Somali mothers was their children's schools. In particular, they described the need for greater understanding of the local school system and a desire to be more involved.

Although the U.S. education system may have different expectations and functions than schools in the refugee camps, these mothers seemed more aware of the role of schools as compared to some of the other host community institutions. For example, parents identified access to education as a key protective factor in their post-migration experience. Schools are an essential component of refugee families' post-migration experience and provide an ideal setting to implement family-focused programs (Tyrer & Fazel, 2014). School personnel can collaborate with local refugee agencies to implement parent workshops for incoming refugees that focus on various aspects of the school systems including school organization and policies, parent rights, special education, and other important information. Similarly, hosting parent education classes in the school that focus on language or skills building (e.g., learning computer skills) as well as various aspects of parenting (e.g., parent-child interaction, discipline, promoting healthy social and emotional development) can increase parent self-efficacy as well as parent involvement in the schools. Schools should also create opportunities for refugee parents to serve on various school committees or provide supports in the classroom (e.g., serving as cultural liaisons or school paraprofessionals). Finally, developing school family nights that promote child-parent engagement through games or movies can nurture healthy family interaction as well as strengthen parent and child school involvement.

Implementing the types of programs outlined above requires extensive coordination and training by the school system. School psychologists are in an ideal position to serve as liaisons between the family and the school. First, school psychologists can be at the forefront of creating culturally responsive and trauma informed schools by offering consultation and training for school administrators,

teachers, and other school professionals on the impact of pre- and post-migration experiences on refugee children's emotional and academic development. Furthermore, school psychologists can implement individual and group supports for refugee children in the schools to foster healthy social and psychological adjustment. Finally, they can help develop and implement parent programs as well as family-focused programs in the school setting that support refugee children's emotional and academic needs as well as foster healthy transition and development for refugee children and their families.

Critique and Limitations

The findings of this research suggest that the women experienced the group as a source of support, belonging, and empowerment. However, since it was not a program evaluation study, it would be premature to conclude the effectiveness of this group. Instead, more research is needed to assess actual attitude and behavior change. Therefore methodological limitations should be considered when interpreting the findings. Although the program was originally designed to be a family-focused program for both fathers and mothers, only Somali mothers participated in the implementation of the program. As such, the findings represent the experiences of the Somali mothers and do not capture the full picture of the family, except in those cases where there was not a male parent. The characteristics and the experiences of the Somali refugee mothers who chose not to participate in the program or who did not attend the local refugee center where the research participants were recruited is unknown. Similarly, it is unclear if SPP would have had a similar impact on other refugee groups, such as Iraqi or Burmese mothers.

The program had an open door policy, in which any Somali mother who attended the local refugee center could attend SPP sessions anytime throughout the 8-week period. Therefore, demographic data and initial interviews were not completed on all participants which made it difficult to assess the effectives of the program for those participants. Similarly, attendance varied across the 10 participants who completed the initial interviews, with one individual not attending any sessions, and only six completing the concluding interviews. As a clinician, this type of open door policy was considered an important aspect of the program, however from a research perspective, not having access to initial and concluding interviews data on all participants limits the findings.

Working transculturally added another layer of complexity to the current study. Pernice (1994) identified six methodological challenges that should be considered when working with refugees and immigrants, these include, contextual differences between refugees and the host country, translation of instruments, sampling difficulties, language challenges, understanding refugee groups structure and roles, and personality characteristics of researchers. One of the most salient methodological challenges in this study was language. More specifically, phenomenology relies on capturing the essence of one's experience. For this study, due to language barriers, I was not able to analyze any in-depth oral or written expression directly from the participants. Instead I had to rely on the interpreter to capture each participant's point of view. Furthermore, despite being proficient in both Somali and English and culturally sensitive, the interpreter was not professionally trained. Therefore, it is likely that various language and cultural nuances were not truly captured and may have impacted phenomenological data analysis.

Within SPP, every aspect of the program development, implementation, and evaluation was completed in collaboration with a local Somali leader and cultural broker. Similarly, the SPP interpreter was also a member of the Somali community. After every interview and every group session, I reviewed the data with the interpreter in order to ensure that the participants' voices were captured. Additionally, during the 4th SPP session, I checked in with the participants to review areas of the program that they had enjoyed thus far and if there were any areas that needed to be improved. Although every effort was made to capture the true essence of the Somali mothers experience in SPP, various aspects of data collection during initial interviews, discussions throughout the program, and concluding interviews may have been lost in translation. Therefore, it is difficult to determine to what extent complexities related to transcultural interpretation and translation had on developing and reporting the underlying central themes in the study.

Implications for Future Research

The emerging themes suggest that the SPP provided a positive experience for the Somali mothers who participated in the program. As such, SPP shows great promise for the development and implementation of community and family-focused programs with refugee families. The current study explored how the Somali mothers who participated in the program made meaning of their experience in SPP, however, future research that utilizes quantitative and mixed methodology to measure program effectiveness may enhance our knowledge of the most important program elements. In order to assess what aspects of the program were effective, it would be important to use culturally-relevant assessment tools to measure the degree to which acculturation, emotional health and

wellbeing, and community integration variables varied pre- and post-completion of the program.

Researchers have suggested that culturally specific family focused programs may moderate psychological distress and reduce the risk of future development of psychopathology (Weine, 2011), but the current study was not able to assess this factor directly. Therefore, future research may be directed toward evaluating whether family-focused programs help reduce psychological distress in refugee mothers. Furthermore, longitudinal studies could address the impact of these community programs on the psychological well-being and integration of refugee families as they settle into their new lives.

The current study captured Somali mothers' thoughts and experiences in relation to family transition, wellbeing, and community integration. Exploring the experiences of other members of the family system (e.g., children, husbands) in relation to these constructs as well as their perceptions of the impact of SPP on their families would add depth to the findings. More specifically, interviewing the children would provide insight into the refugee children's transition experience, their perception of family dynamics and their relationship with their parents and other siblings. Similarly little is known about Somali father's transition experiences. Therefore, conducting interviews with Somali fathers would provide new insight into their role within the family system and how they conceptualize their post-migration experience.

The SPP showed great promise with Somali mothers, but it would be important to assess the effectiveness of the SPP model with other ethnic and cultural groups. For example, while taking cultural practices into consideration, could similar program

principles be applied with another cultural group? Would applying this program model have a similar level of impact and effectiveness? What aspects of the program would need to be adjusted or changed to meet the needs of other ethnic groups such as Syrian, Iraqi, or Burmese refugee families? Thus, it would be valuable to explore and determine what aspects of the program curriculum are universal (e.g., culturally specific programming, emphasis on social support) and can be utilized with any ethnic group and which aspects would need to be adjusted based on the needs of another specific group.

Finally, much of current development and implementation of community-based program for refugee families is facilitated by researchers and clinicians who do not culturally represent the refugee community. In order to develop and implement programs that truly capture the refugee experience and give refugees a voice, there is a great need for community-based participatory research (Ellis, Kia-Keating, Yusuf, Lincoln, & Nur, 2007) that relies on the voices of the refugee communities. Furthermore, there is also a need for empowering and training refugees to implement community-based programs within their own communities. For example, at the end of SPP, several women expressed a desire to continue to meet and support one another after SPP ended. Creating avenues in which refugees can facilitate and guide community programs will lead to development of programs that are rooted in community strengths and family needs. More importantly, it may lead to greater sense of agency and empowerment within refugee community that can foster adaptive transition and psychological adjustment.

Conclusion

The Somali mothers who participated in the SPP expressed an increase in their cultural understanding and more confidence in how to integrate their own culture and that

of the host country. They grew more aware of adaptive ways to identify and express emotions and strengthened their parent-child relationships. With this new knowledge, they became more comfortable in accessing community supports and building their support networks with other Somali women. For many, they gained a new sense of meaning and empowerment in their own lives. These findings suggest that culturally-specific family focused programs such as the SPP that highlight prevention may provide an effective way of addressing acculturation, adjustment, and recovery amongst refugee families. Furthermore, the findings also highlight that family-focused program may increase social and community supports and resources and provide refugee families with a newfound sense of awareness and meaning. Although there is a need for continued research on trauma-informed practices with refugees, it is critical that these approaches are built upon broad community and family supports such as those represented by the SPP. These types of preventive approaches can potentially ameliorate psychological distress and promote adaptive transition, adjustment, and psychological wellbeing in all refugee families.

REFERENCES

Abu-Ras, W., Gheith, A., & Cournos, F. (2008). The imam's role in mental health promotion: A study at 22 mosques in New York City's Muslim Community. *Journal of Muslim Mental Health, 3*, 155-176.

Akinsulure-Smith, A. (2009). Brief psychoeducational group treatment with re-traumatized refugees and asylum seekers. *The Journal for Specialists in Group Work, 34*(2), 137-150. doi:10.1080/01933920902798007

American Psychological Association. (2014). *Trauma.* Retrieved from http://www.apa.org/topics/trauma/

Barrett, P. M., Moore, A. F., & Sonderegger, N. L. (2000). The FRIENDS program for young former-Yugoslavian refugees in Australia: A pilot study. *Behaviour Change, 17,* 124-133.

Barrio, C. (2000). The cultural relevance of community support programs. *Psychiatric Services*, 51, 879-884.

Bentley, J. A., & Owens, C. W. (2008, November 1). *Somali refugee mental health cultural profile*. Retrieved from http://ethnomed.org/clinical/mental-health/somali-refugee-mental-health-cultural-profile

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

Betancourt, T. S., Abdi, S., Ito, B. S., Lilienthal, G. M., Agalab, N., & Ellis, H. (2015). We left one war and came to another: Resource loss, acculturative stress, and caregiver-child relationships in Somali refugee families. *Cultural Diversity and Ethnic Minority Psychology, 21*(1), 114-125.

Birman, D. (2006). Acculturation gap and family adjustment findings with soviet jewish refugees in the United States and implications for measurement. *Journal of Cross-Cultural Psychology, 37*(5), 568-589. doi:10.1177/00220221 06290477.

Birman, D., Beehler, S., Harris, E. M., Everson, M. L., Batia, K., Liautaud, J., . . ., Capella, E. (2008). International family, adult, and child enhancement services (FACES): A community-based comprehensive services model for refugee children in resettlement. *American Journal of Orthopsychiatry, 78*(1), 121-132. doi:10.1037/0002-9432.78.1.121

Bridging Refugee Youth & Children's Services (BRYCS). (2003). *Helping refugee parents adjust to life in the U.S.* Retrieved from http://www.brycs.org/documents/ upload/brycs_spotfeb2004.pdf

Bridging Refugee Youth & Children's Services (BRYCS). (2005). *Strengthening services for refugee parents: Guidelines and resources*. Retrieved from www.brycs.org/documents/upload/**parenting**_manual.pdf

Bridging Refugee Youth & Children's Services (BRYCS). (2014). *Promising practices program*. Retrieved from http://www.brycs.org/promisingpractices/ promising-practices-program.cfm?docnum=0108

Bronfenbrenner, U. (1979). *The ecology of human development: experiments by nature and design*. Cambridge, MA: Harvard University Press.

Bronfenbrenner, U. (1994). Ecological models of human development. In *International Encyclopedia of Education, Vol. 3, 2nd. Ed.* Oxford: Elsevier. (Reprinted from *Readings on the development of children* 2nd ed., pp. 37-43, by M. Guavain & M. Cole, Eds., New York, NY: Freeman.)

Carswell, K., Blackburn, P., & Barker, C. (2011). The relationship between trauma, poast-migration problems and the psychological well-being of refugees and asylum seekers. *International Journal of Social Psychiatry, 57* (2), 107-119. doi:10.1177/0020764008105699.

Ciftci, A., Jones, N., & Corrigan, P. W. (2013). Mental health stigma in the Muslim community. *Journal of Muslim Mental Health, 7*(1), 17-32.

Creswell, J. W. (2013). *Qualitative inquiry & research design: Choosing among five approaches.* Long Angeles, CA: Sage.

de Anstiss, H., & Ziaian, T. (2010). Mental health help-seeking and refugee adolescents: Qualitative findings from a mixed-methods investigation. *Australian Psychologist, 45*(1), 29-37

DeCarlo Santiago, C., & Miranda, J. (2002). Progress in improving mental health services for racial-ethnic minority groups: A ten-year perspective. *Psychiatric Services, 65*(2), 180-185.

del Valle, P. (2002). Traumatized refugee children. In. S. E. Brock, P. J. Lazarus, & S. R. Jimerson (Eds.), *Best practices in school crisis prevention and program* (pp. 599-614). Bethesda, MA: National Association of School Psychologists.

Denzin, N. K., & Lincoln, Y. S. (2011). *The SAGE handbook on qualitative research.* Thousand Oaks, CA: Sage Publications.

Ellis, B. H., Kia-Keating, M., Yusuf, S. A., Lincoln, A., & Nur, A. (2007). Ethical research in refugee communities and the use of community participatory methods. *Transcultural Psychiatry*, 44(3), 459-481. doi:10.1177/1363461 507081642

Ellis, B. H., Lincoln, A., MacDonald, H. Z., & Cabral, H. J. (2008). Mental health of Somali adolescent refugees: The role of trauma, stress, and perceived discrimination. *Journal of Consulting and Clinical Psychology, 76*(2*), 1984-193.*

Ellis, B. H., Miller, A. B., Abdi, S., Barrett, C., Blood, E. A., & Betancourt, T. S. (2013). Multi-tier mental health program for refugee youth. *Journal of Consulting and Clinical Psychology, 81*(1), 129-140. doi:10.1037/a0029844

Ellis, B. H., Miller, A. B., Baldwin, H., & Abdi, S. (2011). New directions in refugee youth mental health services: Overcoming barriers to engagement. *Journal of Child & Adolescent Trauma*, 4, 69-85. doi:10.1080/19361521.2011.545047

Erikson, E. H. (1950). *Childhood and society*. New York, NY: Norton.

Fazel, M., Reed, R. V., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *The Lancet*, 379, 266-282. doi:10.1016/S0140-6736(11)60051-2

Fazel, M., & Stein, A. (2002). The mental health of refugee children. *Archives of Disease in Childhood*, 87, 366-370.

Fazel, M.,Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorders in 7000 refugees resettled in western countries: a systemic review. *The Lancet*, 365, 1309-1314.

Fox, S., & Tang, S. (2000). The Sierra Leonean refugee experience: traumatic events and psychiatric sequel. *Journal of Nervous and Mental Disease,* 188, 490-495.

Goldstein, R. D., Wampler, N. S., & Wise, P. H. (1997). War experiences and distress symptoms of Bosnian children. *Pediatrics, 100*(5), 873-878.

Goodkind, J. R., & Foster-Fishman, P. G. (2002). Integrating diversity and fostering interdependence: Ecological lessons learned about refugee participation in multiethnic communities. *Journal of Community Psychology, 30*(4), 389-409. doi:10.1002/jcp.10012

Griswold, D. (2002, July 21). *As immigrant move in, Americans move up*. Retrieved from http://www.cato.org/publications/free-trade-bulletin/immigrants-move-americans-move

Gundel, J. (2002). The migration-development nexus: Somalia case study. *International Migration, 40*(5), 255-281.

Hamilton, R., & Moore, D. (2004*). Educational programs for refugee children: Theoretical perspectives and implementing best practice*. London, UK: RoutledgeFalmer.

Heptinstall, E., Sethna, V., & Taylor, E. (2004). PTSD and depression in refugee children: Associations with pre-migration trauma and post-migration stress. *European Child and Adolescent Psychiatry, 13,* 373-380.

Hinton, D. E., Rasmussen, A., Leakhena, N., Pollack, M. H., & Good, M. (2009). Anger, PTSD, and the nuclear family: A study of Cambodian refugees. *Social Science & Medicine*, 69, 1387-1394.

Hinton, D. E., Reis, S., & de Jong, J. (2015). The "thinking a lot" idiom of distress and PTSD: An examination of their relationship among traumatized refugees using the "thinking a lot" questionnaire. *Medical Anthropology Quarterly, International Journal for the Analysis of Health, 29*(3), 279-436. doi 10.1111/maq.12204

Hopkins, G. (2006). Somali community organizations in London and Toronto: Collaboration and effectiveness. *Journal of Refugee Studies, 19*(3), 361-380. doi:10.1093/jrs/fel013

Hycner, H. R. (1985). Some guidelines for the phenomenological analysis of interview data. *Human Studies, 8*(3), 279-303.

Ibraka, A. Y., & Nagaya Hall, G. C. (2014). The components of cultural match in psychotherapy. *Journal of Social and Clinical Psychology, 33*(10), 936-953.

Jasinkaja-Lahti, I., Liebkind, K., Jaakkola, M., & Reuter, M. (2006). Perceived discrimination, social support networks, and psychological well-being among three immigrant groups. *Journal of Cross-Cultural Psychology, 37*(3), 293-311. doi:10.1177/0022022106286925

Jimale, M., Ahmed, B., Hamud, M., Leinonen, S., Mohamed, H., & Hughes, J. (2002). *Cultural awareness: The Somali culture*. Paper presented at the Mayo Clinic Foundation Education, Mayo Clinic Foundation, Rochester, MN.

Jordan, S., Matheson, K., & Anisman, H. (2009). Supportive and unsupportive social interactions in relation to cultural adaptation and psychological distress among Somali refugees exposed to collective or personal traumas. *Journal of Cross-Cultural Psychology, 40*(5), 853-874. doi:10.1177/0022022109339182

Keen, E. (1975). *A primer in phenomenological psychology*. New York, NY: Hold, Reinhart and Winston, Inc.

Kemp, C., & Rasbridge, L. (2004). *Refugee and immigrant health: A handbook for health professional*. Cambridge, UK: Press Syndicated of the University of Cambridge.

Kensit, D. A. (2000). Togerian theort: A critique of the effectiveness of pure-client centered therapy. *Counseling Psychology Quarterly, 13*(4), 345-342.

Khawaja, N. G., White, K. M., Schweitzer, R., & Greenslade, J. (2008). Difficulties and coping strategies of Sudanese refugees: A qualitative approach. *Transcultural Psychiatry,* 45, 3, 489-512. doi.10.1177/1363461508094678

Kinzie, J. D., Sack, W. H., Angell, R. H., Clarke, G., & Ben, R. (1989). A three-year follow-up of Cambodian young people traumatized as children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 28, 501-504.

Kroll, J., Yusuf, A. I., & Fujiwara, K. (2011). Psychoses, PTSD and depression in Somali refugees in Minnesota. *Social Psychiatry and Psychiatric Epidemiology, 46(*6) 481-493. doi:10.1007/s00127-010-0216-0

Kroner, G. K. (2007). *Transit or dead end? The Somali diaspora in Egypt*. In A. M. Kusow & S. R. Bjork (Eds.), *From Mogadishu to Dixon* (pp. 45-70). Trenton, NJ & Asmara, Eritrea: The Red Sea Press, Inc.

Lewig, K., Arney, F., Salverson, M., & Barredo, M. (2010). Parenting in a new culture: Working with refugee families. In F. Arney & D. Scott (Eds.), *Working with vulnerable families: A partnership approach* (pp.157-185). New York, NY: Cambridge University Press.

Lewis, I. (2008). *Understanding Somalia and Somaliland. Culture, history, society*. London, England: Hurst and Company.

Lightfoot, E., Blevins, J., Lum, T., Dube, A. (2016). Cultural health assets of Somali and Oromo refugees and immigrants in Minnesota: Findings from a community-based participatory research project. *Journal of Health for the Poor and Underserved*, 27, 252-260.

Lincoln, A. K., Lazarevic, V., White, M. T., & Ellis, B. H. (2015). The impact of acculturation style and acculturative hassles on the mental health of Somali adolescents refugees. *Journal of Immigrant and Minority Health*, 1-8.

Lukens, E. P., & McFarlane, W. R. (2004). Psychoeducation as evidence-based practice: Considerations for practice, research, and policy. *Brief Treatment and Crisis Program, 4*(3), 205-225. doi:10.1093/brief-treatment/mhh019

Lustig, S. L., Kia-Keating, M., Knight, W. G., Geltman, P., Ellis, H., Kinzie, J. D., . . ., Saxe, G. N. (2004). Review of child and adolescent refugee mental health. *American Academy of Child and Adolescent Psychiatry, 43*(1), 24-36. doi:10.1097/01.chi.0000096619.64367.37

Macgowan, M. J. (2006). The group engagement measure. *Journal of Groups in Addiction and Recovery, 1*(2), 33-52. doi:10.1300/J384v01n02_04

McBrien, J. L. (2005). Educational needs and barriers for refugee students in the United States: A review of the literature. *Review of Educational Research, 75*(3), 329-364.

McCarthy, F. E. & Vickers, M. H. (2012). Refugee and immigrant students: achieving equity in education. *Diaspora, Indigenous, and Minority Education: Studies of Migration, Integration, Equity, and Cultural Survival, 7*(4). 256-261. doi:10.1080/15595692.2013.828199

McGown, R. 1999. *Muslims in the diaspora: The Somali communities of London and Toronto.* Toronto, Canada: University of Toronto Press Inc.

McGraw-Schuchman, D. (2004). Somali mental health. *Bildhaan- An International Journal of Somali Studies*.

Merriam, S. B. (2009). *Qualitative research, A guide to design and implementation*. San Francisco, CA: John Wiley & Sons.

Migration Policy Institute. (2014). *The U.S. refugee resettlement program*. Retrieved from http://www.migrationpolicy.org/article/us-refugee-resettlement-program

Miller, K.E. (1996). The effects of state terrorism and exile on indigenous Guatemalan refugee children: A mental health assessment and an analysis of children's narratives. *Child Development* 67: 89-106

Miller, K. E. (1999). Rethinking a familiar model: Psychotherapy and the mental health of refugees. *Journal of Contemporary Psychotherapy, 29*(4), 283-306.

Miller, K. E., & Rasco, L. M. (2004). *The mental health of refugees: Ecological approaches to healing and adaptation.* New York, NY: Psychological Press.

Miller, K. E., Worthington, G. J., Muzarovic, J., Tipping, S., & Goldman, A. (2002). Bosnian refugees and stressors of exile: A narrative study. *American Journal of Orthopsychiatry, 72*(3), 341-354.

Mohamed, A., & Yusuf, A. M. (2011). Somali parent-child conflict in the western world: Some brief reflections. *Bildhaan: An International Journal of Somali Studies, 11*(17), 164-173.

Morland, L., Duncan, J., Hoebing, J., Kirschke, J., & Schmidt, L. (2005). Bridging refugee youth and children's services: A case study of cross-service training. *Child Welfare, 84*(5), 791-812.

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

Moyerman, D. R., & Forman, B. D. (1992). Acculturation and adjustment: A meta-analytic study. *Hispanic Journal of Behavioral Sciences, 14*(2), 163-200. doi:10.1177/07399863920142001

Muecke, M. A. (1992). New paradigms for refugee health problems. *Social Sciences and Medicine*, *35*(4), 515-523.

Murphy, D., Ndegwa, D., Kanani, A., Rojas-Jaimes, C., & Webster, A. (2002). Mental health of refugees in inner-London. *Psychiatric Bulletin*, 26, 222-224.

Neuner, F., Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T. (2004). A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. *Journal of Consulting and Clinical Psychology, 72*(4), 579-587. doi:10.1037/0022-006X.72.4.579

Norwegian Refugee Council/Internal Displacement Monitoring Centre (NRC/IDMC). (2013). *Global overview 2012: People internally displaced by conflict and violence*. Retrieved from http://www.refworld.org/docid/ 517fb05918.html

Ogata, S. (1994). *Refugee children: Guidelines on protection and care*. United Nations High Commissioner for Refugees. Retrieved from http://www.unicef.org /violencestudy/pdf/refugee_children_guidelines_on_protection_and_care.pdf

Palinkas, L. A., Pickwell, S. M., Brandstein, K., Clark, T. J., Hill, L. L., Moser, R. J., & Osman, A. (2003). The journey to wellness: Stages of refugee health promotion and disease prevention. *Journal of Immigrant Health, 5*(1) 19-28.

Palmer, D. (2006). Imperfect prescription: Mental health perceptions, experiences and challenges faced by the Somali community in the London Borough of Camden and service responses to them. *Primary Care Mental Health*, 4, 45-56.

Papadopoulos, R. (1999). Working with families of Bosnian medical evacuees: Therapeutic dilemmas. *Clinical Child Psychology and Psychiatry*. 4, 107-120.

Papageorgiou, V., Frangou-Garunovic, A., Iordanidou, R., Yule, W., Smith, P., & Vostanis, P. (2000). War trauma and psychopathology in Bosnian refugee children. *European Child and Adolescent Psychiatry, 9,* 84-90.

Pernice, R. (1994). Methodological issues in research with refugees and immigrant. *Professional psychology Research and Practices, 25*(3), 207-213.

Pumariega A. J., Rothe E. M., & Pumariega J. A. (2005). Mental health issues in immigrant and refugee children in the United States. *Community Mental Health Journal, 41*(5), 581-597.

Putman, D. B., & Noor, M. C. (1993). *The Somalis: Their history and culture.* Washington, DC: Refugee Service Center.

Refugee Council USA. (2014). *History of U.S. refugee resettlement program.* Retrieved from http://www.rcusa.org/history

Refugees International. (2014). *Somalia*. Retrieved from http://refugeesinternational.org/where-we-work/africa/somalia

Reincke, K. (2011). *Developing a Somali Bantu refugee parenting program*. (Doctoral dissertation, Antioch University New England). Retrieved from ProQuest. (Accession No.2011-99160-316)

Renzaho, A. M. N., & Vignjevic, S. (2011). The impact of a parenting program in Australia among migrants and refugees from Liberia, Sierra Leone, Congo, and Burundi: Results from the African migrant parenting program. *Journal of Family Studies, 17*(1), 71-79.

Rousseau, C., & Guzder, J. (2008). School-based prevention programs for refugee children. *Child and Adolescent Psychiatric Clinics of North America, 17*, 533-549.

Ruiz, M., Kabler, B., & Sugarman M. (2011). Understanding the plight of immigrant and refugee students, *Communiqué, 39*(5), 1, 23-25.

Savic, M., Chur-Hansen, A., Mahmood, M. A., & Moore, V. M. (2016). 'We don't have to go and see a special person to solve this problem': Trauma, mental health beliefs and processes for addressing 'mental health issues' among Sudanese refugees in Australia. *International Journal of Social Psychiatry, 62*(1), 76-83. doi:10.1177/0020764015595664.

Schuchman McGraw, D., & McDonald, C. (2004). "Somali Mental Health," *Bildhaan: An International Journal of Somali Studies, 4*(8), 8.

Schweitzer, R., Melville, F., Steel, Z., & Lacherez, P. (2006). Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. *Australia & New Zealand Journal of Psychiatry*, 40, 179-187.

Scuglik, D. L., & Alarcon, R. D. (2005). Growing up whole: Somali children and adolescents in America. *Psychiatry, 2*(8), 20-31.

Scuglik, D. L., Alarcon, R. D., Lapeyre III, A. C., Williams, M. D., & Logan, K. M. (2007). When the poetry no longer rhymes: Mental health issues among Somali immigrants in the USA. *Transcultural Psychiatry, 44*(4), 581-595. doi:10.1177/13633461507083899

Sheikh, S., & Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeing professional help. *Social Psychiatry/ Psychiatric Epidemiology,* 35, 326-334.

Simich, L., Beiser, M., & Mawani, F. N. (2003). Social support and the significance of shared experience in refugee migration and resettlement. *Western Journal of Nursing Research, 25*(7), 872-0891. doi:10.1177/0193945903256705

Singer, A., & Wilson, J. H. (2006). From "there' to 'here": Refugee resettlement in metropolitan America. *Metropolitan Policy Program, The Brookings Institute.* Retrieved from http://www.brookings.edu/~/media/research /files/reports/2006/9/demographics-singer/20060925_singer.pdf

Smith, P., Perrin, S., Yule, W., Hacam, B., & Stuvland, R. (2002). War exposure among children from Bosnia-Hercegovina: Psychological adjustment in a community sample. *Journal of Traumatic Stress*, 15, 147-156.

Smith, R. S. (2008). The case of a city where 1 in 6 residents is a refugee: Ecological factors and host community adaptation in successful resettlement. *American Journal of Community Psychology, 42,* 328-342.

Stewart, M., Anderson, J., Beiser, M., Mwakarimba, E., Neufeld, A., Simich, L., & Spitzer, D. (2008). Multicultural meanings of social support among immigrants and refugees. *International Migration, 46*(3), 123-159.

Stewart, M. L., Makwarimba, E., Beiser, M., Neufeld, A., Simich, L., & Spitzer, D. (2010). Social support and health: Immigrants' and refugees' perspectives. *Diversity in Health and Care*, 7, 91-103.

Stewart, M., Simich, L., Beiser, M., Makube, K., Makwarimba, E., & Shizha, E. (2011). Impacts of a social support program for Somali and Sudanese refugees in Canada. *Ethnicity and Inequalities in Health and Social Care, 4*(4), 186-199. doi: 10.1108/17570981111250840

Teodorescu, D. S., Heir, T., Hauff, E., Wentzel-Larsen, T., & Lien, L. (20012). Mental health problems and post-migration stress among multi-traumatized refugees attending outpatient clinics upon resettlement in Norway. *Scandinavian Journal of Psychology, 53*(4), 316-322. doi:10.1111/j/1467-9450.2012.00954.x

Thabet, A., & Vostanis, P. (2000). Post traumatic stress disorder reactions in children of war: A longitudinal study. *Child Abuse& Neglect,* 24, 291-298.

Thomson, M. D., & Hoffman-Goetz, L. (2009). Defining and measuring acculturation: A systematic review of public health studies with Hispanic populations in the United States. *Social Sciences & Medicine*, 69, 983-991. doi:10.1016/jsocscimed.2009.05.011

Tolan, P. H., Hanish, L. D., McKay, M. M., & Dickey, M. H. (2002). Evaluating process in child and family programs: Aggression prevention as an example. *Journal of Family Psychology,* 16, 220-236.

Tribe, R. (2002). Mental health of refugees and asylum-seekers. *Advances in Psychiatric Treatment*, 8, 240-248.

Tyrer, R. A., & Fazel, M. (2014). School and community-based programs for refugee and asylum seeking children: A systemic review. *PLoS ONE, 9*(2), e89359. doi:10.1371/journal.pone.0089359

Uitterhaegen, B. (2005). Psycho-education and psychosocial support in the Netherlands; a program by and for refugees. *Program, 3*(2), 141-147.

United Nations General Assembly. (1951). *Convention and protocol relating to the status of refugees*. Retrieved from http://www.unhcr.org/protect/ PROTECTION/ 3b66c2aa10.pdf

United Nations High Commissioner for Refugees (UNHCR). (2014). *Refugees*. Retrieved from http://www.unhcr.org/pages/49c3646c125.html

United Nations International Children's Emergency Fund (UNICEF). (2014). *Somalia.* Retrieved from http://www.unicef.org/somalia/

U.S. Census Bureau. (2010). *Welcome to quickfacts.* Retrieved from http://www.census.gov/quickfacts/table/ PST045215/0832155/accessible

U.S. Department of State. (2014, July 1). *Refugee admission statistics*. Retrieved from http://www.state.gov/j/prm/releases/statistics

U.S. Office of Refugee Resettlement. (2011). Report to Congress: FY 2008. U.S. Department of Health and Human Services. Retrieved from http://www.acf.hhs.gov/sites/default/files/orr/annual_orr_report_to_congress_2008.pdf

U.S. Office of Refugee Resettlement. (2014, February 11). *Emotional wellness*. Retrieved from http://www.acf.hhs.gov/programs/orr/emotional-wellness-0

Van der Veer, G. (1998) *Counseling and therapy with refugees and victims of trauma.Psychological problems of victims of war, torture and repression*. West Sussex, England: John Wiley.

van Wyk, S., Schweitzer, R., Brough, M. K., Vromans, L., & Murray, K. (2012). A longitudinal study of mental health in refugees from Burma: The impact of therapeutic programs. *Australian and New Zealand Journal of Psychiatry*, *46*(10), 995-1003.

Voulagaridou, M. G., Papadopoulos, R. K., & Tomaras, V. (2006). Working with refugee families in Greece: systemic considerations. *Journal of Family Therapy,* 28, 200-220.

Warfa, N., Bhui, K., Craig, T., Curtis, S., Mohamud, S., Stansfeld, S., . . Thornicroft, G. (2006). Post-migration geographical mobility, mental health and health service utilisation among Somali refugees in the UK: a qualitative study. *Health Place, 12*(4), 503-515.

Weine, S. M. (2001). From war zone to contact zone: Cultural and refugee mental health services. *Medical Student Journal of the American Medical Association,* 285, 1214.

Weine, S. M. (2009). Family roles in refugee youth resettlement from a prevention perspective. *Child and Adolescent Psychiatric Clinics of North America*, 17, 515-532.

Weine, S. (2011). Developing preventive mental health programs for refugee families in resettlement. *Family Process, 50*(3), 410-430.

Weine, S., Feetham, S., Kulauzovic, Y., Knafl, K., Besic, S., Klebic, A., . . ., Pavkovic, I. (2006). A family beliefs framework for socially and culturally specific preventive programs with refugee youths and families. *American Journal of Orthopsychiatry, 76*(1), 1-9. doi:10.1037/0002-9432.76.1.1

Weine, S., Knafl, K., Feetham, S., Kulauzovic, Y., Klebic, A., Sclove, S., . . . Spahovic, D. (2003). A mixed methods study of refugee families engaging in multiple-family groups. *Family Relations*, *54*(4), 558-568.

Weine, S., Kulauzovic, Y., Klebic, A., Besic, S., Mujagic, A., Muzurovic, J., . . . Rolland, J. (2008). Evaluating a multiple-family group access intervention for refugees with PTSD. *Journal of Marital and Family Therapy, 34*(2), 149-164.

Weine, S. M., Kulenovic, A.D., Pavkovic, I., & Gibbons, R. (1998). Testimony psychotherapy in Bosnian refugees: A pilot study. *American Journal of Psychiatry, 155*(12), 1720-1726.

Weine, S., Muzurovic, N., Kulauazovic, Y., Besic, S., Lezic, A., Mujagic, A., . . ., Pavkovic, I. (2004). Family consequences of refugee trauma. *Family Process*, 43(2), 147-160.

World Health Organization. (2004*). Prevention of mental disorders: Effective programs and policy options: Summary report*. Retrieved from http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf

World Health Organization. (2007, September 3). What is mental health? Retrieved from http://www.who.int/features/qa/62/en/

World Health Organization. (2013). Mental health: a state of well-being. Retrieved from http://www.who.int/features/factfiles/mental_health/en/

Wynaden, D., Chapman, R., Orb, A., McGpwan, A., Zeeman, Z., & Yeak, A. (2005). Factors that influence Asian communities' access to mental health care. *International Journal of Mental Health Nursing,* 14, 88-95.

APPENDIX A

INITIAL INTERVIEWS: SEMI-STRUCTURED INTERVIEW QUESTIONS

INITIAL INTERVIEWS: SEMI-STRUCTURED INTERVIEW QUESTIONS

1. How would you describe your family's resettlement process to the United States?
    a. What are some of the most challenging aspects of your family's life in the United States?
    b. What were some of the most rewarding aspects of your family's life in the United States?
2. How would you describe your family's health?
    a. How would you describe your children's physical health?
    b. How would you describe your children's emotional health?
3. How would your describe your parenting style and/or technique?
    a. What have you found to be most successful in parenting your children?
    b. What have you found to be the most challenging about parenting your children?
4. What or who do you rely on in your community?
    a. What kind of community services do you use the most?
    b. What are some community services that you would like to use more?
5. How do you think being part of this parent program will help you and your family in the future?
6. What challenges do you foresee in attending the Somali Parent Program?

APPENDIX B

CONCLUDING INTERVIEWS: FOCUS GROUP QUESTIONS

CONCLUDING INTERVIEWS: FOCUS GROUP QUESTIONS

1. What was your experience like with the Somali Parent Program?

2. What aspects of the program were important to you?

3. When you think about how you were with your children prior to the group, how have things changed after the group?

4. When you think about your understanding of family emotional health, how have things changed after the group?

5. What social supports and community resources have you used in your daily life since the completion of the group?

6. What if any challenges did you experience in attending the Somali Parent Program?

7. How would you describe this program to other Somali parents?

APPENDIX C

DEMOGRAPHIC SURVEY--ENGLISH

DEMOGRAPHIC SURVEY

1. Sex: Female _____ Male _____

2. Age: _____

3. Country of Origin: _____

4. When did you live in your native country? _____

5. Other countries that you lived in prior to resettling in the Unites States?

   _____

6. Have you lived in a refugee camp? Yes _____ No_____

a. If yes, for how long did you live in a refugee camp? _____

7. How long have you lived in the United States? _____

8. Primary languages spoken?

   _____

9. Other states you have lived in prior to settling in Greeley?

   _____

10. How long have you lived in Greeley? _____

11. How many children do you have? _____

12. What are the ages of your children?

    _____

13. Do you have any children living in your native country?

    a. Yes _____ No _____

    b. If so, how many and their ages?

       _____

14. Are you married: Yes _____ No _____

15. How many people live in your home? _____

16. Are you employed? Yes _____ No _____

What is your current job?

_____

APPENDIX D

DEMOGRAPHIC SURVEY--SOMALI

MACLUUMAADKA QOFKA LA XIRIIRA

1. Nooca qofka: Dhadig _____ Lab _____

2. Da'da? _____

3. Dalka aad u dhalatay? _____

4. Goormaad kasoo tagtay dalkii aad u dhalatay? _____

5. Dalka aad ku noolayd intaadan mareykanka imaanin?

_____

6. Xero qoxooti miyaad ku soo noolaan jirtay?

   a. Haa _____ Maya_____

   b. Haday haa tahay jawaabtu , muddo intee dhan? _____

7. Imisaad joogtay Mareykanka? _____

8. Waa maxay luuqadaada hooyo? _____

9. Gobol kale ma ku noolaan jirtay intaadan Greeley imaanin?

_____

10. Imisa sanaad joogtay Greeley? _____

11. Imisa caruuraad haysataa? _____

12. Caruurtaada da'doodu maxay kala tahay?

_____

13. Caruur miyaa kaagaga maqan dalkaagii aad ka timid?

   a. Haa _____ Maya _____

   b. Haday jawaabtu haa tahay imisa?

_____

14. Reer Maleedahay: Haa _____ Maya _____

15. Imisa qof baa guriga kugula nool? _____

16. Ma shaqaysaa? Haa _____ Maya _____

Maxaad kasaqaysaa hadda?

_____

APPENDIX E

INSTITUTIONAL REVIEW BOARD APPROVAL

UNIVERSITY of NORTHERN COLORADO

Institutional Review Board

DATE:	September 9, 2014
TO:	Vanja Pejic
FROM:	University of Northern Colorado (UNCO) IRB
PROJECT TITLE:	[635266-2] Promoting Family Transition and Support in Somali Refugee Parents: Outcomes of a Community Based Program
SUBMISSION TYPE:	Amendment/Modification
ACTION:	APPROVED
APPROVAL DATE:	September 3, 2014
EXPIRATION DATE:	September 3, 2015
REVIEW TYPE:	Expedited Review

Thank you for your submission of Amendment/Modification materials for this project. The University of Northern Colorado (UNCO) IRB has APPROVED your submission. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of September 3, 2015.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Sherry May at 970-351-1910 or Sherry.May@unco.edu. Please include your project title and reference number in all correspondence with this committee.

APPENDIX F

CONSENT FORM--ENGLISH

UNIVERSITY of
NORTHERN COLORADO

CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Project Title:	Promoting Healthy Family Transition and Support in Somali Refugee Parents: Outcomes of a Community-Based Program
Researcher:	Vanja Pejic
Program Affiliation:	School Psychology
E-mail:	Vanja.pejic@unco.edu
Phone Number:	xxx-xxx-xxxx
Research Advisor:	Robyn S. Hess, Ph.D.
Program Affiliation:	School Psychology
E-mail:	robyn.hess@unco.edu
Phone number:	970-351- 1636

The primary purpose of this study is to implement a 8-week Somali Parent Program at the XXXXX Center that will provide education about parenting in relation to family transition to the United States, family health and wellbeing, and families use of community resources. The participants will meet once a week for 2 hours each and each session will focus on a different parenting topic through the use of group discussion and group activities. The program will be implemented by a graduate level School Psychology student from University of Northern Colorado along with a Somali community advocate, XXXXX who will help lead the group and help with the interpretation. In addition to Ms. XXXX, Mr. XXXX will assist in interpretation throughout the project. A total of 10 to 15 Somali parents will participate in the Somali Parent Program. If you complete the entire program you will be given an $80.00 gift card for your participation in the Somali Parent Program, otherwise you will receive $10.00 for each session that you complete.

If you agree to participate in the Somali Parent Program, you will be asked to complete a demographic survey and an individual interview prior to attending the 8 week program. The demographic survey should take approximately 5 minutes to complete. After the completion of the survey, you will be asked to participate in a 60 minute individual interview to discuss your family's transition to the United States, your family's health and wellbeing, and how often you access community supports and services. The interview will be audiotaped in order for us to collect more accurate information. We will not use your real name in your survey or interview, but will allow you to choose a made up name for yourself.

As noted above, the Somali Parent Program will last for 8 weeks, meeting once a week at the XXXXX Center for 2 hours. The sessions will be educational and activity based. During each of the session you will be provided with food. Additionally, Ms. XXXX will serve as Somali interpreter throughout all of the sessions. If agreed upon by the group, all group sessions will be video taped in order to ensure that accurate information is collected.

After the completion of the Somali Parent Program, you will also be asked to meet with other Somali Parent Program Participants for a discussion lasting approximately two hours. The group will be asked questions to describe their experience in being part of the program as well as how has the program impacted their parenting, awareness of family health, and their access and use of community resources.

During the group discussion one of the researchers will take notes and digitally record the session so that the focus group facilitator can remember everything that people tell them. The information discussed throughout the focus group will not be shared with anyone (other than the researchers) outside of this session. Ms. XXXX will act as an interpreter in order to ensure that you understand and are comfortable with the interview process.

At the end of the study, we will be happy to share what we learned with you, and to confirm that the facilitators have represented your thoughts accurately. We will take every precaution in order to protect your confidentiality. Only the lead investigators (Vanja Pejic and Dr. Robyn Hess) will know the name connected with your pseudonym, and when we report data, your name will not be used. Data collected and analyzed for this study along with consent forms and audio and video recordings will be kept in a locked cabinet in the office of Robyn Hess, Ph.D., McKee Hall 293, Campus Box 13, Greeley, CO 80639-0001,phone: (970) 351-1636 email: robyn.hess@unco.edu.

Potential risks in this project are minimal. Participants may find it somewhat uncomfortable to express their views in the parent group. The discussions may also lead to conversations that a participant may be uncomfortable addressing (i.e., discussing past trauma in a group. Every effort will be made to protect the identity of participants through the use of made up names. Participants are advised of the researcher's legal obligation to report suspected mistreatment of children and serious threats against self or others.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Having read the above and having had an opportunity to ask any questions, please sign below if you would like to participate in this research. A copy of this form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact the Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-2161.

I have read aloud the consent form discussed above to the participant in this study and have received verbal consent from the participant to participate in the focus group.

Participant Name	
Interpreter Name	Interpreter Signature
Researcher Name	Research Signature

I have read aloud the consent form discussed above to the participant in this study and have received verbal consent from the participant to be video taped throughout the Somali Parent Program and be audio taped during the focus groups.

Interpreter Signature

APPENDIX G

CONSENT FORM - SOMALI

UNIVERSITY of
NORTHERN COLORADO

WARQADA HESHIISKA KA QAYB-QAADASHADA CILMI-BAADHISTA
JAAMACADDA WOQOOYIGA KOLORADO

Magaca Mashruuca:	Sare u qaadista iyo kaalmaynta laqabsiga nolosha cusub ee waalidiinta qoxootiga qoysaska Soomaaliyeed: Iyo natiijada Bulshadan khaaska ah.
Cilmi baadhaha:	Vanja Pejic.
Qorshe hawleedka la xidhiidha:	Iskuulka Saykoolojiga.
E-mailka:	Vanja.pejic@unco.edu
Taleefankeeda:	xxx-xxx-xxxx
Lataliyaha Cilmibaadhistan:	Robyn S. Hess, Ph.D.
E-mailkeeda:	robyn.hess@unco.edu.
Taleefankeeda:	970-351-1636

Ogolanshaha ka qeebqadashada dadweynaha ee macluumaadka ay qaadeeyso jaamacada kutaalo Greeley ee lagu magacaabo University of northern Colorado.
Qasadka laga leeyahay macluumaadkan ayaa waxaa uu yahay in lagu hirgaliyo lix todobaad oo lagu qabanayo xafiiska qeybta qaxootiga caawiso ee lagu magacabo global refugee center. Taaso logu diyaarinayo waalidiinta soomaliyeed waxbarasho ku saabsan lana xiriirto waalidnimada iyo isbadalka qoyska ee dalka mareykanka, caafimaadka qoyska, jiritaanka qoyska iyo qaabka loo isticmaalo adeega bulshada eey wadaledahay. Ka qebgalayasha waxaa lala kulmi asbuucii halmar oo qadanayo labo sacdood oo waxbarasho ah. Kulan walbo waxaa diirada lagu sarayaa cashiro kala duwan kuna saabsan walidnimada iyadoo la isticmaalay wada hadal koox koox ah iyo wax qabad koox koox ah. Qorshahan ayaa waxaa hirgalinaya ardayda wax kabara jamacada ku taalo Greeley iyo qoomiyada soomalida dadka u dooda.

Gabadha lagu magacaabo XXXXX ayaa hogaamineysa kooxda iyadoo ka caawineyso dhanka turjubaanimada, mida kale waxaa cawini doono XXXXX, ninka lagu magacaabo XXXXX ilaa inta uu socdo mashruucan. Tobon (10) ila shan iyo toban (15) waalidiin ah ayaa ka qebqaadanaya mashruuncan. Hadii aad dhameysato cashirada dhamaan waxa lagu siinayaa lixdan dollar (80) oo hadiyad kaar ah ka qebgalayasha mashruucan, hadii kale waxaad heleysaa tobon dollar (10) halkii cashir aad dhameysato. Hadii aad ogolatid inaad ka qebqaadato mashruucan waxaa lagu weydinaya inaad dhameystirato cashirada iyo su'aalaha cilmi baadhiseed ee la socdaba. Did u egidan aad xorka utahay waxeey qadaneysaa qayaas ahaan 5 daqiiqo oo kaliyah.
Markii la dhameystiro dib u eegidan waxaa lagu weydiinayaa inaad ka qebqadato 60 daqiiqo oo su'aalo lagu wediinayo, shaqsi walbo oo aad kawada hadleysan qoyskaada

kaaso la xirirta isbadalka qoyska ee dalka mareykanka. Qoyskada caafimaadkiisa iyo jiritaankiisa iyo sida inta badan aad u hesho caawimaada bulshada iyo adeegaba. Cilmi baadhistan waa la duubayaa si aan u aruurino warbixin sax ah. Si qofka cashirka bixinayo uu u xasuusto qof kasto waxa u dhahay. Warbixintan laga wadahadlayo qof kale lalama wadaagayo aan ka aheen qofka maclumaadkan barayo. Asad ayaa idinka caawinayo si loo hubsado inaad fahanteen su'aalaha lagu weydinayo into eey socoto waxbarashadan, markeey dhamaato wabarashadan waxaan ku faraxsanahay inaan idin la wadagno waxa aan barangay iyo inan xaqiijino qofka idinka cawiyay baritanka inuu idin shegay warka saxada ah.

Waxaan si taxadar leh u qaadaneynaa si aan u ilalino kalsoonida. Qof kale oo oganaxo magacaad shegatay majirto aan ka aheen baritanka kuwa hogaminaya oo lagu magacaabo (Vanja Pejic iyo Dr Robyn Hess) markii warbixin la qudbinayo lama isticmalayo magacada. Qatarka ka iman karto mashruucan wa mid xadigeda aad u yaryahay daka ka qeb qadanaya waxaa la weydinaya iney qeexaan fikradaha ku sabsan walidrimada iyo in laga wada hadlo waxyaabaha ku soo maray ee qaracanka leh. Wax walibo aan qadano ma isticmaaleyno magacada saxda ah inta wax lagu wey dinayo balse waxaa laguu ogalani dorato magic adiga aad saeysatay nafsadada.

Mashruucan waxuu soconayaa lix asbuuc iyo kulan asbuucii halmar. Waxbarashadu waxeey soconeysaa labo saacadood iyo waxqabasho waxaa lagu kulmi qebta qaxootiga cawiso xafiskoda inta lagu guda jiro xiliga waxbarashada waxaa lagu diyarmi cunto.

Fardowsa Abdullahi, ayaa kuu turjumeysa luuqadda Soomaaliga inta ay socoto waxbarashadan hadii la isla ogolado dhamaan waxbarashadan wala dubaya si aan u xagijino inan helno warbixin saxan inan aruurinay.

Markii aad dhameyso mashruucan waxa lagu weydinaya inad la kulanto walidinta kale ee kala qebqadatay mashruucan si aad u wadahadashaan. Waxuna qadanaya waxa la wey dinaya sualo eey ku qexayaan waayo aragnimada eey ka qaateen waxbarashada ito sida mashruucan u hirgaliyay cafimaadka qoyska iyo sida kugu surto gasho isticmaalka adeega bulshada. Inta uu socdo ka qebgalka koox kasto mid ka mid ah barayasha ayaa waxaa u sameynayaa inuu qoro, duubo waxaan ku xaqijineynaa jiritanka ka qebgalayasha anagoo isticmaaleyno magaca aad sameysateen ee ka qebgalayasha waxaa lagu wargalinaya iney u sheegaan barayasha hadii eey ka shakiyaan caruur sixun lola dhaqmayo iyo handadaad Qatar ku ah jiritanka qof aadame ah. Ka qeyb qaadashada waa bilaash ama iskaa wax u qabso.

Waad go'ansan kartaa inaad ka qeyb qaadanin waxbarashadan hadii aad bilowday xitaa waad joojin kartaa waqti kasto.Go'aakaada waan tix galineynaa waxbo kuma weyneysid faa'iidooyinka aad qaadato shaqsi ahaan. Waxaad fursad u heysataa inad weydiiso su'aal. Fadlan saxiix qeybta hoose hadii aad ogolaatay inaad ka qebqaadato baritaanka.
Nuqul kamid ah ayaa lagu siinayaa si aad u heysato mustaqbalka hadii aad qabtid wax-su'aal ah lasoo xariir xafiiska maal galinayo mashruucan talefonkiisu yahay 970-351-2161 Greeley, CO.

Waan agriyay waana yeelay inaan ka qeeb qaato waxbaritankan simaqal iyo muqal ah inaan oga qebqaato.

Magaca Ka qayb qaataha	
Magaca Turjubaanka	Saxiixa Turjubaanka
Magaca Cilmi Baadhaha	Saxiixa Cilmi Baadhaha

Waxaan ogolaaday in la iga duubo maqal ahaan iyo muuqaal ahaanba inta cashirkani soconayo si ay cilmi baadhahan ay ugu suurto gasho ururinta xog sax ah, kadib markaan akhriyay si fiicanna aan u fahmay qoraalkan iyo xuquuqdayda aas aasiga ahba

Magaca Turjubaanka

APPENDIX H

SOMALI PARENT PROGRAM CURRICULUM

SESSION 1: DEFINING THE FAMILY

Purpose:

Primary goal of this session is introduce the family program to the participants and to allow the participants to introduce themselves to one another while sharing their family history. This session will allow each participant to introduce themselves to the rest of the group, outline group norms, define what a family is, and share their past, present, and future hopes for their family.

Time:

- 11:30 -11:50 → Sign in, Get a name tag, Get food
- 11:50 -12:05 → Introductions
- 12:05 -12:10 → Parent Program Overview
- 12:10 -12:40 → Define Family
- 12:40 -1:25 → Tree of Life Activity
- 1:25 – 1:30: → Group Wrap-Up

Materials Needed:

- *Sign In:* Food: Food, Plates, Forks, Spoons, Napkins, Drinks, Cups; Name Tags, Sign In Sheet
- *Introductions:* None
- *Parent Program Overview:* Markers, Post-it Sheets
- *Define Family:* Discussion Questions
- *Tree of Life Activity:* Family Tree Sheets, Pens, Tree of Life Drawing
- *Wrap-Up*: None

Procedure

- *Sign in*: Participants will sign in, receive a name tag, and get food prior to the start of the group.
- *Introductions:* Group facilitator will welcome everyone into the group and allow each participant to introduce themselves to the rest of the group by asking each participant to a) state their name, b) choose one word that best describes them. If the participant does not provide a reason as to why they chose to share that word, group facilitator will ask the participant why they chose that specific word to share.
- *Parent Program Overview:* Group facilitator will give a brief overview of the program and allow participants to ask any questions that they may have in regards to the program. Group facilitator will also establish group norms during this time and review them with the group.
- *Define Family:* Group facilitator will open a group discussion on what is a family. The following questions will facilitate the discussion:
    - What it is a family?
    - Who makes up a family?
    - How do you define your family?

    - What are your family beliefs, values, traditions, roles, etc.?
- *Tree of Life Activity:* The group facilitator will introduce the Tree of Life activity by asking the participants what a tree symbolizes (its roots, trunk, and branches) or by explaining it to them and writing the words: roots = past, trunk = present, branches = future (point to the sample tree).

  Ask the participants to close their eyes and imagine human life through the metaphor of the tree. Talk about how we do not see other people's past, as we do not see the roots of the tree, but as roots provide water and minerals to the other parts of the tree, past events and memories have shaped who we are now and can influence our future. The bigger the roots are (the more we reflect on our past experiences and integrate them into our lives), the more stable the trunk is (our ability to endure difficulties in life) and the more stretched the branches become (we have more hope for the future). Once the group facilitator has explained the meaning of the tree, distribute Tree of Life worksheets and ask each participant to draw their own family's tree of life. Some participants may need further assistance based on their writing abilities.

  When projects are completed, ask each participant to show their trees of life and share them with others. Sharing will be voluntary and will be dependent on the comfort level of each individual participant.
- *Wrap-Up:* The group facilitator will summarize the topics that have been discussed throughout the session and remind the participants of the next meeting.

SESSION 2: FAMILY & TRANSITION

Purpose:

Primary goal of this session is to discuss the family trans and post-migration process and ways in which their resettlement process has impacted their family. The participants will check in using feeling cards, followed by a discussion around their family's transition and an experiential activity that will allow them to reflect how the resettlement process has impacted their family.

Time:

- 11:30 -11:50 → Sign in, Get a name tag, Get food
- 11:50 -12:05 → Check-In
- 12:05 -12:50 → Lesson on the migration process (pre-trans-post)
- 12:50 -1:25 → Family Transition Collage
- 1:25 – 1:30: → Group Wrap-Up

Materials Needed:

- *Sign In:* Food: Food, Plates, Forks, Spoons, Napkins, Drinks, Cups; Name Tags, Sign In Sheet
- *Check-In:* Expression Cards
- *The Migration Process:* Markers, Post-it Sheets, Bio-Ecological Model
- *Family Transition Collage:* Drawing paper, magazines, scissors, glue
- *Wrap-Up:* None

Procedure

- *Sign in*: Participants will sign in, receive a name tag, and get food prior to start of the group.
- *Check-In:* Participants will check in using the expression cards to identify how they are feeling. The group facilitator will process the feelings identified with each participant and allow other group members to provide support for each other.
- *The Migration Process:* The group facilitator will walk the group members through the various stages of the migration process (pre, trans, post). During each of the stages discussed, the group facilitator will use the Bronfenbrenner Bio-Ecological Systems model to discuss how each of the participant's has been affected during each of the stages (micro, meso, exo, macro). Major emphasis will be places on the post-resettlement challenges and how these challenges have impacted their family functioning.
- *Family Transition Collage:* The group facilitator will instruct the group members to cut out pictures from various magazines that represent their family's post-resettlement process. The group facilitator will show an example of a collage and encourage the group members to depict their resettlement story. Once the collages are completed, the group facilitator will allow group members to share their collages with the rest of the group.
- *Wrap-Up:* The group facilitator will summarize the topics that have been discussed throughout the session and remind the participants of the next meeting.

SESSION 3: PARENTING IN THE HOST COUNTRY

Purpose:

Primary goal of this session is explore the participants parenting experiences while living in the United States. In particular, the session will focus on discussing their transition to the United States and the impact of acculturation on parenting. The session will highlight parenting practices that have shown to be effective and those that are challenging. While the first half of the session will allow the participants to share their experiences, the second half will allow the participants to reflect on their parenting methods using mask. Once the masks are completed, the parents will share their individual masks with others in the group.

Time:

- 11:30 -11:50 → Sign in, Get a name tag, Get food
- 11:50 -12:05 → Check-In
- 12:05 -12:50 → Parenting in the United States Discussion
- 12:50 -1:25 → Parent Mask Activity
- 1:25 – 1:30: → Group Wrap-Up

Materials Needed:

- *Sign In:* Food: Food, Plates, Forks, Spoons, Napkins, Drinks, Cups; Name Tags, Sign In Sheet
- *Check-In:* Expression Cards
- *Parenting in the U.S. Discussion:* Discussion Questions, Parenting Style Picture Cards
- *Parent Mask Activity:* Masks, Markers, Paint, Brushes, Cups, Newspaper, Glue Gun, Feathers, Glitter, Beads
- *Wrap-Up:* None

Procedure

- *Sign in*: Participants will sign in, receive a nametag, and get food prior to the start of the group.
- *Check-In:* Participants will check in using the expression cards to identify how they are feeling. The group facilitator will process the feelings identified with each participant and allow other group members to provide support to one another.
- *Parenting in the U.S.:*
    - The facilitator will open discussion by asking the participants about their parenting experiences:
        - When you hear the word parent, what do you think of? The word mother? Father?
        - How has your role as a mother stayed the same since moving to the United States? How has it changed?
        - What would you say are your greatest challenges parenting in the United States? Your greatest strengths?

        - How do you define good parenting?
        - How do you define bad parenting?
    - The facilitator will share different parenting styles using picture cards, followed by a set of discussion questions:
        - Which one of the parenting styles best describes you?
        - What are some things that you could do to ensure positive parenting interactions and outcomes with your children?
- *Parent Mask Activity:* The facilitator will introduce the mask activity and ask the participants to think about how they think their children view them and how they want to be viewed by their children? The facilitator will follow up, by asking the participants what are some things that come to mind when thinking about how their children view them? How do they want to be viewed by their children? Using various art supplies (i.e., paint, beads, markers, feathers, glitter), the facilitator will ask the participants to express how they think their children view them on the left side of the mask and how they want to be viewed by their children on the right side of the mask. While the participants are working on their masks, the facilitator will walk around and assist the participants in painting, gluing, etc. After the masks have been completed, participants will share their masks with the rest of the group.
- *Wrap-Up:* The group facilitator will summarize the topics that have been discussed throughout the session and remind the participants of the next meeting.

SESSION 4: MARRIAGE & PARENTING

Purpose:

This is considered a bonus session because the local refugee center is closed for Spring Break. Therefore, the goal of this session will be to check in with each of the participants on how the group is going, review the session that we have completed and continue the discussion on the impact of family transition to the United States and marriage and parenting roles. This session will primarily focus on group discussion to elicit group participation and allow participants to ask questions.

Time:

- 11:30 -11:50 → Sign in, Get a name tag, Get food
- 11:50 -12:05 → Check-In
- 12:05 -12:15 → Previous Sessions Review
- 12:15 -1:00→ Marriage Roles & Parenting Discussion
- 1:00 – 1:05 → Group Wrap-Up

Materials Needed:

- *Sign In:* Food: Food, Plates, Forks, Spoons, Napkins, Drinks, Cups; Name Tags, Sign In Sheet
- *Check-In:* Expression Cards
- *Previous Session Review:* Bronfenbrenner Model, Parenting Style Picture Cards
- *Marriage Roles & Parenting Discussion:* None
- *Wrap-Up:* None

Procedure

- *Sign in*: Participants will sign in, receive a name tag, and get food prior to the start of the group.
- *Check-In:* Participants will check in using the expression cards to identify how they are feeling. The group facilitator will process the feelings identified with each participant and allow other group members to provide support for one another.
- *Previous Session Review:* Participants will review how the group is going and the sessions that they have covered this far using the following questions:
    - What has your experience been like so far in the group?
    - What are some things that stand out to you?
    - What are some things that you would like to learn about in the future sessions?
- *Marriage Roles & Parenting Discussion*: Continuing their discussion from the previous session on parenting roles, participants will discuss how their marriage and marriage roles have been impacted throughout their post-resettlement transition. Furthermore, the discussion will highlight how the new marriage roles have impacted their parenting roles and interactions with their children. The following questions may be used to guide discussion.

    - How has your marriage been impacted throughout the post-resettlement process?
    - How have your marriage roles stayed the same or changed throughout the post-resettlement transition process?
    - What are some of the relationship challenges that you have experienced during this transition?
    - How have these changes impacting your parenting roles?
    - How have these changes impacted your children?
- *Wrap-Up:* The group facilitator will summarize the topics that have been discussed throughout the session and remind the participants of the next meeting.

SESSION 5: STAGES OF SOCIAL-EMOTIONAL DEVELOPMENT

Purpose:

Primary goal of this session is explore the participants understanding of social emotional development in children, adolescents, and adults. This will be accomplished by defining Erikson's Psychosocial Stages and discussing the participants view and understanding of each of the stages. Following this discussion, the participants will have an opportunity to identify their family members social-emotional stages.

Time:

- 11:30 -11:50 → Sign in, Get a name tag, Get food
- 11:50 -12:05 → Check-In
- 12:05 -12:25 → Development Timeline
- 12:25-12:50 → Define & Discuss Stages of Social Emotional Development
- 12:50 -1:25 → Social Emotional Development Activity
- 1:25 – 1:30: → Group Wrap-Up

Materials Needed:

- *Sign In:* Food: Food, Plates, Forks, Spoons, Napkins, Drinks, Cups; Name Tags, Sign In Sheet
- *Check-In:* Expression Cards
- *Development Timeline:* Post-It Sheets, markers, leaves
- *Define & Discuss Stages of Social Emotional Development:* Erikson Social Emotional Stages Model, Discussion Questions
- *Social Emotional Development Activity:* Tree outline sheet, 8 types of colored leaves, glue, pencils and/or markers
- *Wrap-Up:* None

Procedure

- *Sign in*: Participants will sign in, receive a name tag, and get food prior to the start of the group.
- *Check-In:* Participants will check in using the expression cards to identify how they are feeling. The group facilitator will process the feelings identified with each participant and allow other group members to provide support for one another.
- *Development Timeline:* The facilitator will open this activity by exploring the participants understanding of developmental. Using a post-it sheet of paper, the facilitator will draw a line and mark eight stages of development using different age groups. At each stage, the facilitator will ask the participants to identify how the child thinks, behaves, and feels using the participants' personal experiences and cultural beliefs. During each of the stages, the facilitator will highlight the development process and allow for discussion time.

- *Define & Discuss Stages of Social Emotional Development:* The participants will be introduced to Erikson's Psychosocial Stages for children, adolescents, and adults. The stages will be reviewed using a 3D model to help the participants better understand and apply each of the stages. Following an overview of the model, the facilitator will engage the participants in a discussion about the model. Below are potential questions that may be used during the discussion:
    - Which of the eight stages seems more important? Why?
    - How does this model compare/differ to your own understanding of social and emotional development?
    - How does this model compare/differ from you cultural and/or religious beliefs?
    - What aspects of this model are most important for parents to understand?
    - What stage do you feel that you fit in within this model?
- *Social Emotional Development Activity:* Following the discussion about the Erikson Psychosocial Model, the participants will be asked to identify where their own family members fall across the eight stages. Using a tree outline, participants will be asked to glue tree leaves on their tree that represent different stages of social-emotional development. In order to identify the different stages, there will be eight different colors of leaves to represent the eight stages of social-emotional development using Erikson's model. After each participant has finished their tree, they will be able to share the tree with the rest of the group members.
- *Wrap-Up:* The group facilitator will summarize the topics that have been discussed throughout the session and remind the participants of the next meeting.

SESSION 6: FAMILY HEALTH & WELLBEING

Purpose:

The goal of this session is explore the participants understanding of health and wellbeing with primary emphasis on mental health. Using the Erikson Social Emotional Stages Model discussed in the previous session, the participants will discuss unfavorable outcomes related to each stage of development. The participants will address symptoms related to mental health, as well as causes, treatment modalities, and the impact of culture as related to mental health. Following the discussion, the participants will review several vignettes and discuss potential symptoms, causes, and treatment modalities for each vignette presented.

Time:

- 11:30 -11:50 → Sign in, Get a name tag, Get food
- 11:50 -12:05 → Check-In
- 12:05 -12:15 → Social Emotional Stages Review
- 12:25-12:55 → Health & Wellbeing Discussion
- 12:55 -1:25 → Vignette Activity
- 1:25 – 1:30: → Group Wrap-Up

Materials Needed:

- *Sign In:* Food: Food, Plates, Forks, Spoons, Napkins, Drinks, Cups; Name Tags, Sign In Sheet
- *Check-In:* Expression Cards
- *Social Emotional Stages Review:* Erikson Social Emotional Stages Model
- *Health & Wellbeing Discussion:* Discussion Questions
- *Vignette Activity:* Vignette outline
- *Wrap-Up:* None

Procedure

- *Sign in*: Participants will sign in, receive a nametag, and get food prior to the start of the group.
- *Check-In:* Participants will check in using the expression cards to identify how they are feeling. The group facilitator will process the feelings identified with each participant and allow other group members to provide support to one another.
- *Social Emotional Stages Review:* The facilitator will review the stages of social emotional development discussed in the previous session. Following the review, the primary emphasis will be on discussing unfavorable outcomes related to each stages and how they may impact mental health.
- *Health & Wellbeing Discussion:* Following the review, the facilitator will open a discussion about how unfavorable outcomes discussed may be related to mental illness, potential causes to mental illness, symptoms, treatment modalities and

ways culture impacts each of these components. Potential discussion questions may include:

- What causes unfavorable outcomes in social emotional development?
- What are some symptoms related to social emotional health that may be viewed as negative?
- What does the word mental illness mean to you?
- What does the word mental illness mean to the Somali community?
- How is mental illness treated in adults?
- How is mental illness treated in children?
- What are some differences in understanding and treating mental illness in Somalia versus here in the United States?

- *Vignette Activity:* Following the discussion, the participants will have an opportunity to review vignettes related to social emotional health. The participants will discuss each of the vignettes.
- *Wrap-Up:* The group facilitator will summarize the topics that have been discussed throughout the session and remind the participants of the next meeting.

SESSION 7: COMMUNITY INTEGRATION & RESOURCES

Purpose:

Primary goal of this session is to discuss family resources. In particular, during the session, the participants will help define the role of social and community supports in their lives and have an opportunity to develop their own community genograms that identify positive or supportive community relationships, broken community relationships, and stressful or problematic relationships. The participants will close the session by sharing their community genograms and discussing ways in which they can strengthen the different community relationships identified.

Time:

- 11:30 -11:50 → Sign in, Get a name tag, Get food
- 11:50 -12:05 → Check-In
- 12:05 -12:25 → Defining Social Supports & Community Resources
- 12:25-1:10 → Community Genogram & Discussion
- 1:10 -1:25 → The Somali Parent Program
- 1:25 - 1:30: → Group Wrap-Up

Materials Needed:

- *Sign In:* Food: Food, Plates, Forks, Spoons, Napkins, Drinks, Cups; Name Tags, Sign In Sheet
- *Check-In:* Expression Cards
- *Defining Social Supports & Community Resources* Discussion Questions & Bronfenbrenner Model
- *Community Genogram & Discussion:* Paper, markers, pencils, Community Genogram Model, & discussion questions
- *The Somali Parent Program:* None
- *Wrap-Up:* None

Procedure

- *Sign in*: Participants will sign in, receive a name tag, and get food prior to the start of the group.
- *Check-In:* Participants will check in using the expression cards to identify how they are feeling. The group facilitator will process the feelings identified with each participant and allow other group members to provide support to one another.
- *Defining Social Supports & Community Resources:* The group facilitator will open up a discussion with the participants on defining social supports and community resources. The following questions may be used to facilitate discussion:
    - What is a community?
    - How would you define your community?
    - How is your community in the United States different from your community in Somalia?

    - What does it mean to be part of a community?
- *Community Genogram & Discussion:* Using a community genogram model as an example, the facilitator will guide the participants to develop their own community genogram. Once each participant has developed their genogram, they will share it with the group and discuss ways in which they can strengthen their community supports. The following steps will be used:
    - Choose the community you wish to represent. Choose a community of origin, on which the genogram will be centered. Any community to which you have belonged can be used, however, it is best to use the community in which you were raised.
    - Draw yourself at the center of the paper or in an area that makes sense to you. You can place yourself by drawing a circle or star or a shape that you like. You can be creative in how you draw the diagram, there are no strict rules.
    - Place your family members on the paper in relation to your symbol. Then place your community and community groups on the paper. These can include neighbors, coworkers, school, church, social service and other community groups that are important to your life. You may group them in any way you like.
    - Draw lines connecting you to these groups and individuals. You can choose to use different types of lines to represent different relationships.
        - Two solid lines mean a positive and supportive relationship, a broken line means a distant relationship and a jagged line indicates problematic or conflictual relationship.
    - After each participant has created their community genogram, they will share the genogram with the rest of the group.
- *The Somali Parent Group*: The facilitator will spend some time wrapping up the 7 sessions and discussing ways in which this program has acted as a social support for the families and more importantly ways in which the participants can continue to be a source of support for each other in the future. The facilitator will discuss the Celebration session with the participants.
- *Wrap-Up:* The group facilitator will summarize the topics that have been discussed throughout the session and remind the participants of the next meeting.

SESSION 8: CELEBRATION

Purpose:
Primary goal of this session is to review and reflect on the seven sessions completed by facilitating discussion with participants and using the photo language cards. Furthermore, the goal of the session is to also celebrate the participants' accomplishments with food, music, and program completion certificates.

Time:
- 12:00- 12:15 → Sign in, Set Up Food, Get food
- 12:15 -12:20 → Check-In
- 12:20 -12:45 → Photo Language Activity
- 12:45-1:05 → Lessons Learned: Reflections & Discussion
- 1:05-1:20 → Certificate Ceremony
- 1:20 – 1:30 → Group Wrap-Up

Materials Needed:
- *Sign In:* Food: Food, Plates, Forks, Spoons, Napkins, Drinks, Cups;, Sign In Sheet
- *Check-In:* Expression Cards
- *Photo Language Activity*: Photo Language Cards
- *Lessons Learned: Reflections & Discussion:* General reflections outline, discussion questions, writing tablet, markers
- *Certificate Ceremony:* Certificates, flowers
- *Wrap-Up:* None

Procedure
- *Sign in*: Participants will sign in, receive a nametag, and get food prior to start of the group.
- *Check-In:* Participants will check in using the expression cards to identify how they are feeling. The group facilitator will process the feelings identified with each participant and allow other group members to provide support to one another..
- *Photo Language Activity:* The group facilitator will ask each participant to pick out two photographs, one photo representing them at the beginning of the Somali Parent Program and one photo representing them at the end of the Somali Parent Program. Once each participant has chosen their two photographs, each participant will share their photographs with the rest of the group. The group facilitator will use the writing tablet to write down each participant's reflections.
- *Lessons Learned: Reflections & Discussion:* As the group participants reflect on their experiences in the program using Photo Language Cards, the group facilitator will review and reflect on each of the sessions and lessons learned. The group facilitator will also take this opportunity to reflect on what she has learned throughout the process and allow the co-facilitator (the interpreter) to do the

same. After the facilitators reflections, the group facilitator will ask group participants the following discussion questions:
    - What will you take away from this group?
    - What did you learn about yourself by being part of this group?
    - What did you learn about others by being part of this group?
    - If you could share something you learned from this group with another parent who was not part of our program, what would you tell them?
- *Certificate Ceremony:* The group facilitator will call each participants name and award them with the certificate of completion for the Somali Parent Program. In addition to receiving a certificate, the facilitator will also give each participant a single rose.
- *Wrap-Up:* The group facilitator will summarize the topics that have been discussed throughout the session and discuss the concluding interviews focus groups with the participants.

APPENDIX I

DATA ANALYSIS PROCESS TABLE