Carlijn van Es

Circles of care

Supporting refugee families, children, and adolescents

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Circles of care

Supporting refugee families, children, and adolescents

Cirkels van zorg

Het ondersteunen van vluchtelinggezinnen, kinderen en adolescenten
(met een samenvatting in het Nederlands)

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Carlijn Maria van Es

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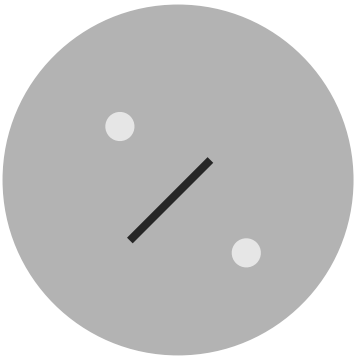

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Introduction

Amira recently turned nine years old. Lately, she has been noticing tension at home. There have been many whispers and her mother has been reclusive. One morning her parents tell their children that the family will be going away for a while. Amira does not really understand what is happening. She does not know where they are going and why they are leaving. As they leave their house she asks the first of many questions: 'When will we come back?' Her parents do not answer. For weeks, the family is traveling. Amira walks through the woods until her feet hurt. One night they get onto a boat, waves crashing around them. People yell that she has to hold on to her mother and she sees someone passing out. Finally, after more exhausting travel by train, bus, and foot, Amira and her family arrive in a country which name she has heard before: the Netherlands. As time goes by, Amira is eager to learn the language and picks up Dutch fast. Her parents have more difficulties with this and after a while Amira starts translating letters, phone calls and questions asked during appointments and visits of officials to her parents.

Merhawi, 15 years old, has lived in Eritrea his entire life. In Eritrea everyone between 18 and 40 years old is confronted with compulsory military service. Merhawi also heard about major human rights violations against prisoners. Because of the situation in Eritrea, he talks about leaving the country with his friends. One day they decide it is time to go. Four young boys embark on their flight together. When they arrive in Ethiopia, they come into contact with human traffickers and continue their flight to Sudan. In Sudan, Merhawi is witness to physical violence and rape. After a distressing and dangerous boat journey, he reaches Europe. He resides in camps in Italy for a long time, unable to move further. He is uncertain about his safety and future. During his flight, Merhawi continuously worries about the wellbeing of his family members. He has heard stories about family members left behind that are arrested and imprisoned. Ultimately, he arrives in the Netherlands where he is placed under the legal guardianship of Nidos - the national guardianship institution for unaccompanied and separated children under the age of 18 in the Netherlands. As an unaccompanied refugee minor, he is placed in a children's living group, where he lives with other Eritrean and Syrian minors under the supervision of mentors. Since his arrival in the Netherlands he has been fighting for family reunification, just as he promised his family that was left behind in Eritrea.

As illustrated by the stories of Amira and Merhawi, no refugee experience is identical. The only common factor in the stories of all 82 million forcibly displaced persons worldwide is that they were forced to leave their country or region and often left their loved ones behind (UNHCR, 2021). They fled because of persecution, for example on grounds of their beliefs or sexual orientation, or to find a safe environment for their family, away from warfare. They are often exposed to serious human rights violations prior to their flight. Approximately 42% of these forcibly displaced persons are children and adolescents under the age of 18 (UNHCR, 2021). Most will leave their countries together with their families, but a substantial minority will embark on their flight without a caregiver. These minors are referred to as unaccompanied refugee minors (URMs) (Separated Children in Europe Programme, 2004). Fleeing from war or persecution, refugees are often faced with a harrowing and dangerous journey, and are at risk of human trafficking, physical violence, and abuse. Bean et al. (2007a) found URMs to be more likely to experience potentially traumatic events, possibly as a result of the absence of adult supervision.

Families and URMs often flee for safety for themselves and for the safety of their families. URMs sometimes decide to flee their country to provide safety for their families by applying for family reunification. Both families and URMs hope to start resettling and rebuilding their lives once they have reached their country of resettlement. However, the post-migration situation most asylum seekers face is not without challenges. Recent studies indicate that stressors related to their post-migration situation, including a complex family reunification procedure, worries about loved ones who are left behind, asylum procedures, and frequent relocations can negatively impact the wellbeing of refugees (Drožđek et al., 2014; Laban et al., 2005; Unterhitzenberger et al., 2019).

Although URMs and refugee families are at risk of developing mental health problems and psychosocial problems as a result of the potentially traumatic experiences and post-migration related stressors, many studies have reported on their strengths and resilience (Carlson et al., 2012; Hutchinson & Dorsett, 2012; Sleijpen et al., 2016; Sleijpen et al., 2017). Accordingly, this dissertation not only focuses on mental health problems, but also takes into account resilience and protective factors. This chapter presents the background of the dissertation and an outline of the included studies.

Definitions

Refugee: any person who owing to 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/her nationality and is unable or, owing to such fear, is unwilling to avail him/herself of the protection of that country; or who, not having a nationality and being outside the country of his/her former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it (UNHCR, 2013; p. 121).

Asylum-seeker: an individual who is seeking international protection. In countries with individualized procedures, an asylum-seeker is someone whose claim has not yet been finally decided on by the country in which the claim is submitted (UNHCR, 2013; p. 118).

Unaccompanied refugee minor (URM): a person under 18 years who is separated from both parents and is not being cared for by an adult who, by law or by custom, is responsible for doing so (UNHCR, 2011; p. 186).

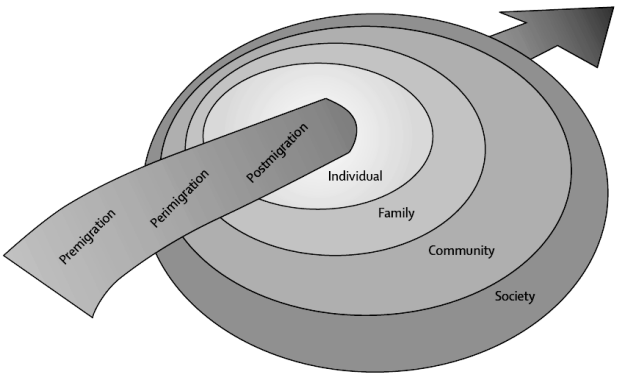
Asylum center: a regular reception center for asylum-seekers and for refugees awaiting regular accommodation/housing.

Children's living group: living arrangement with housing for approximately 12 URMs, aged 14-18. These minors are under supervision by a mentor 24/7.

ECOLOGICAL AND CHRONOLOGICAL DETERMINANTS OF MENTAL HEALTH – A FRAMEWORK

Individuals' stories cannot be understood without gaining insight in their life experiences and context. To broaden the understanding of children's experiences, Reed et al. (2012) presented a conceptual framework including chronological and contextual determinants of mental health (see Figure 1). They explain the impact that pre-migration, peri-migration, and post-migration experiences might have on children's mental health. Similarly, the children's context plays a major role in their mental health. Protective as well as risk factors for their psychological wellbeing can be found on individual, family, community, and societal levels. In short, children cannot be seen in isolation from their context.

Figure 1.



Note. Conceptual framework on mental health in forcibly displaced children. Reprinted from "Mental health of displaced and refugee children resettled in low-income and middle-income countries: risk and protective factors," by R.V. Reed, M. Fazel, L. Jones, C. Panter-Brick, & A. Stein, 2012, *The Lancet, 379*, p. 258. Copyright by Elsevier. Reprinted with permission.

On the **individual level**, the impact of exposure to potentially traumatic events has received much attention. Studies consistently show that refugee children are at increased risk of developing mental health problems, such as post-traumatic stress disorder (PTSD), depression, and anxiety (Fazel & Stein, 2002). Protective factors on the individual level include, but are not limited to, religion, hope, and use of healthy coping strategies (Carlson et al., 2012; Fazel et al., 2012; Sleijpen et al., 2017). Risk factors include exposure to potentially traumatic events and female sex (Fazel et al., 2012).

Family relationships form an important source of support and protection in refugee wellbeing and adaptation (Jordans et al., 2018), but can damage individual psychological wellbeing as well. Protective factors on the **family level** include high parental support and family cohesion. Risk factors include being separated from caregivers, parental exposure to violence, parental psychiatric problems, and having a single-parent household (Derluyn & Broekaert, 2008; Fazel et al., 2012; Sangalang & Vang, 2017). Research has suggested that a complex interaction between parents and children exists when psychiatric problems are present. Individual mental health problems can affect other family members and future generations alike (Fazel, 2019). For example, parents suffering from PTSD are more likely to be less sensitive and structuring, and to show more hostile behaviour (Van Ee et al., 2012). As a result of their own mental health issues, it becomes more difficult to be available to their children. Similarly, children of mothers suffering from PTSD are less likely to show responsiveness and involvement towards their mothers (Van Ee et al., 2012). In addition, the child may be directly exposed to distressing experiences itself. The child's symptoms, such as nightmares and crying, can trigger parental symptoms, such as intrusions and nightmares (Almqvist & Broberg, 2003). Thus, the complaints of one family member can affect the entire family.

Protective factors on the **community level** include perceived support from friends, a stable resettlement in the host country, and educational and employment opportunities. Risk factors pertain to perceived discrimination and several relocations in the host country (Fazel et al., 2012; Montgomery & Foldspang, 2008; Nielsen et al., 2008). When refugees arrive in their country of resettlement they often experience drastic changes within their socio-ecological system, including major social, cultural, and linguistic differences (Murray et al., 2010). They are faced with a new system that presents its own unique challenges. For example, refugees might have to deal with discrimination and isolation. Children have to adapt to a new school system even though previously, they experienced no or minimal schooling (Fazel et al., 2012). A recent report indicated that families living in asylum centres in the Netherlands experience stress due to their insecure future and unanswered questions about the duration of the asylum procedure. In addition, access to suitable health care is often out of reach due to linguistic differences, relocations, and long waiting lists. Moreover, several families felt unsafe at their living locations (Werkgroep Kind in azc, 2021).

Finally, refugees are impacted by factors on the **society level**, such as the political climate (Carlsson et al., 2014). Risk factors include immigration policies that are out of

the refugees' reach, insecurities concerning the asylum decision, and frequent (forced) relocations (Drožđek et al., 2014; Fazel et al., 2012; Laban et al., 2005). In addition, norms and beliefs can result in policy changes that affect refugees, such as changes in waiting time until a decision concerning asylum status has been reached or changes in accommodation and relocations (Djelantik et al., 2021).

The current dissertation focuses on the psychological wellbeing and problems of refugee families and URMs. These subjects are best understood when ecological and pre-migration, peri-migration, and post-migration variables are taken into account. Accordingly, this dissertation aims to explore how to support refugee families and URMs, looking beyond the individual and beyond the current time, taking into account the impact of previous and current stressors, and protective and risk factors on different levels.

REFUGEE FAMILIES

The majority of studies have focused on the impact of pre-, peri- and post-migration distressing experiences on the individual, suggesting refugee children are at increased risk of developing mental health issues, such as PTSD and depression (Bronstein & Montgomery, 2011; Heptinstall et al., 2004; Thabet et al., 2004). The development of stress-related complaints in childhood is an important issue, as these complaints can persist over time (Scheeringa et al., 2011) and can negatively affect many domains of the lives of (refugee) children and adolescents, such as their emotional, social, academic, and physical functioning (Fairbank & Fairbank, 2009; Seng et al., 2005). Notably, many refugee children exposed to distressing events recover well and do not develop mental health problems (Fazel et al., 2012; Fazel & Stein, 2002). Studies have indicated that individual vulnerabilities can be counteracted by the environment of the child and that social and psychological support can aid families in adapting after distressing events (Fazel et al., 2012; Walsh, 2003). Strong family cohesion and parental support can aid positive adaptation (Van Essen & Bala, 2007; Walsh, 2003). Clinical experience suggests that social and psychological support can mitigate the impact of stress-related complaints on parenting skills (Fazel & Betancourt, 2018; Mooren & Bala, 2016). As families and family functioning can serve as protective as well as risk factors in the development of mental health problems in family members, it is important for research to examine how refugee families can be supported better.

Very few studies have addressed family interventions and programs for refugee families (Slobodin & de Jong, 2015). Fazel and Betancourt (2018) state that authors should consider adapting existing family interventions developed for other populations, without adapting the core components of the program. Cultural adaptations may include applying a broader understanding of family relationships and child-rearing, collaborating with facilitators or researchers with a similar background to the participants, or using relevant examples and metaphors when offering the program (El-Khani et al., 2020; Slobodin & de Jong, 2015;

Weine et al., 2008).

An example of a family intervention applied worldwide is multiple family therapy (MFT). MFT was developed to improve the parent-child relationship and to increase social support (Asen & Scholz, 2010; Mooren & Bala, 2016). MFT brings together multiple families who have an issue in common (Asen & Scholz, 2010; Lacquer et al., 1964; Mooren & Bala, 2016). Using a multi-family approach, the therapist can focus on different systems, including only the parents, the parent-child dyads, or all participants at once. One of the key goals is to foster the development of mentalization - the ability to distinguish and understand one's own and another's perspective (Mooren & Bala, 2016). Although MFT has been offered increasingly to families dealing with a wide range of stressors, a major challenge in researching this program is the lack of clarity surrounding the concept of MFT and its impact on mental health and family functioning (O'Shea & Phelps, 1985). As MFT is offered within many different settings and for different populations and mental health problems, there is a large heterogeneity in studies examining its effectiveness. In addition, researchers and clinicians use a variety of definitions, conceptual ideas, and theoretical models when implementing MFT. As a result, it is not always clear how MFT distinguishes itself from other family- and group therapy formats. These issues can complicate establishing a strong empirical basis for MFT.

For more than a decade, ARQ Centrum'45 has offered MFT, adapted specifically for high-risk refugee families. Many refugee parents state that the accumulation of stressful life events has led to a depletion of resources and that previous coping strategies may no longer serve them in their current situation (Mooren & Bala, 2020). MFT at ARQ Centrum'45 aims to enhance resilience, coping strategies, the ability to mentalize, and emotion regulation. Working with several refugee families at once offers opportunities to enhance mutual support and to minimize feelings of isolation and stigmatization (Mooren & Bala, 2020). An adaptation of this MFT-program is Family Empowerment (FAME), a secondary preventive program for families living at asylum centres. The manual for this program has been published, but the program has not yet been systematically evaluated (Mooren & Bala, 2016).

UNACCOMPANIED REFUGEE MINORS

Another important population highly impacted by changes in their context, apart from refugee families, is formed by URMs. Between 2016 and 2021, approximately 1.300 URMs arrived in the Netherlands on a yearly basis, the majority arriving from Eritrea, Syria, and Morocco (Centraal Bureau voor de Statistiek, 2021). Their direct context is vastly different from children and adolescents who arrived in the country of resettlement with their families. URMs are separated from their homes as well as from their primary caregivers. The family members of URMs – if alive – reside in other countries, often at a great distance. At the same time, URMs are placed within a new system. When URMs resettle in the Netherlands,

legal guardians and mentors act *in loco parentis* whilst they are separated from their primary caregivers.

Most URMs are adolescents and, therefore, challenged with important developmental tasks, including personality development, sexual identity formation, autonomy, and building a personal system of values (Derluyn & Broekaert, 2007; Hurrelmann & Quenzel, 2018). Achieving these developmental tasks is put under pressure as URMs are dealing with their past experiences, current stressors, and worries about the future, whilst being separated from their families and loved ones (Ajdukovic, 1998; Derluyn & Broekaert, 2007). The combination of being a refugee, unaccompanied, as well as an adolescent can put these minors at risk of developing emotional and behavioural difficulties (Derluyn & Broekaert, 2007). URMs in the Netherlands and Belgium appear to be at a higher risk of developing psychopathology, including internalizing problems and traumatic stress, than accompanied minors (Bean et al., 2007a). Previous studies on URMs have predominantly focused on mental health problems. However, a broader understanding of challenges and needs URMs encounter during their transition to adulthood is needed to improve care structures for URMs.

The direct context of URMs plays a significant role in their wellbeing and daily functioning. For example, studies have indicated that residing in highly supported living arrangements, for example foster care and small living groups, is positively related to the wellbeing of URMs (Bean et al., 2007b; Ní Raghallaigh, 2013). Understanding URMs' challenges and needs during placement in a living location can help us to improve support systems and living arrangements to meet these needs (Carlson et al., 2012).

Although the increased vulnerability of URMs is clear, there is a shortage of studies evaluating specialized treatments specifically for URMs (Demazure et al., 2018). It remains unknown how programs can address the specific needs of URMs whilst keeping in account the impact of continuous stressors related to their postmigration situation, including the separation from their families.

CHALLENGES OF CONDUCTING RESEARCH AMONG REFUGEES

Conducting research with refugees often goes hand in hand with ethical and methodological challenges (Djelantik et al., 2021). Common challenges and limitations described in recent literature include high drop-out rates, low treatment fidelity, cultural and linguistic differences, and obtaining meaningful informed consent (Acarturk et al., 2016; Block et al., 2013; Jacobsen & Landau, 2003; Ter Heide et al., 2011). Obtaining meaningful informed consent means that the participant is able to make a well-informed decision on participating in research. Issues such as cultural and language differences, unfamiliarity with Western research methods and illiteracy, pose challenges to obtaining meaningful informed

consent (Czymoniewicz-Klippel et al., 2010). In addition, issues linked to the post-migration environment, such as relocations, the asylum procedure, and the family reunification procedure can also result in difficulties in conducting rigorous evaluations (Djelantik et al., 2021). As a result of this issues, it can be difficult to prioritize research, recruitment, and inclusion (Fazel & Betancourt, 2018). In this dissertation we describe these challenges we faced in a naturalistic setting and, in addition, aim to provide recommendations for future implementation and research efforts.

AIM OF THIS DISSERTATION

In this dissertation, we aim to increase our understanding of the needs of refugee families and URMs in order to inform the future development and improvement of care systems and programs developed for refugee families and URMs in the Netherlands. Additionally, we provide our first experiences with offering mental health intervention programs for these populations. This dissertation focuses on two specific groups: refugee families and URMs. Part 1 focuses on the following question: How can refugee families be supported in strengthening family functioning and social support? and Part 2 aims to answer the question: How can URMs be supported in strengthening the caregiver-child relationship and mental health?

Not only refugee children and families suffer from the consequences of potentially traumatic events. Across the world, millions of families are exposed to accidents, natural disasters, illnesses, sexual abuse, or medical problems every year. The impact of trauma is often visible in these families. In addition, URMs are not the only children or adolescents separated from their close relatives, as many other youngsters reside in foster care due to the loss of their parents or abuse and negligence. This dissertation will not only inform the field of refugees, but may also help us in understanding how we can meet the needs of other children, adolescents, and families who have to deal with the consequences of trauma and who are separated from their close relatives.

METHODOLOGY

This dissertation aims to give voice to the participating refugees themselves by using different approaches and designs, combining quantitative and qualitative methodologies. Applying only quantitative designs can result in limitations as it focuses only on questions that can be ‘controlled, measured, and counted’ (Malterud, 2001), thereby limiting the possibility to explore new topics. In addition, quantitative methods and questionnaires are often based on Western norms and values, and cultural translations do not always prove valid and adequate for measuring cross-cultural expressions and experiences (Bartholomew &

Brown, 2012; Betancourt & Williams, 2008; Pernice, 1994). To broaden our understanding of the experiences and needs of participating refugees and to provide an in-depth exploration of these topics, this dissertation uses different designs, including qualitative and mixed-methods studies.

GENERAL OUTLINE

Part 1

To answer the first question (How can refugee families be supported in strengthening family functioning and social support?), this dissertation begins with a systematic review and meta-analysis of MFT, assessing its impact on family functioning and mental health problems (Chapter 2). Chapter 3 presents a study protocol for a pilot implementation and evaluation of a preventive multi-family program for asylum-seeker families: FAME. The mixed-methods pilot evaluation of FAME is described in Chapter 4, which assesses the feasibility of FAME delivered in a naturalistic setting.

Part 2

The second question of this dissertation (How can URMs be supported in strengthening the caregiver-child relationship and mental health?) is addressed in the following three chapters. In order to explore the challenges and needs experienced by Eritrean URMs resettled in the Netherlands, Chapter 5 describes a focused ethnography on Eritrean URMs and their caregivers. The next two chapters evaluate a multimodal trauma-focused treatment approach developed for URMs in the Netherlands. Chapter 6 provides a mixed-methods evaluation of the feasibility of this treatment approach, whereas Chapter 7 offers an initial evaluation of its effectiveness by conducting a multiple baseline design as well as a qualitative evaluation of the treatment approach. Finally, in Chapter 8 we summarize and discuss the findings of the aforementioned chapters.

REFERENCES

Acarturk, C., Konuk, E., Cetinkaya, M., Senay, I., Sijbrandij, M., Gulen, B., & Cuijpers, P. (2016). The efficacy of eye movement desensitization and reprocessing for post-traumatic stress disorder and depression among Syrian refugees: Results of a randomized controlled trial. *Psychological Medicine*, *46*(12), 2583-2593.

Ajdukovic, M. (1998). Displaced adolescents in Croatia: Sources of stress and posttraumatic stress reaction. *Adolescence*, *33*(129), 209.

Almqvist, K., & Broberg, A. G. (2003). Young children traumatized by organized violence together with their mothers–The critical effects of damaged internal representations. *Attachment & Human Development*, *5*(4), 367-380.

Asen, E., & Scholz, M. (2010). *Multi-family therapy: Concepts and techniques*. Routledge.

Bartholomew, T. T., & Brown, J. R. (2012). Mixed methods, culture, and psychology: A review of mixed methods in culture-specific psychological research. *International Perspectives in Psychology: Research, Practice, Consultation*, *1*(3), 177.

Bean, T., Derluyn, I., Eurelings-Bontekoe, E., Broekaert, E., & Spinhoven, P. (2007a). Comparing psychological distress, traumatic stress reactions, and experiences of unaccompanied refugee minors with experiences of adolescents accompanied by parents. *The Journal of Nervous and Mental Disease*, *195*(4), 288-297.

Bean, T. M., Eurelings-Bontekoe, E., & Spinhoven, P. (2007b). Course and predictors of mental health of unaccompanied refugee minors in the Netherlands: One year follow-up. *Social Science & Medicine*, *64*(6), 1204-1215.

Betancourt, T. S., & Williams, T. (2008). Building an evidence base on mental health interventions for children affected by armed conflict. *Intervention*, *6*(1), 39.

Block, K., Warr, D., Gibbs, L., & Riggs, E. (2013). Addressing ethical and methodological challenges in research with refugee-background young people: Reflections from the field. *Journal of Refugee Studies*, *26*(1), 69-87.

Bronstein, I., & Montgomery, P. (2011). Psychological distress in refugee children: a systematic review. *Clinical Child and Family Psychology Review*, *14*(1), 44-56.

Carlson, B. E., Cacciatore, J., & Klimek, B. (2012). A risk and resilience perspective on unaccompanied refugee minors. *Social Work*, *57*(3), 259-269.

Carlsson, J., Sonne, C., & Silove, D. (2014). From pioneers to scientists: challenges in establishing evidence-gathering models in torture and trauma mental health services for refugees. *The Journal of Nervous and Mental Disease*, *202*(9), 630-637.

Centraal Bureau voor de Statistiek. (2021). *Alleenstaande minderjarige vreemdeling; nationaliteit, geslacht en leeftijd*. Retrieved 24-19 from https://www.cbs.nl/nl-nl/cijfers/detail/82045NED

Czymoniewicz-Klippel, M. T., Brijnath, B., & Crockett, B. (2010). Ethics and the promotion of inclusiveness within qualitative research: Case examples from Asia and the Pacific. *Qualitative Inquiry*, *16*(5), 332-341.

Demazure, G., Gaultier, S., & Pinsault, N. (2018). Dealing with difference: a scoping review of psychotherapeutic interventions with unaccompanied refugee minors. *European Child & Adolescent Psychiatry*, *27*(4), 447-466.

Derluyn, I., & Broekaert, E. (2007). Different perspectives on emotional and behavioural problems in unaccompanied refugee children and adolescents. *Ethnicity and Health*, *12*(2), 141-162.

Derluyn, I., & Broekaert, E. (2008). Unaccompanied refugee children and adolescents: The glaring contrast between a legal and a psychological perspective. *International Journal of Law and Psychiatry*, *31*(4), 319-330.

Djelantik, A. A. A. M. J., Van Es, C. M., Lahuis, A. M., & Mooren, N. (2021). *The challenges of conducting mental health research among resettled refugee populations: an ecological framework from a researchers' perspective*. Manuscript in preparation.

Drožđek, B., Kamperman, A. M., Tol, W. A., Knipscheer, J. W., & Kleber, R. J. (2014). Seven-year follow-up study of symptoms in asylum seekers and refugees with PTSD treated with trauma-focused groups. *Journal of Clinical Psychology*, *70*(4), 376-387.

El-Khani, A., Maalouf, W., Baker, D. A., Zahra, N., Noubani, A., & Cartwright, K. (2020). Caregiving for children through conflict and displacement: a pilot study testing the feasibility of delivering and evaluating a light touch parenting intervention for caregivers in the West Bank. *International Journal of Psychology*, *55*, 26-39.

Fairbank, J. A., & Fairbank, D. W. (2009). Epidemiology of child traumatic stress. *Current Psychiatry Reports*, *11*(4), 289-295.

Fazel, M. (2019). Focusing a lens on refugee families to address layers of avoidance. *The Lancet Public Health*, *4*(7), e318-e319.

Fazel, M., & Betancourt, T. S. (2018). Preventive mental health interventions for refugee children and adolescents in high-income settings. *The Lancet Child & Adolescent Health*, *2*(2), 121-132.

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*(9812), 266-282.

Fazel, M., & Stein, A. (2002). The mental health of refugee children. *Archives of Disease in Childhood*, *87*(5), 366-370.

Heptinstall, E., Sethna, V., & Taylor, E. (2004). PTSD and depression in refugee children. *European Child & Adolescent Psychiatry*, *13*(6), 373-380.

Hurrelmann, K., & Quenzel, G. (2018). *Developmental tasks in adolescence*. Routledge.

Hutchinson, M., & Dorsett, P. (2012). What does the literature say about resilience in refugee people? Implications for practice. *Journal of Social Inclusion*, *3*(2), 55-78.

Jacobsen, K., & Landau, L. B. (2003). The dual imperative in refugee research: some methodological and ethical considerations in social science research on forced migration. *Disasters*, *27*(3), 185-206.

Jordans, M. J., Van den Broek, M., Brown, F., Coetzee, A., Ellermeijer, R., Hartog, K., Steen, F., & Miller, K. E. (2018). Supporting children affected by war: Towards an evidence based care system. In *Mental health of refugee and conflict-affected populations* (pp. 261-281). Springer.

Laban, C. J., Gernaat, H. B., Komproe, I. H., Van Der Tweel, I., & De Jong, J. T. (2005). Postmigration living problems and common psychiatric disorders in Iraqi asylum seekers in the Netherlands. *The Journal of Nervous and Mental Disease*, *193*(12), 825-832.

Lacquer, H., La Burt, H., & Morong, E. (1964). Multiple family therapy: further developments. *International Journal of Social Psychiatry*, *10*, 69-80.

Malterud, K. (2001). The art and science of clinical knowledge: evidence beyond measures and numbers. *The Lancet*, *358*(9279), 397-400.

Montgomery, E., & Foldspang, A. (2008). Discrimination, mental problems and social adaptation in young refugees. *European Journal of Public Health*, *18*(2), 156-161.

Mooren, G. T. M., & Bala, J. (2016). *Goed ouderschap in moeilijke tijden: Handleiding voor meergezinsgroepen met vluchtelingen*. Pharos.

Mooren, T., & Bala, J. (2020). Mobilizing in Multifamily Resources Groups. In L. de Haene and C. Rousseau (Eds.), *Working with Refugee Families. Trauma and Exile in Family Relationships* (pp.117-131). Cambridge: Cambridge University Press.

Murray, K. E., Davidson, G. R., & Schweitzer, R. D. (2010). Review of refugee mental health interventions following resettlement: best practices and recommendations. *American Journal of Orthopsychiatry*, *80*(4), 576.

Ní Raghallaigh, M. (2013). *Foster care and supported lodgings for separated asylum seeking young people in Ireland: the views of young people, carers and stakeholders*. Barnados and the Health Service Executive.

Nielsen, S. S., Norredam, M., Christiansen, K. L., Obel, C., Hilden, J., & Krasnik, A. (2008). Mental health among children seeking asylum in Denmark–the effect of length of stay and number of relocations: a cross-sectional study. *BMC Public health*, *8*(1), 1-9.

O'Shea, M. D., & Phelps, R. (1985). Multiple family therapy: Current status and critical appraisal. *Family Process*, *24*(4), 555-582.

Pernice, R. (1994). Methodological issues in research with refugees and immigrants. *Professional Psychology: Research and Practice*, *25*(3), 207.

Reed, R. V., Fazel, M., Jones, L., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in low-income and middle-income countries: risk and protective factors. *The Lancet*, *379*(9812), 250-265.

Sangalang, C. C., & Vang, C. (2017). Intergenerational trauma in refugee families: A systematic review. *Journal of Immigrant and Minority Health*, *19*(3), 745-754.

Scheeringa, M. S., Zeanah, C. H., & Cohen, J. A. (2011). PTSD in children and adolescents: toward an empirically based algorithm a. *Depression and Anxiety*, *28*(9), 770-782.

Seng, J. S., Graham-Bermann, S. A., Clark, M. K., McCarthy, A. M., & Ronis, D. L. (2005). Posttraumatic stress disorder and physical comorbidity among female children and adolescents: results from service-use data. *Pediatrics*, *116*(6), e767-e776.

Separated Children in Europe Programme. (2004). *Statement of Good Practice*. Save the Children & UNHCR.

Sleijpen, M., Boeije, H. R., Kleber, R. J., & Mooren, T. (2016). Between power and powerlessness: a meta-ethnography of sources of resilience in young refugees. *Ethnicity & Health*, *21*(2), 158-180.

Sleijpen, M., Mooren, T., Kleber, R. J., & Boeije, H. R. (2017). Lives on hold: A qualitative study of young refugees' resilience strategies. *Childhood*, *24*(3), 348-365.

Slobodin, O., & de Jong, J. T. (2015). Mental health interventions for traumatized asylum seekers and refugees: What do we know about their efficacy? *International Journal of Social Psychiatry*, *61*(1), 17-26.

Ter Heide, F. J. J., Mooren, T., Kleijn, W., de Jongh, A.,

& Kleber, R. (2011). EMDR versus stabilisation in traumatised asylum seekers and refugees: Results of a pilot study. *European Journal of Psychotraumatology*, *2*(1), 5881.

Thabet, A. A. M., Abed, Y., & Vostanis, P. (2004). Comorbidity of PTSD and depression among refugee children during war conflict. *Journal of Child Psychology and Psychiatry*, *45*(3), 533-542.

UNHCR. (2011). *UNHCR resettlement handbook*.

UNHCR. (2013). *UNHCR Global Appeal 2013 Update - Glossary*.

UNHCR. (2021). *Global trends - Forced displacement in 2020*.

Unterhitzenberger, J., Wintersohl, S., Lang, M., König, J., & Rosner, R. (2019). Providing manualized individual trauma-focused CBT to unaccompanied refugee minors with uncertain residence status: a pilot study. *Child and Adolescent Psychiatry and Mental Health*, *13*(1), 1-10.

Van Ee, E., Kleber, R. J., & Mooren, T. T. (2012). War trauma lingers on: Associations between maternal posttraumatic stress disorder, parent–child interaction, and child development. *Infant Mental Health Journal*, *33*(5), 459-468.

Van Essen, J., & Bala, J. (2007). *Als glas in lood: integratieve behandeling van vluchtelingenkinderen en-gezinnen*. Pharos.

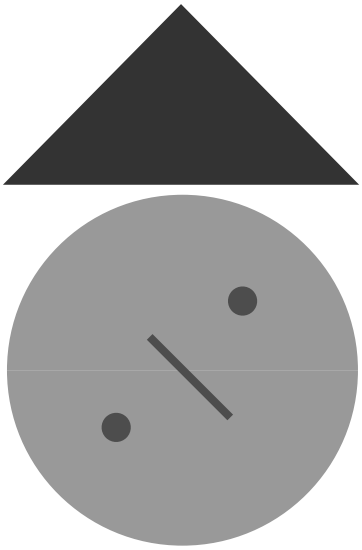
Walsh, F. (2003). Family resilience: A framework for clinical practice. *Family Process*, *42*(1), 1-18.

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

Werkgroep Kind in azc. (2021). *Monitor: leefomstandigheden van kinderen in de asielopvang*. Retrieved 10-12-2021 from https://www.unicef.nl/files/Rapport%20Kind%20in%20azc_mei2021.pdf

PART I

Refugee Families



2

The effect of multiple family therapy on mental health problems and family functioning: A systematic review and meta-analysis

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ABSTRACT

The aim of this systematic review and meta-analysis was to examine the effect of multiple family therapy on mental health problems and family functioning. Thirty-one studies were included in the systematic review based on a search for peer-reviewed, English, controlled studies evaluating the effect of multiple family therapy. Sixteen articles presenting 16 trials were included in the meta-analysis. All but one studies were at risk of bias, with problems concerning confounding, selection of participants, and missing data. The meta-analysis showed that multiple family therapy is associated with improvements in family functioning, with a small effect size. Multiple family therapy is suggested to result in improvements in positive and negative symptoms of schizophrenia with a large effect size, although this effect was not statistically significant. Multiple family therapy was not associated with changes in mood and conduct problems. More research is needed to further examine the effectiveness of multiple family therapy, its core components, and potential working mechanisms.

Keywords
Multiple Family Therapy; Mental Health Problems; Family Functioning; Systematic Review; Meta-Analysis.

INTRODUCTION

Over five decades ago Laqueur et al. (1964) introduced 'Multiple Family Therapy' (MFT) as a treatment for patients with schizophrenia and their relatives. MFT was based on the notion that illness can affect close relatives and that relatives may impact and perpetuate illness (Laqueur et al., 1964). During MFT, close relatives of the patient are involved in treatment as multiple families facing similar difficulties and issues are brought together. This setting allows families to share experiences, offer and receive mutual support and feedback, and learn about different perspectives on, and solutions for, difficulties within families (Asen, 2002; Asen & Scholz, 2010).

O'Shea and Phelps (1985) wrote a critical appraisal on MFT, stating it was conceptually underdeveloped and poorly differentiated from other treatments. According to the authors, MFT is defined as a psychosocial intervention, where two or more families represented by at least two family generations are present for most or all sessions. The sessions of MFT have an explicit focus on problems or concerns shared by the attending families, an emphasis on (inter)familial interaction, and utilize alliances between members of different families (p. 573). MFT distinguishes itself from therapy focusing on a single family and groups without the primary patient present.

Over the past decades, MFT has received increased interest and several studies have reviewed research on MFT (Cook-Darzens et al., 2018; Gelin et al., 2016; McFarlane, 2016; Stuart & Schlosser, 2009). The literature reveals a variety of approaches to MFT. For one, various therapeutic models have been used, including a systemic, psychoeducational, and cognitive behavioral model (Gelin et al., 2016). Also, MFT has been applied to families with a wide range of focal problems, ranging from chronic medical illnesses to marital distress.

The vast majority of studies have focused on the empirical evidence regarding MFTs applications to psychiatric problems (Cook-Darzens et al., 2018; Gelin et al., 2018). A review conducted by Gelin et al. (2018) concluded that most empirical support has been found for the treatment and prevention of schizophrenia, suggesting that MFT is superior to single family approaches for first-episode psychosis patients with a high risk of relapse and high levels of family stress. The authors further suggest that the psychoeducational model, which includes a focus on education, problem-solving, communication, vocational skills and social skills, offers one of the best available practices (Gelin et al., 2018; McFarlane, 2016). According to a literature review by McFarlane (2016), MFT is associated with lower relapse rates in patients with schizophrenia than single family therapy. In addition, there is a growing body of literature covering its applicability for mood disorders, eating disorders, and alcohol-substance abuse (Gelin et al., 2016; Gelin et al., 2018). To our knowledge, none of the previous reviews has performed a systematic review or meta-analysis.

Several factors have limited the possibility to conduct a systematic review and meta-analysis on MFT. MFT has been offered within a wide variety of illnesses, disorders, and populations, resulting in a large heterogeneity in studies (Cook-Darzens et al., 2018; Gelin et

al., 2016; Gelin et al., 2018). In addition, in some studies it remains unclear in what way MFT is different from individual and other forms of family therapy (Gelin et al., 2016). Jewell and Lemmens (2018) recommended that future reviews should include systemic search strategies while considering the risk of bias in the identified studies. The current study follows up on existing literature by providing a systematic review and meta-analysis of literature on MFT. According to O'Shea and Phelps (1985), the main aims of MFT are to target focal problems as well as family interactions. With regard to focal problems, MFT is most often offered to participants who suffer from mental health problems (Cook-Darzens et al., 2018; Gelin et al., 2018). Therefore, this study evaluates the effect of MFT on mental health problems and family functioning. Our first aim was to conduct a systematic review to provide an overview of existing controlled trials focusing on the impact of MFT on mental health problems and family functioning. Our second aim was to conduct a comprehensive meta-analysis to examine the efficacy of MFT in terms of improving mental health and family functioning.

METHODS

Identification and Selection of Studies

The systematic review and meta-analysis was pre-registered at PROSPERO (ID: CRD42020196491). Relevant studies published before June 2021 were identified through searches in seven databases (PsycInfo, Ovid Medline, Ovid Evidence Based Medicine Reviews, Embase, Published International Literature on Traumatic Stress, Web of Science, and Google Scholar) using the search terms related to MFT (e.g., multiple family therapy) and study design (e.g., trials). Individual search terms were generated for each database. Full electronic searches can be found on PROSPERO. In addition, we performed a hand search including relevant references from two key review articles on MFT, namely Gelin et al. (2018) and Jewell and Lemmens (2018).

Studies were included if they assessed the impact of MFT on mental health problems and/or family functioning in comparison to a control condition. In line with the definition proposed by O'Shea and Phelps, we defined MFT as a prevention or intervention program in which two or more families, including the patient and at least one family member, together representing at least two generations, take part. The following active and passive control conditions were included: waiting list and care as usual (i.e., any type of care participants would normally receive, such as routine psychiatric services and medication). All controlled studies, not only randomized controlled trials, were included. Trials that only compared MFT to another structured family treatment(s) were excluded. Studies were excluded if they a) lacked quantitative pre- and post-treatment assessments and/or b) were not written in English.

Titles and abstracts were independently screened by two researchers. Based on this screening, full text articles were retrieved and independently assessed by two researchers.

If the researchers disagreed on in- or exclusion, the article was discussed. If they could not reach agreement, a third researcher decided whether the article should be in- or excluded. Four authors were contacted and requested to supply additional information as their publication supplied insufficient information to calculate effect sizes (25% response rate).

Data Extraction Systematic Review

Data extraction for the systematic review included participant characteristics (presenting problem; relation between participating family members and primary patient; N in MFT and control condition; gender; age; ethnicity), program characteristics (description of therapeutic models/techniques; training of facilitators; use of manual; frequency and duration; whether MFT was combined with another service), and study characteristics (study design; characteristics of control condition; main findings based on the abstract). Data extraction for the meta-analyses included information on mental health problems and/or family functioning in the MFT- and control conditions. Data extraction for both the systematic review and the meta-analysis was conducted independently by two researchers.

Statistical Analysis

The primary outcomes were post-treatment indices of mental health symptoms and/or family functioning. In one case, data on these outcomes were unavailable and the estimated differences of slopes were used. In some studies several instruments were used to measure the same construct. Then, a hierarchy was defined to establish which instruments would be included. The most used instrument (determined by two assessors) was chosen first, if that instrument was not available, the second most used was chosen. Outcomes were categorized based on the mental health problems addressed in the study. Intention-to-treat data were used when available. When three or more studies focused on the same mental health problem, a meta-analysis of treatment effects was conducted.

The program Comprehensive Meta-Analysis, version 3 (Biostat) was used to compute effect sizes, using random-effects models. Hedges' *g* was used to indicate differences between treatment and control conditions at posttreatment. Higher effect sizes represent effects in favor of MFT relative to the comparison condition. The pooled effect sizes were converted to number needed to treat (NNT) by using the conversion table by Kraemer and Kupfer (2006). The NNT indicates the number of patients that have to be treated to result in one additional patient with positive outcomes (Cuijpers, 2016). In addition, we calculated 95% prediction intervals in order to estimate the effect size range. Studies from which the 95% confidence interval did not overlap with the 95% confidence interval of the pooled effect size were identified as potential outliers.

For the quality assessment of the included studies, risk of bias was evaluated using the Cochrane revised tool for Risk of Bias in randomized trials (RoB 2.0 tool) (Sterne et al., 2019) and the Risk Of Bias in Non-randomized Studies of Interventions tool (ROBINS-I tool) (Sterne et al., 2016), completed by CvE. A second researcher (TM) independently scored

three articles (19%) to verify the reliability of the scoring. Heterogeneity was assessed by a visual inspection of the forest plot and the I^2 statistic (Borenstein et al., 2017). The I^2 statistic represents the proportion of the total variance that can be explained by heterogeneity (range 0-100%). Finally, publication bias was assessed by conducting the Egger's test of the intercept (Egger et al., 1997). To adjust for publication bias, a trim and fill technique based on the funnel-plot-based method was used (Duval & Tweedie, 2000).

RESULTS

Figure 1 presents the PRISMA flow diagram of the selection and inclusion process. In total 3.376 titles and abstracts were screened and 426 full-text articles retrieved; 395 articles were excluded based on the in- and exclusion criteria. Thirty-one trials met all inclusion criteria. When three or more studies focused on the same mental health issue, a meta-analysis of treatment effects was conducted. Consequently, 16 articles presenting 16 trials were included in the meta-analysis.

Part I: Systematic Review

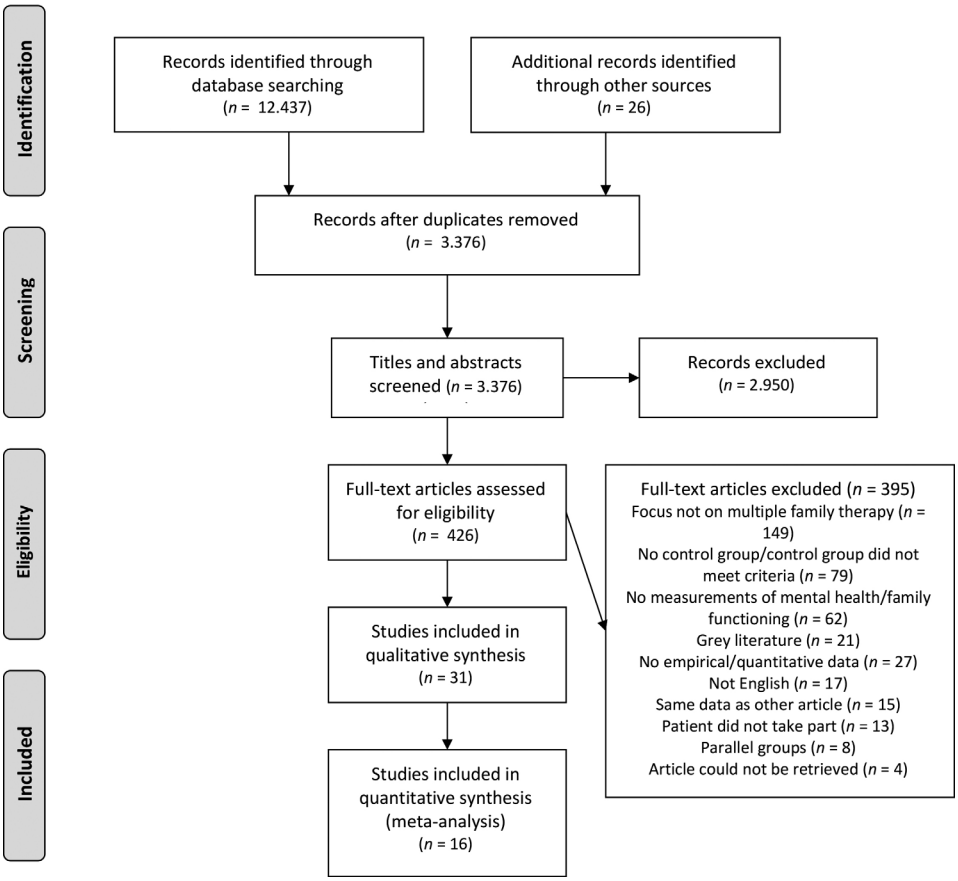
Characteristics of Included Studies

Participant Characteristics

Characteristics of participants are summarized in the Supplementary Material (Table A). Approximately 4.760 participants were included in the 31 MFT trials analyzed in this review. About half of the participants (53%) were included in the MFT conditions and 47% in the control conditions. Most of the 31 trials were conducted in the United States of America (52%), Western Europe (19%), China or Hong Kong (16%), and Australia (6%). The studies predominantly examined MFT offered to families of patients dealing with schizophrenia/psychosis (k = 9, 29%), mood problems, such as depressive disorders (k = 5, 16%), and conduct problems, such as disruptive behavior (k = 5, 16%). Other studies focused on families dealing with cancer, lower social capital, (opiate or internet) addiction, Attention Deficit Hyperactivity Disorder (ADHD), trauma, diabetes, cognitive impairment, and specific minority target groups (American Indian, Latino, and Hmong refugee families).

Most studies were conducted with children between 0 and 18 years old (55%), their caregivers, and sometimes their siblings. The studies focusing on adults included adults and their care dyad and/or key relative (i.e. spouse, child, friend, parent). Twenty-nine studies reported the gender of participants. In these studies, 57% of the participants were male. Nine studies did not report the ethnicity of the participants. Other studies reported that the majority of participants was white (k = 8), Asian (k = 5), Latino (k = 4) or of another ethnicity (k = 6).

Figure 1. *PRISMA Flow Diagram*



Program Characteristics

Program characteristics are summarized in the Supplementary Material (Table B). A broad range of implemented therapeutic models have been described in the studies evaluating MFT. Five trials (16%) explicitly refer to (psychoeducational) MFT as developed by McFarlane (McFarlane et al., 2002; McFarlane et al., 1995) and five studies (16%) to Families and Schools Together (FAST), developed by McDonald (2002). Other studies focused on 4Rs and 2Ss (rules, responsibility, relationships, respectful communication, stress and social support) (McKay et al., 1999). Psychoeducation focused on concepts such as adaptation to illness, coping skills, social support, and illness management skills. Other techniques applied involved (behavioral) parenting interventions, social skills training, and cognitive behavioral techniques. The majority (k = 18, 58%) of the studies explained the training that MFT facilitators obtained. Most studies (k = 22, 71%) explicitly reported the use of a manual by the facilitators. There was a wide variety in duration and frequency, ranging from six weekly sessions to biweekly meetings for two years. Most studies (k = 19, 61%) reported that

MFT was offered in combination with another service, including pharmacological treatment, medical care, and treatment as usual/routine outpatient care.

Study Characteristics

Table C in the Supplementary Material presents the study characteristics of the included trials. Most studies were RCTs (*k* = 19, 61%). Seven studies presented a quasi-experimental design (23%). Other designs included a school-randomized trial, a risk-based allocation study, a prospective cohort study, and a naturalistic follow-up study. Most comparison conditions consisted of treatment as usual (*k* = 13, 42%), including case management, routine psychiatric services, pharmacological treatment, mental health services, and medical care. Other active control conditions included psychoeducation, relaxation workshops, mailings of parenting skills information, and school-based interventions. Some studies implemented passive control conditions (*k* = 7, 23%), including waiting list and no treatment.

Schizophrenia

Nine trials (29%) focused on addressing symptoms of schizophrenia, of which all but one focused on adult participants and their relatives. Studies reported a decrease in symptoms of schizophrenia, including negative and positive symptoms (Bradley et al., 2006; Dyck et al., 2000; McFarlane et al., 2015; Valencia et al., 2010), lower relapse rates (Bradley et al., 2006; Liberman et al., 1984; Valencia et al., 2010), and improvements in the number and duration of (re-)hospitalizations (Chien et al., 2018; Chien & Chan, 2004; Valencia et al., 2010). However, one study reported that MFT participants had significantly less improvement in positive and excitation symptoms, and a longer duration of psychotic symptoms compared to participants who refused or were not offered MFT (Rossberg et al., 2010).

Changes concerning family functioning included improved family functioning (Chien et al., 2018), decreased relative burden (Jeppesen et al., 2005), and reduced family conflict and expressed emotion (Liberman et al., 1984). One study found no impact of MFT on expressed emotion (Jeppesen et al., 2005).

Other findings concerned improvements in vocational outcomes (Bradley et al., 2006; McFarlane et al., 2015), (global) functioning (Chien et al., 2018; Chien & Chan, 2004; McFarlane et al., 2015), medication adherence, and attendance to appointments and social functioning (Valencia et al., 2010). Although one study reported an increase in knowledge of schizophrenia (Liberman et al., 1984), another found no impact of MFT on knowledge (Jeppesen et al., 2005).

Mood Problems

Five trials (17%), of which three studies included children and their relatives, and two studies included adults and their relatives, had a main focus on mood problems. MFT was associated with improvements in mental health, including mood severity, emotional health, and psychological distress (Fristad et al., 2009; Lemmens, Eisler, et al., 2009; Ma et al.,

2021). Lemmens et al. (2009) reported a decrease in the number of study participants using antidepressant medication. Poole et al. (2018) found no difference in depressive symptoms between participants attending MFT and participants in the control condition,

Changes concerning family functioning included improvements in parental knowledge about childhood mood symptoms, positive family interactions, and parental support (Fristad et al., 2003b), and reduced parental stress and parental depressive symptoms (Poole et al., 2018). Fristad et al. (2003) did not find an impact of MFT on negative family interactions and Ma et al. (2021) found no difference between the MFT- and control condition regarding parental and family functioning.

Other results included increased service utilization (Fristad et al., 2003) and higher rates treatment responders in the MFT-condition (Lemmens et al., 2009).

Conduct Problems

Five (16%) of all 31 trials considered the impact of MFT on conduct problems. All trials focused on children and their relatives. The studies reported improvements in conduct problems, including disruptive, oppositional, and externalizing behavioral issues (Chacko et al., 2015; Kratochwill et al., 2009; McKay et al., 1999; Morris et al., 2014), symptoms of hyperactivity and impulsivity (McKay et al., 1999), and emotional functioning (Morris et al., 2014). Chacko et al. (2015) did not find a difference in impairment between participants attending MFT and participants in the control condition. Pérez-García et al. (2020) suggested that MFT was associated with improvements in internalizing behavior, but also reported greater improvements in externalizing behavior, especially verbal aggression, and depression in the control condition.

Concerning the impact on family functioning, a smaller decline in family adaptability in families attending MFT was reported by Kratochwill et al. (2009). Morris et al. (2014) found that participants in the MFT-condition reported stable family functioning, whereas participants in the control condition showed a deterioration in family functioning.

Other changes associated with MFT included improvements in learning difficulties (McKay et al., 1999) and social functioning (Chacko et al., 2015; Morris et al., 2014).

Medical Illness

Chiquelho et al. (2011) reported that MFT for families dealing with cancer prevented a deterioration of psychosocial adjustment and was associated with family cohesion and lower perceived stress of patients and family members.

Concerning MFT for families dealing with diabetes, (Satin et al., 1989) reported that MFT resulted in increased positive perceptions of being a teenager with diabetes and improvements in diabetes control. Both studies on diabetes found that participation in MFT was associated with improvements in blood sugar levels (Satin et al., 1989; Wysocki et al., 2006).

Addiction

Garrido-Fernández et al. (2017) reported that participation in MFT was associated with a reduction in opiate addiction severity and improvements in employment, drug use, and psychiatric condition. Alcohol consumption worsened in participants in the MFT as well as the control condition. Liu et al. (2015) stated that participants attending MFT showed a decline in internet addiction, which was partly explained by the satisfaction of the participants' psychological needs and improved parent-adolescent communication and closeness.

Specific Cultural Adaptations of MFT

Kratochwill et al. (2004) found improvements in aggressive and withdrawn behavior, and academic performance in American Indian participants. McDonald et al. (2006) reported that Latino participants showed improvements in academic performance and classroom behaviors, including aggression and social skills. Finally, according to McDonald et al. (2012), Hmong refugees taking part in MFT showed improvements in child anxiety, social skills, and family adaptability. This study found no change in family cohesion or externalizing behavior.

Miscellaneous Target Groups

Gamoran et al. (2012) reported improvements in social networks and behavioral outcomes in families with lower social capital. Rosenblum et al. (2017) stated that MFT for families dealing with trauma resulted in improvements in mental health and parenting stress. Schmitter-Edgecombe and Dyck (2014) explored MFT for participants with cognitive impairment and reported improvements everyday functioning, and memory, and coping of care-partners. The authors did not find a difference in psychological functioning. Finally, Ma et al. (2018) found that MFT for children with ADHD resulted in parents perceiving their children's symptoms as less serious and pathological and improvements parent-child relationship, parenting stress, parental efficacy, hope, and social support.

Part II: Meta-analyses

Risk of Bias

Sixteen articles presenting 16 trials were included in the meta-analysis. Risk of bias assessments are presented in Figure 2 and Figure 3. Only one of all trials considered met criteria for high quality (Lemmens et al., 2009). In non-randomized studies, most problems concerning bias were related to confounding (meaning that factors that predict the outcome also predict the condition in which an individual is placed) and selection of participants (Liberman et al., 1984) and missing data (Ma et al., 2021). High risk in RCTs was mostly due to missing outcome data (Bradley et al., 2006; Jeppesen et al., 2005).

Figure 2. *Risk of Bias Assessment of Non-randomized Studies*

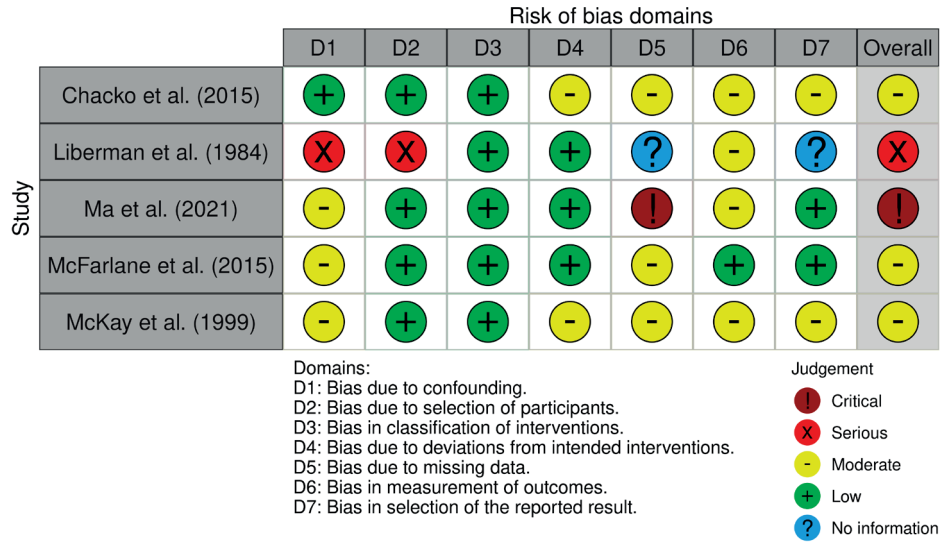
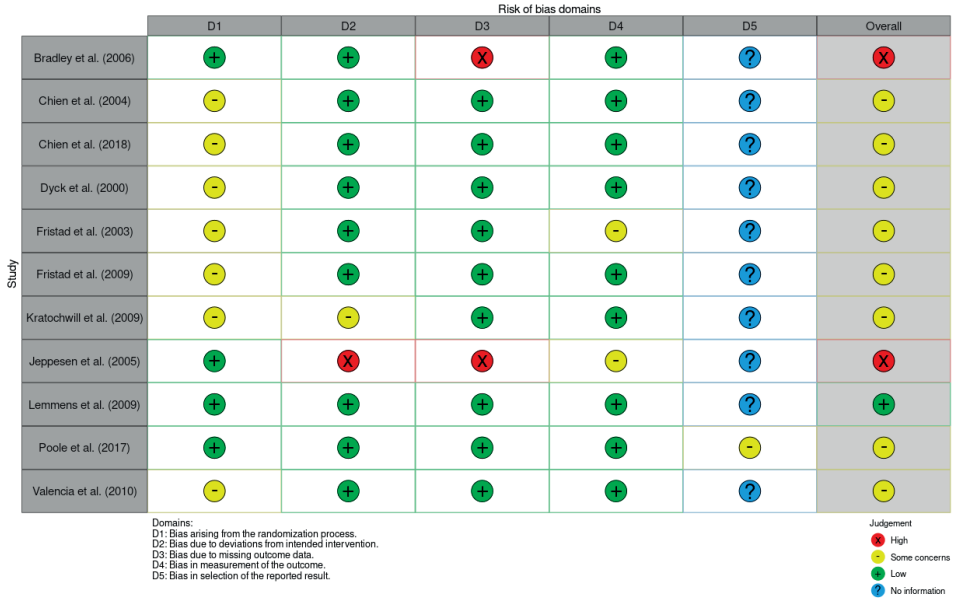


Figure 3. *Risk of Bias Assessment of Randomized Studies*



Main Analyses

Sufficient studies were found to calculate effect sizes for schizophrenia, mood problems, and conduct problems. In addition, a meta-analysis on the impact of MFT on family functioning was conducted for all articles included in the meta-analyses on mental health problems that also measured family functioning. Table 1 presents the effect sizes (Hedges' *g*) using the random effects model, the NNT, and heterogeneity indices (I^2). Forest plots are reported in the Supplement material (Figure A).

Table 1. *Treatment Effects and Heterogeneity Indices*

	k/N	*g* (95% CI)	*p*	NNT	I^2 (95% CI)
Schizophrenia	6/564	0.96 (-0.19 - 2.11)	0.10	1.99	97
Mood problems	4/348	0.05 (-0.34 – 0.44)	0.79	35.71	67
Conduct problems	3/467	0.32 (-0.14 – 0.77)	0.17	5.56	75
Family functioning	7/621	0.26 (0.05-0.51)	0.046*	6.85	50

Abbreviations: CI = confidence interval, *k* = number of studies, NNT = number needed to treat.
* Effect sizes that are statistically significant ($p < 0.05$).

Schizophrenia

At treatment completion, the pooled effect size of the impact of MFT conditions compared to control conditions on positive and/or negative symptoms was large, but not statistically significant (Hedges *g,* 0.96; 95% CI, -0.19-2.11; $p > 0.05$). The NNT was 1.99. The Egger's test of the intercept was not significant (intercept β, -2.57; 95% CI, -46.15–41.02; $p > 0.20$), suggesting there was no indication for publication bias. The trim and fill procedure did not result in other results concerning the effect of MFT. The heterogeneity in studies on schizophrenia and psychosis was very high ($I^2 = 97$). One study McFarlane et al. (2015) was identified as an outlier. Removal of this study did not result in a statistically significant effect size (Hedges *g*, 0.39; 95% CI, -0.13-0.90, $p > 0.05$).

Mood Problems

The pooled effect size of the impact of MFT conditions compared to control conditions on mood problems was small and not statistically significant (Hedges *g,* 0.05, 95%; CI, -0.34–0.44, $p > 0.05$), corresponding with a large NNT of 35.71. The Egger's test did not indicate a risk of publication bias (intercept β, -3.84; 95% CI, -19.39–11.71; $p > 0.20$). The trim and fill procedure resulted in the same effect size. The heterogeneity in studies on mood problems was high ($I^2 = 67$). No study was considered an outlier.

Conduct Problems

A small and not statistically significant effect size was found for the impact of MFT conditions compared to control conditions on conduct problems (Hedges *g,* 0.32, 95%; CI, -0.14–0.77, $p > 0.05$), resulting in a NNT of 5.56. No risk of publication bias was indicated by the Egger's

test (intercept β, 1.26; 95% CI, -55.10-57.61; $p > 0.20$). The trim and fill procedure yielded a lower adjusted effect size (Hedges g, 0.13; 95% CI, -0.35–0.61; $p > 0.05$). There was a high amount of heterogeneity in studies ($I^2 = 75$). No outliers were found.

Family Functioning

Finally, the pooled effect size of the impact of MFT on family functioning was small and statistically significant (Hedges g, 0.26; 95% CI, 0.05–0.51; $p < 0.05$). The Egger's test was not significant (intercept β, 0.95; 95% CI, -4.29-6.19; $p > 0.20$) The trim and fill procedure resulted in a small effect size as well (Hedges g, 0.12; 95% CI, -0.17–0.41; $p < 0.05$). The heterogeneity of the included studies was heightened ($I^2 = 50$). There were no outliers.

DISCUSSION

To our knowledge, this is the first systematic review and meta-analysis to date examining the effect of MFT on mental health problems and family functioning. The systematic review confirmed that MFT is offered within a wide setting, with studies presenting a variety of therapeutic modalities, focal problems, populations, and durations. In line with the review by Gelin et al. (2018), we found most evidence that MFT can result in improvements in symptoms of schizophrenia. Subsequently, empirical studies focused most on mood and conduct problems. MFT programs described in the studies were most often based on models developed by McFarlane, Lukens, et al. (1995) and McDonald (2002). Individual studies reported some positive findings, including improvements in mental health, vocational outcomes, medication usage and treatment adherence, and social functioning.

In summary, the meta-analysis suggests that MFT is associated with improvements in symptoms of schizophrenia. However, this effect was found not to be significant due to the large amount of heterogeneity (i.e. variability) of the results of the included studies. The high levels of heterogeneity in the included studies limits the drawing of conclusions on the effect of MFT. Therefore, the reported effect estimates should be interpreted with caution. Moreover, MFT was associated with small improvements in family functioning. We found little evidence to suggest that MFT successfully alleviates mood and conduct problems. These findings are in line with a recent review on the MFT program FAST, suggesting that FAST is associated with a very small impact on school performance, internalizing behavior or family relationships (Valentine et al., 2019).

Strengths and Limitations

The current study has several strengths. As proposed by Jewell and Lemmens (2018) we included systemic search strategies and provided a rigorous quality assessment of the included articles. Independent assessors screened the titles, abstracts, and full-texts, and performed the data-extraction for the systematic review and meta-analysis. Several

limitations of the current study should be considered as well. A first limitation is that the study focused only on the impact of MFT on mental health symptoms and family functioning. As suggested by the systematic review presented in this article, MFT might have an impact on other important outcomes, such as social functioning and vocational outcomes. A second limitation is the relatively small number of studies included in the meta-analysis. The lack of significant findings might be due to the limited number of English, peer-reviewed, controlled studies evaluating MFT. In addition, we only selected studies based on the definition of MFT suggested by, to distinguish MFT from other therapeutic modalities and techniques, such as group therapy or single family therapy. A larger number of included studies would increase the power of the analyses. Finally, the current meta-analysis focused only assessment obtained immediately post-treatment. It would be interesting to establish the longer term outcomes of MFT as results might strengthen or decrease over time.

Recommendations

Because there is limited evidence for the positive impact of MFT, clinicians implementing MFT should take caution, monitoring the effects of MFT (Valentine et al., 2019). More rigorous evaluations of MFT are warranted. Future studies should provide a clear explanation of the therapeutic modalities and techniques they used. In addition, a description is needed of how the program was adapted to suit the needs of the specific target group the study focuses on. Moreover, it is important to handle a structured manual and training of facilitators as this can improve the implementation and replication of the program. Finally, future studies should take into account potential sources of risk of bias and methodological limitations including missing data, selection bias and problems with randomization.

Similar issues to those listed by O'Shea and Phelps (1985) almost four decades ago continue to exist. MFT is still covering a wide range of therapeutic modalities and therapeutic aims. In addition, the potential added value of MFT to existing evidence-based treatments is not well defined. Clinicians and researchers have suggested that MFT touches upon factors that other therapies cannot reach (Jewell & Lemmens, 2018; Schmidt & Asen, 2005), suggesting that the added value of MFT might be social support (McFarlane, 2016) or the interaction between participants from different families, including mutual feedback and support (Hellemans et al., 2011; Jewell & Lemmens, 2018; Lemmens, Eisler, Dierick, et al., 2009). However, it is still unknown whether factors such as psychoeducation, social support, the multifamily format, or a combination of such factors, contribute to the potential effectiveness of MFT. Firstly, more rigorous studies on the effectiveness of MFT are needed. Future studies must also pay attention to defining outcome measures that capture the potential specific impact of MFT. If the effectiveness of MFT is shown in future studies, research should focus on identifying the specific added value of MFT, including potential working mechanisms.

Finally, as more studies become available, future meta-analyses can take into account potential mediators for the effect of MFT on mental health, such as family functioning

and social support. In addition, future meta-analyses might shed light on the causes of heterogeneity in the results of the studies on MFT.

Conclusion

The results of this meta-analysis suggest that MFT might have beneficial effects for families dealing with schizophrenia. Additionally, overall small improvements in family functioning were found. There was no indication of the impact of MFT on mood problems or conduct problems, although studies on MFT in these focal areas were scarce. More methodologically rigorous research focusing on the potential benefits of MFT as well as the working mechanisms and core components of MFT is warranted.

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REFERENCES

Asen, E. (2002). Multiple family therapy: An overview. *Journal of Family Therapy*, *24*(1), 3-16.

Asen, E., & Scholz, M. (2010). *Multi-family therapy: Concepts and techniques*. Routledge.

Borenstein, M., Higgins, J. P., Hedges, L. V., & Rothstein, H. R. (2017). Basics of meta-analysis: I2 is not an absolute measure of heterogeneity. *Research Synthesis Methods*, *8*(1), 5-18.

Bradley, G. M., Couchman D Psych, G. M., Perlesz, A., Nguyen, A. T., Singh, B., & Riess, C. (2006). Multiple-family group treatment for English- and Vietnamese-speaking families living with schizophrenia*. *Psychiatric Services*, *57*(4), 521-530.

Chacko, A., Gopalan, G., Franco, L., Dean-Assael, K., Jackson, J., Marcus, S., Hoagwood, K., & McKay, M. (2015). Multiple family group service model for children with disruptive behavior disorders: Child outcomes at post-treatment*. *Journal of Emotional and Behavioral Disorders*, *23*(2), 67-77.

Chien, W. T., Bressington, D., & Chan, S. W. (2018). A randomized controlled trial on mutual support group intervention for families of people with recent-onset psychosis: A four-year follow-up*. *Frontiers in Psychiatry*, *9*, 710.

Chien, W. T., & Chan, S. W. (2004). One-year follow-up of a multiple-family-group intervention for Chinese families of patients with schizophrenia*. *Psychiatric Services*, *55*(11), 1276-1284.

Chiquelho, R., Neves, S., Mendes, A., Relvas, A., & Sousa, L. (2011). proFamilies: a psycho-educational multi-family group intervention for cancer patients and their families. *European Journal of Cancer cCare*, *20*(3), 337-344.

Cook-Darzens, S., Gelin, Z., & Hendrick, S. (2018). Evidence base for Multiple Family Therapy (MFT) in non-psychiatric conditions and problems: a review (part 2). *Journal of Family Therapy*, *40*(3), 326-343.

Cuijpers, P. (2016). *Meta-analyses in mental health research. A practical guide*. Amsterdam, the Netherlands: Pim Cuijpers Uitgeverij.

Duval, S., & Tweedie, R. (2000). Trim and fill: a simple funnel-plot–based method of testing and adjusting for publication bias in meta-analysis. *Biometrics*, *56*(2), 455-463.

Dyck, D. G., Short, R. A., Hendryx, M. S., Norell, D., Myers, M., Patterson, T., McDonell, M. G., Voss, W. D., & McFarlane, W. R. (2000). Management of negative symptoms among patients with schizophrenia attending multiple-family groups*. *Psychiatric Services*, *51*(4), 513-519.

Egger, M., Smith, G. D., Schneider, M., & Minder, C. (1997). Bias in meta-analysis detected by a simple, graphical test. *BMJ*, *315*(7109), 629-634.

Fristad, M. A., Goldberg-Arnold, J. S., & Gavazzi, S. M. (2003). Multi-family psychoeducation groups in the treatment of children with mood disorders*. *Journal of Marital and Family Therapy*, *29*(4), 491-504.

Fristad, M. A., Verducci, J. S., Walters, K., & Young, M. E. (2009). Impact of multifamily psychoeducational psychotherapy in treating children aged 8 to 12 years with mood disorders*. *Archives of General Psychiatry*, *66*(9), 1013-1021.

Gamoran, A., Turley, R. N. L., Turner, A., & Fish, R. (2012). Differences between Hispanic and non-Hispanic families in social capital and child development: First-year findings from an experimental study. *Research in Social Stratification and Mobility*, *30*(1), 97-112.

Garrido-Fernández, M., Marcos-Sierra, J. A., López-Jiménez, A., & Ochoa de Alda, I. (2017). Multi-family therapy with a reflecting team: A preliminary study on efficacy among opiate addicts in methadone maintenance treatment. *Journal of Marital and Fmily Therapy*, *43*(2), 338-351.

Gelin, Z., Cook-Darzens, S., Simon, Y., & Hendrick, S. (2016). Two models of multiple family therapy in the treatment of adolescent anorexia nervosa: a systematic review. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity*, *21*(1), 19-30.

Gelin, Z., Cook-Darzens, S., & Hendrick, S. (2018). The evidence base for Multiple Family Therapy in psychiatric disorders: a review (part 1). *Journal of Family Therapy*, *40*(3), 302-325.

Hellemans, S., De Mol, J., Buysse, A., Eisler, I., Demyttenaere, K., & Lemmens, G. (2011). Therapeutic processes in multi-family groups for major depression: Results of an interpretative phenomenological study. *Journal of Affective Disorders*, *134*(1-3), 226-234.

Jeppesen, P., Petersen, L., Thorup, A., Abel, M.-B., Christensen, T. Ø., Krarup, G., Hemmingsen, R., & Nordentoft, M. (2005). Integrated treatment of first-episode psychosis: effect of treatment on family burden: OPUS trial*. *The British Journal of Psychiatry*, *187*(S48), s85-s90.

Jewell, T., & Lemmens, G. (2018). Multiple Family Therapy: forever promising? Commentary on Gelin et al.(2018) and Cook-Darzens et al.(2018), The evidence base for Multiple Family Therapy in psychiatric and non-psychiatric conditions: a review (parts 1 and 2). *Journal of Family Therapy*,

40(3), 344-348.

Kraemer, H. C., & Kupfer, D. J. (2006). Size of treatment effects and their importance to clinical research and practice. *Biological Psychiatry*, *59*(11), 990-996.

Kratochwill, T. R., McDonald, L., Levin, J. R., Bear-Tibbetts, H. Y., & Demaray, M. K. (2004). Families and schools together: An experimental analysis of a parent-mediated multi-family group program for American Indian children. *Journal of School Psychology*, *42*(5), 359-383.

Kratochwill, T. R., McDonald, L., Levin, J. R., Scalia, P. A., & Coover, G. (2009). Families and schools together: An experimental study of multi-family support groups for children at risk*. *Journal of School Psychology*, *47*(4), 245-265.

Laqueur, H. P., LaBurt, H., & Morong, E. (1964). Multiple Family Therapy. *Current Psychiatric Therapies*, *4*, 150-154.

Lemmens, G. M., Eisler, I., Buysse, A., Heene, E., & Demyttenaere, K. (2009). The effects on mood of adjunctive single-family and multi-family group therapy in the treatment of hospitalized patients with major depression*. *Psychotherapy and Psychosomatics*, *78*(2), 98-105.

Lemmens, G. M., Eisler, I., Dierick, P., Lietaer, G., & Demyttenaere, K. (2009). Therapeutic factors in a systemic multi-family group treatment for major depression: patients' and partners' perspectives. *Journal of Family Therapy*, *31*(3), 250-269.

Liberman, R. P., Falloon, I. R., & Aitchison, R. A. (1984). Multiple family therapy for schizophrenia: A behavioral, problem-solving approach*. *Psychosocial Rehabilitation Journal*, *7*(4), 60.

Liu, Q.-X., Fang, X.-Y., Yan, N., Zhou, Z.-K., Yuan, X.-J., Lan, J., & Liu, C.-Y. (2015). Multi-family group therapy for adolescent Internet addiction: Exploring the underlying mechanisms. *Addictive Behaviors*, *42*, 1-8.

Ma, J. L., Lai, K. Y., & Xia, L. L. L. (2018). Treatment efficacy of multiple family therapy for Chinese families of children with attention deficit hyperactivity disorder. *Family Process*, *57*(2), 399-414.

Ma, J. L., Xia, L. L., Yau-Ng, M., & Yan-Yee, C. Y. (2021). Treatment efficacy of multiple family therapy in helping Hong Kong Chinese parents recover from depression*. *Journal of Family Therapy*.

McDonald, L. (2002). Evidence-based, family-strengthening strategies to reduce delinquency: FAST--Families and Schools Together. *Social Workers' Desk Reference*, 717-722.

McDonald, L., Coover, G., Sandler, J., Thao, T., & Shalhoub, H. (2012). Cultural adaptation of an evidence-based parenting programme with elders from South East Asia in the US: co-producing Families and Schools Together–FAST. *Journal of Children's Services*.

McDonald, L., Moberg, D. P., Brown, R., Rodriguez-Espiricueta, I., Flores, N. I., Burke, M. P., & Coover, G. (2006). After-school multifamily groups: A randomized controlled trial involving low-income, urban, Latino children. *Children & Schools*, *28*(1), 25-34.

McFarlane, W. R. (2016). Family interventions for schizophrenia and the psychoses: A review. *Family Process*, *55*(3), 460-482.

McFarlane, W. R., Hornby, H., Dixon, L., & McNary, S. (2002). Psychoeducational multifamily groups: Research and implementation in the United States. *Family Interventions in Mental Illness: International Perspectives*, 43-60.

McFarlane, W. R., Levin, B., Travis, L., Lucas, F. L., Lynch, S., Verdi, M., Williams, D., Adelsheim, S., Calkins, R., & Carter, C. S. (2015). Clinical and functional outcomes after 2 years in the early detection and intervention for the prevention of psychosis multisite effectiveness trial*. *Schizophrenia Bulletin*, *41*(1), 30-43.

McFarlane, W. R., Lukens, E., Link, B., Dushay, R., Deakins, S. A., Newmark, M., Dunne, E. J., Horen, B., & Toran, J. (1995). Multiple-family groups and psychoeducation in the treatment of schizophrenia. *Archives of General Psychiatry*, *52*(8), 679-687.

McKay, M. M., Gonzales, J., Quintana, E., Kim, L., & Abdul-Adil, J. (1999). Multiple family groups: An alternative for reducing disruptive behavioral difficulties of urban children*. *Research on Social Work Practice*, *9*(5), 593-607.

Morris, E., Le Huray, C., Skagerberg, E., Gomes, R., & Ninteman, A. (2014). Families changing families: The protective function of multi-family therapy for children in education. *Clinical Child Psychology and Psychiatry*, *19*(4), 617-632.

O'Shea, M. D., & Phelps, R. (1985). Multiple family therapy: Current status and critical appraisal. *Family Process*, *24*(4), 555-582.

Pérez-García, M., Sempere-Pérez, J., Rodado-Martínez, J. V., López, D. P., Llor-Esteban, B., & Jiménez-Barbero, J. A. (2020). Effectiveness of multifamily therapy for adolescent disruptive behavior in a public institution: A randomized clinical trial. *Children and Youth Services Review*, *117*, 105289.

Poole, L. A., Knight, T., Toumbourou, J. W., Lubman, D. I., Bertino, M. D., & Lewis, A. J. (2018). A randomized controlled trial of the impact of a family-based adolescent depression intervention on both youth and parent mental health outcomes*. *Journal of Abnormal Child Psychology*, *46*(1), 169-181.

Rosenblum, K. L., Muzik, M., Morelen, D. M., Alfafara, E. A., Miller, N. M., Waddell, R. M., Schuster, M. M., & Ribaudo, J. (2017). A community-

based randomized controlled trial of Mom Power parenting intervention for mothers with interpersonal trauma histories and their young children. *Archives of Women's Mental Health*, *20*(5), 673-686.

Rossberg, J. I., Johannessen, J. O., Klungsoyr, O., Opjordsmoen, S., Evensen, J., Fjell, A., Haahr, U., Joa, I., Langeveld, J., & Larsen, T. K. (2010). Are multi family groups appropriate for patients with first episode psychosis? A 5-year naturalistic follow-up study. *Acta Psychiatrica Scandinavica*, *122*(5), 384-394.

Satin, W., La Greca, A. M., Zigo, M. A., & Skyler, J. S. (1989). Diabetes in adolescence: effects of multifamily group intervention and parent simulation of diabetes. *Journal of Pediatric Psychology*, *14*(2), 259-275.

Schmitter-Edgecombe, M., & Dyck, D. G. (2014). Cognitive rehabilitation multi-family group intervention for individuals with mild cognitive impairment and their care-partners. *Journal of the International Neuropsychological Society*, *20*(9), 897-908.

Sterne, J. A., Hernán, M. A., Reeves, B. C., Savović, J., Berkman, N. D., Viswanathan, M., Henry, D., Altman, D. G., Ansari, M. T., & Boutron, I. (2016). ROBINS-I: a tool for assessing risk of bias in non-randomised studies of interventions. *BMJ*, *355*.

Sterne, J. A., Savović, J., Page, M. J., Elbers, R. G., Blencowe, N. S., Boutron, I., Cates, C. J., Cheng, H.-Y., Corbett, M. S., & Eldridge, S. M. (2019). RoB 2: a revised tool for assessing risk of bias in randomised trials. *BMJ*, *366*.

Stuart, B. K., & Schlosser, D. A. (2009). Multifamily group treatment for schizophrenia. *International Journal of Group Psychotherapy*, *59*(3), 435-440.

Valencia, M., Rascon, M. L., Juarez, F., Escamilla, R., Saracco, R., & Liberman, R. P. (2010). Application in Mexico of psychosocial rehabilitation with schizophrenia patients*. *Psychiatry: Interpersonal and Biological Processes*, *73*(3), 248-263.

Valentine, J. C., Leach, S. M., Fowler, A. P., Stojda, D. K., & Macdonald, G. (2019). Families and Schools Together (FAST) for improving outcomes for children and their families. *Cochrane Database of Systematic Reviews*(7).

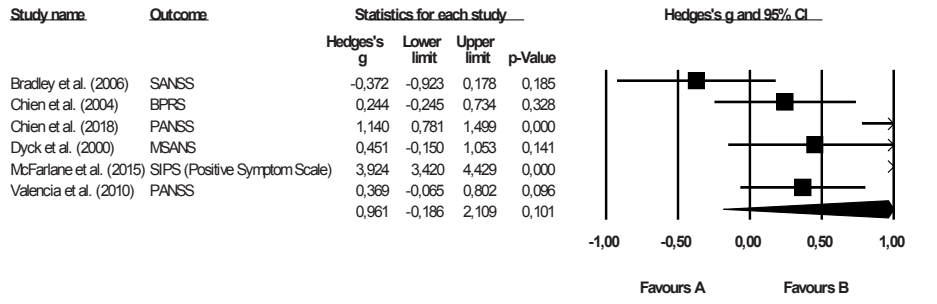
Wysocki, T., Harris, M. A., Buckloh, L. M., Mertlich, D., Lochrie, A. S., Taylor, A., Sadler, M., Mauras, N., & White, N. H. (2006). Effects of behavioral family systems therapy for diabetes on adolescents' family relationships, treatment adherence, and metabolic control. *Journal of Pediatric Psychology*, *31*(9), 928-938.

* Included in meta-analysis

SUPPLEMENTARY MATERIAL

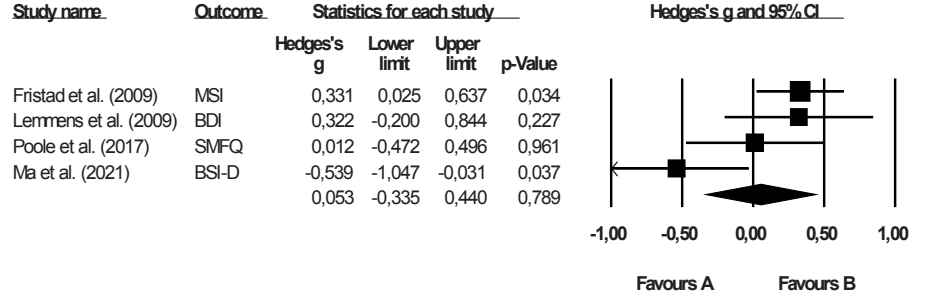
Figure A.

Standardized Effect Sizes of Comparisons Between MFT and Control Groups on Symptoms of Schizophrenia



Abbreviations: BPRS = Brief Psychiatric Rating Scale, MSANS = Modified Scale for the Assessment of Negative Symptoms, PANSS = Positive and Negative Syndrome Scale, SANSS = Scale for the Assessment of Negative Symptoms, SIPS = Structured Interview of Psychosis-risk Syndromes.

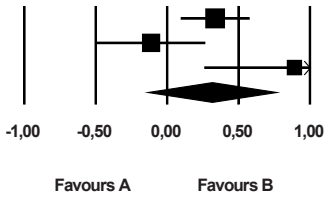
Standardized Effect Sizes of Comparisons Between MFT and Control Groups on Symptoms of Mood Problems



Abbreviations: BDI = Beck Depression Inventory, BSI-D = Brief Symptom Inventory, Depression Subscale, MSI = Mood Severity Index, SMFQ = Short Mood and Feelings Questionnaire.

Standardized Effect Sizes of Comparisons Between MFT and Control Groups on Symptoms of Disruptive Problems

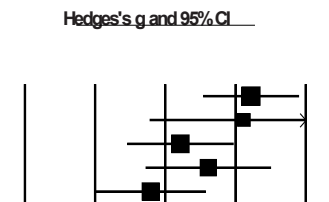
Study name	Outcome	Hedges's g	Lower limit	Upper limit	p-Value
Chacko et al. (2015)	IOWA CRS OD subscal	0,336	0,096	0,577	0,006
Kratochwill et al. (2009)	CBCL	-0,112	-0,490	0,266	0,561
McKay et al. (1999)	CPRS	0,892	0,261	1,523	0,006
		0,315	-0,136	0,765	0,171



Abbreviations: CBCL = Child Behavior Checklist, CPRS = Conner's Parent Rating Scales, IOWA CRS OD = Iowa Connors Rating Scale – Oppositional/Defiant Subscale.

Standardized Effect Sizes of Comparisons Between MFT and Control Groups on Family Functioning

Study name	Outcome	Hedges's g	Lower limit	Upper limit	p-Value
Chien et al. (2018)	FAD	0,611	0,270	0,952	0,000
Fristad et al. (2003)	EEAC	0,560	-0,110	1,231	0,102
Kratochwill et al. (2009)	FACES	0,108	-0,270	0,486	0,576
Valencia et al. (2010)	LEE	0,306	-0,139	0,752	0,178
Jeppensen et al. (2005)	FMSS	-0,104	-0,495	0,288	0,604
Ma et al. (2021)	GFFS	-0,085	-0,584	0,414	0,740
Liberman et al. (1984)	CFI	0,817	-0,142	1,776	0,095
		0,257	0,005	0,510	0,046



Abbreviations: CFI = Camberwell Family Interview, EEAC = Expressed Emotion Adjective Checklist, FACES = Family Adaptability and Cohesion Evaluation Scale, FAD = Family Assessment Device, FMSS = Five-Minute Speech Sample, GFFS = General Family Functioning Scale, LEE = Level of Expressed Emotion.

Table A. *Participant Characteristics*

Study	Country	Presenting problem	Type of family members	N	% male	Age	Ethnicity
Bradley et al. (2006)	Australia	Schizophrenia	Adults; their caregivers (parent, spouse, sibling)	MFT = 25 Control = 25	70	M = 33.8, SD = 8.27	English speaking (60%), Vietnamese speaking (40%)
Chacko et al. (2015)	USA	Conduct problems	Youth; adult caregivers; siblings	MFT = 225 Control = 95	68	M = 8.87, SD = 1.42	Hispanic/Latino (48.8%), Black (30.6%), white (8.4%), Native American (2.5%), other (6.9%)
Chien and Chan (2004)	Hong Kong	Schizophrenia	Adults; mainly parent, spouse, or child	MFT = 32 Control = 64	65	M = 31.7, SD = 7.2	Chinese
Chien et al. (2018)	Hong Kong	Schizophrenia	Adult; family caregiver (child, parent, spouse, other)	MFT = 70 Control = 140	53	M = 27.3, SD = 6.9	Chinese
Chiquelho et al. (2011)	Portugal	Cancer	Adults; spouses, children, extended family, and/or friends	MFT = 8 Control = 8	32	M = 57.2, SD = 7.3	Unknown
Dyck et al. (2000)	USA	Schizophrenia	Unknown	MFT = 21 Control = 21	73	M = 33, SD = 9	White (95%), other (5%)
Fristad et al. (2003)	USA	Mood problems	Children; parents	MFT = 18 Control = 17	77	M = 10.1, SD = 1.2	White (89%), other (11%: African-American, Hispanic/ Caucasian, Southeast Asian, Native American)
Fristad et al. (2009)	USA	Mood problems	Children; parents	MFT = 78 Control = 87	73	M = 9.9, SD = 1.3	White (90.9%), other (9.1%)
Gamoran et al. (2012)	USA	Lower social capital	Children; parents	Total N = approx. 1.300	Unknown	“First graders” (pp. 101)	Latino (77%), African American (11%), Asian American (1.5%), Native American (1.5%)
Garrido-Fernández et al. (2017)	Spain	Opiate addiction	Unknown	MFT = 41 Control = 41	87	M = 36.8, SD = 7.1	Unknown
Jeppesen et al. (2005)	Denmark	Schizophrenia	Adults; relative (parent, spouse, child, sibling, grandparent, or friend)	MFT = 185 Control = 140	58	M = 25.8, SD = 6.0	96% Danish citizenship
Kratochwill et al. (2004)	USA	American Indian target group	Children; parents	MFT = 50 Control = 50	43	“4 - 9 years” (pp. 359)	American Indian (100%)
Kratochwill et al. (2009)	USA	Conduct problems	Children; parents	MFT = 53 Control = 53	43	“Kindergarten through third-grade” (pp. 245)	European white (40%), African American (35%), Asian (13%), Latino (12%)

Table A. *Continued*

Study	Country	Presenting problem	Type of family members	N	% male	Age	Ethnicity
Lemmens et al. (2009)	Belgium	Mood problems	Adults; their partners and children	MFT = 35 Control = 48	28	M = 42.6, SD = 8.5	Unknown
Liberman et al. (1984)	USA	Schizophrenia	Young adult; immediate family/ closely allied relatives (e.g. parents and siblings)	MFT = 11 Control = 11	100	Mean age = 26 (pp. 63)	White (100%)
Liu et al. (2015)	China	Internet addiction	Adolescents; parents	MFT = 21 Control = 25	83	M = 15.4, SD = 1.5	Unknown
Ma et al. (2018)	China	ADHD	Child; parents; preferably all family members	MFT = 61 Control = 53	Unknown	"Mean age was 8.3" (pp. 402)	Chinese
Ma et al. (2021)	Hong Kong	Mood problems	Adults; spouses; children	MFT = 54 Control = 86	15	Most aged 41-50 (pp. 8)	Hong Kong (49.2%), mainland China (42.6%), unknown (8.2%)
McDonald et al. (2006)	USA	Latino families	Children; parents	MFT = 80 Control = 50	63	"Average age was seven" (pp. 27)	Latino (100%)
McDonald et al. (2012)	USA	Hmong refugee families	Children; parents	MFT = 5 Control = 5	57	"Average age was 8.6" (pp. 117)	Hmong
McFarlane et al. (2015)	USA	Schizophrenia	Youth; family members	MFT = 250 Control = 87	60	M = 16.6, SD = 3.3	White (62%), African-American (9%), Hispanic (15%), Asian-American (4%)
McKay et al. (1999)	USA	Conduct problems	Children; adult caregivers; siblings	MFT = 34 Control = 54	81	M = 9.8, SD = 2.4	African American (93%), Latino (7%)
Morris et al. (2014)	UK	Conduct problems	Children; parents or other significant family member	MFT = 50 Control = 28	83	M = 8.4, range = 4-15	White British/Irish (45%), Black (18%), Arabic (10%), Asian (6%), other (21%)
Pérez-García et al. (2020)	Spain	Conduct problems	Adolescents; families	MFT = 59 Control = 57	60	M = 13.5, SD = 1.3	Unknown
Poole et al. (2018)	Australia	Mood problems	Children; parents; siblings	MFT = 31 Control = 33	27	M = 15.2, SD = 1.4	Unknown
Rosenblum et al. (2017)	USA	Trauma	Mothers; young children	MFT = 68 Control = 54	0	M = 23.5, SD = 7.2	Minority (70%), white (30%)
Rossberg et al. (2010)	Scandinavia	Schizophrenia	Adults; family	MFT = 147 Control = 153	58	M = 27.8, SD = 8.6	Scandinavian (93%), other (7%)

Table A. *Continued*

Study	Country	Presenting problem	Type of family members	N	% male	Age	Ethnicity
Satin et al. (1989)	USA	Diabetes	Adolescents; parents	MFT = 23 Control = 9	38	M = 14.6, SD = 2.6	Unknown
Schmitter-Edgecombe and Dyck (2014)	USA	Cognitive impairment	Adult; care dyad (spouse, child, friend)	MFT = 23 Control = 23	41	M = 73.2, SD = 7.5	Unknown
Valencia et al. (2010)	Mexico	Schizophrenia	Adults; key relatives	MFT = 46 Control = 36	72	M = 29.7, SD = 7.3	Mexican (100%)
Wysocki et al. (2006)	USA	Diabetes	Adolescents; caregivers	MFT = 36 Control = 68	55	M = 14.2, SD = 1.9	White (63%), African-American (31%), Hispanic (3%), other (3%)

Abbreviations: ADHD = Attention Deficit Hyperactivity Disorder, MFT = multiple family therapy.

Table B. *Program Characteristics*

Study	Therapeutic models/techniques	Facilitator training	Manual*	Frequency and duration	Combined with
Bradley et al. (2006)	Multi-family group approach based on McFarlane, Link, et al. (1995) with cultural modifications.	Three day workshop by McFarlane and regular supervision.	Yes.	Three joining sessions (focused on getting to know each other and forming an alliance between the facilitator and participants), two half day multiple family psychoeducation sessions, 26 bi-weekly multiple family sessions over 12 months. Duration differed per session.	Case management services.
Chacko et al. (2015)	Multi-family group drawing from behavioral parenting training and family therapy. Focus on 4Rs (rules, responsibility, relationships, respectful communication) and 2Ss (stress and social support).	One or two day training conducted by research staff and weekly supervision.	Yes.	Sixteen weekly 90-120 minute sessions.	Participants were allowed to use additional services available to them through the outpatient mental health clinic.
Chien and Chan (2004)	Family psycho-education similar to McFarlane, Lukens, et al. (1995). Focus on survival skills, understanding of facts, and caregiver stress and coping skills.	Trained by research team and one family therapist via two three-day workshops. Supervision and progress monitoring.	Yes.	Twelve bi-weekly two-hour sessions.	Routine outpatient care.
Chien et al. (2018)	Family-led mutual support program. Focus on supportive sharing and information exchanges, problem-solving and caregiving skill practices.	Two peer family caregivers followed a three full-day psycho-eduction and supportive skills workshop.	Yes.	Sixteen bi-weekly two-hour sessions.	Routine psychiatric outpatient care (e.g. psychiatric consultations, treatments by psychiatrists, home visits).
Chiquelho et al. (2011)	proFamilies (developed by Chiquelho et al. (2011)): psycho-educational approach aimed at improving the adaptation of the family to the oncological illness.	Unknown.	Yes.	Six weekly sessions.	None.
Dyck et al. (2000)	(Psychoeducational) multi-family group treatment with focus on improving coping and illness management skills.	Family clinicians trained by clinical supervisors, systematic review of videotapes by supervisors, weekly supervision.	Yes.	Three weekly single family sessions, an educational workshop, biweekly meetings. Total duration 12 months.	Medication.
Fristad et al. (2003)	Multi-family psychoeducational groups for children with mood disorders.	Unknown.	Yes.	Six weekly sessions.	Treatment as usual (on-going medication management and individual/family psychotherapy a child receives).

Table B. *Continued*

Study	Therapeutic models/techniques	Facilitator training	Manual*	Frequency and duration	Combined with
Fristad et al. (2009)	Multifamily psychoeducational psychotherapy: psychoeducation, family systems, and cognitive behavioral psychotherapy techniques.	Training and weekly group supervision by principal investigator.	Yes.	Eight weekly 90-minute sessions.	Encouraged to continue treatment as usual (i.e. psychosocial, psychopharmalogical, and educational interventions).
Gamoran et al. (2012)	FAST: program designed to increase social capital among parents, teachers, and young children (McDonald, 2002).	Certified FAST trainers trained teams using FAST manuals, site visits, program integrity checklist and debriefing.	Yes.	Eight weekly two-hour sessions.	None.
Garrido-Fernández et al. (2017)	Multi-family therapy for addiction and reflecting team	Unknown.	Unknown.	Ten two-hour sessions every two weeks.	Methadone treatment and individual counseling.
Jeppesen et al. (2005)	Integrated treatment: assertive community treatment, psychoeducational multi-family groups (McFarlane, Lukens, et al., 1995), and social skills training.	Unknown.	Yes.	Three individual family meetings, a survival skill workshop, 18 months bi-weekly 90-minute sessions of MFT.	Medication.
Kratochwill et al. (2004)	FAST with American Indian cultural adaptations.	Training and observation by certified FAST trainers, and supervision.	Yes.	Eight weekly sessions and parent-run monthly meetings for two years.	None/unknown.
Kratochwill et al. (2009)	FAST - a family-centered, multi-family support group program (McDonald, 2002) with American Indian Cultural adaptations.	Six days of training and technical advice on program services provided by certified FAST trainers directly supervised by the FAST program founder.	Yes.	Eight weekly 2.5 hour sessions.	None/unknown.
Lemmens et al. (2009)	Multifamily group therapy, based on systemic couple therapy for depression (Asen & Jones, 2018)	Unknown.	Yes.	Six bi-weekly 90-minute sessions and follow-up after three months.	Treatment as usual (i.e. non-verbal therapy, CBT, systemic therapy, pharmacological treatment and activation).
Liberman et al. (1984)	Behavioral educational workshop in a multiple family group with focus on psychoeducation, communication skills, and family problem-solving (Falloon & Liberman, 1983).	Unknown.	Unknown.	Nine weekly two-hour sessions.	Inpatient-based, intensive social skills training program.

Table B. *Continued*

Study	Therapeutic models/techniques	Facilitator training	Manual*	Frequency and duration	Combined with
Liu et al. (2015)	Multi-family group therapy for adolescent internet addition. Focus on strengthening parent-adolescent communication and relationship.	Unknown.	Yes.	Six two-hour sessions every three days.	None/unknown.
Ma et al. (2018)	Multiple family therapy for children with ADHD (Ma et al., 2016) with a cultural component (mindfulness).	Unknown.	Unknown.	Three months program consisting of four full days, two psychoeducational days, two half day reunion	Psycho-education talks, potentially medication.
Ma et al. (2021)	Strengths-based MFT, modified from (Ma et al., 2018) for parental depression.	Training during a two day workshop and supervision.	Unknown.	Three-months program (total 42 hours) consisting of a psychoeducational talk, four day group activities, two half day reunions.	None/unknown.
McDonald et al. (2006)	After-school FAST with focus on increasing parent involvement in schools and improving children's wellbeing.	Unknown.	Yes.	Eight weekly team-led sessions and monthly parent graduate-led meetings for two years.	None.
McDonald et al. (2012)	FAST (McDonald et al., 1997) with cultural adaptations.	A team of four Hmong me participated in a two day training with a standard FAST agenda, manuals, activity simulations and discussions.	Yes.	Eight weekly 2.5 hour sessions.	None/unknown.
McFarlane et al. (2015)	FACT: a package of interventions consisting of psychoeducational multifamily group therapy, elements of assertive community treatment, supported education and employment and psychotropic medication.	Facilitators received training and supervision and fidelity was checked.	Unknown.	Unknown.	Possibly medication.
McKay et al. (1999)	Multi-family group intervention focusing of the four Rs of family live: rules, responsibility, relationships, respectful communication.	Unknown.	Unknown.	Sixteen weekly sessions.	None.
Morris et al. (2014)	Classroom based multifamily group approach by the Marlborough Family Education Centre.	Unknown.	Unknown.	Mean duration: 23.4 weeks. Four times a week at MFEC, or weekly two-three hour sessions at schools.	Access to local generic services.

Table B. *Continued*

Study	Therapeutic models/techniques	Facilitator training	Manual*	Frequency and duration	Combined with
Pérez-García et al. (2020)	Multifamily therapy – "the therapeutic approach was inclusive so that various interventions would complement each other".	Unknown.	Unknown.	Sessions for 12 months, bi-weekly frequency, duration depended on symptoms and commitment.	Potentially in combination with pharmacological treatment.
Poole et al. (2018)	BEST MOOD - a family systems therapy focused on parent-child communication, stress reduction, psychoeducation, and elements of attachment theory.	Facilitators were trained during a workshop, received supervision, and fidelity was monitored.	Yes.	Eight two-hour sessions.	None.
Rosenblum et al. (2017)	Mom Power: A parenting intervention based on attachment based parenting, self-care, social support, and connection to resources.	Facilitators received a three-day training.	Yes.	Thirteen three-hour sessions (three individual sessions, 10 group sessions)	None.
Rossberg et al. (2010)	Psychoeducational multifamily group treatment (McFarlane, Lukens, et al., 1995)	Facilitators received regular supervision and fidelity forms were completed.	Yes.	Bi-weekly meetings during two years.	Standard treatment protocol, including medication.
Satin et al. (1989)	Multifamily group focused on diabetes management, using principles of group therapy.	Unknown.	Unknown.	Six weekly 90-minute sessions.	Medical care.
Schmitter-Edgecombe and Dyck (2014)	Cognitive Rehabilitation multi family groups (McFarlane, 2004) modified for individuals with mild cognitive impairment.	Facilitators read the manual and participated in a two-hour training session. Treatment administration was closely supervised and included videotape review.	Yes.	Individual joining sessions; educational workshop (half day); 20 two-hour MFT sessions twice a week; booster phase: nine monthly two-hour sessions.	Unknown.
Valencia et al. (2010)	Family psychoeducation and psychosocial skills training focused on skills training, symptom management, medication management, social relations, and family relations.	Facilitators participated in treatment team weekly meetings.	Yes.	Forty weekly 90-minute sessions.	Customary pharmacological outpatient treatment.
Wysocki et al. (2006)	Educational support multifamily meetings for diabetes education and social support.	Extensive training and weekly contact between facilitators to ensure cross-site consistency.	Yes.	Twelve 90-minute sessions within six months.	Diabetes care reflecting prevailing clinical practices at each site.

Abbreviations: ADHD = Attention Deficit Hyperactivity Disorder; BEST MOOD = Behavior Exchange Systems Therapy for adolescent depression; CBT = cognitive behavioral therapy; FACT = Family aided assertive community treatment; FAST = Families and Schools Together; MFT = multiple family therapy.
* Indicates whether or not a manual was used.

Table C. *Study Characteristics*

Study	Study design	Control condition	Main findings concerning impact of MFT
Bradley et al. (2006)	RCT.	Case management for 30-60 minutes every two/three weeks on average, sometimes combined with medication.	MFT was associated with lower relapse rates, psychiatric symptoms, and vocational outcomes.
Chacko et al. (2015)	Quasi-experimental.	Clinic-based mental health services as usual (case management, individual therapy, family therapy, group therapy, and/or medication management).	MFT was associated with improved youth oppositional behavior and social competence. Impairment improved over time for both conditions with no difference between treatment conditions.
Chien and Chan (2004)	RCT.	Standard care: routine psychiatric outpatient and family services, consisting of monthly medical consultation and advice, individual nursing advice on community health services, social welfare and financial services provided by medical social workers, and counseling if necessary.	MFT was associated with greater improvements in patients' functioning and rehospitalization and stable use of mental health services.
Chien et al. (2018)	RCT.	1) Psycho-education group. 2) Routine psychiatric outpatient care (e.g. psychiatric consultations, treatments by psychiatrists, home visits).	MFT was associated with greater improvements in family and patient functioning, and reductions in duration of hospitalizations over the follow-up period. There were no increases of medication dosages or service use by participants in the MFT or control condition.
Chiquelho et al. (2011)	Focus groups and quasi-experimental.	No treatment.	It was suggested that MFT responds to the patients' and their families' needs and that participation prevents an increase in the patient's level of psycho-social maladjustment, promotes an adequate level of family cohesion and diminishes the perceived stress of patients and family members.
Dyck et al. (2000)	RCT.	Usual services - treatment team offering medication management, case management, and for some therapeutic and rehabilitative services for 12 months.	MFT was associated with reduced negative symptoms.
Fristad et al. (2003)	RCT.	Waitlist for six months.	MFT was associated with increased parental knowledge about childhood mood symptoms, increased positive family interactions, increased perceptions of parental support, and increased utilization of appropriate services. Expected impact on decreasing negative family interactions was not found.
Fristad et al. (2009)	RCT.	Waitlist, access to treatment as usual (i.e. psychosocial, pharmacological, and educational interventions).	MFT was associated with lower mood severity scores.
Gamoran et al. (2012)	School-randomized trial.	No treatment.	MFT was associated with more extensive social networks and better behavioral outcomes; these differences are more apparent in one city than the other.

Table C. *Continued*

Study	Study design	Control condition	Main findings concerning impact of MFT
Garrido-Fernández et al. (2017)	RCT.	Standard treatment, methadone treatment and individual counseling (usual treatment procedures of the center).	MFT was associated with a reduction of addiction severity, and improvements on employment and support, drug use, and psychiatric condition. Participants in the MFT- and control-condition showed a significant increase in their alcohol use.
Jeppesen et al. (2005)	RCT.	Usual array of mental health services, sometimes medication and/or meeting with psychiatrist or workshop.	MFT was associated with a decrease in burden experienced by relatives. There were no significant effects of intervention groups on knowledge of illness and expressed emotion.
Kratochwill et al. (2004)	RCT.	No treatment.	MFT was associated with reductions in aggressive and withdrawn behavior, and improvements in academic competence.
Kratochwill et al. (2009)	RCT.	Services as usual (ongoing school services).	MFT was associated with a smaller decline in family adaptability and reductions in externalizing behaviors.
Lemmens et al. (2009)	RCT.	1) Treatment as usual (i.e. non-verbal therapy, CBT), systemic therapy, pharmacological treatment and activation). 2) Treatment as usual combined with single-family therapy based on systemic couple therapy for depression.	MFT and single family therapy were associated with higher rates of treatment responders and patients no longer using antidepressant medication. MFT and psycho-education conditions were associated with improvements in emotional health.
Liberman et al. (1984)	Quasi-experimental.	Standard treatment: customary state hospital treatment and follow-up care in local community mental health centers for approx. five weeks	MFT was associated with increased knowledge of schizophrenia and reductions in family conflict, and a reduction of relatives' expressed emotion levels and patient relapse.
Liu et al. (2015)	Quasi-experimental.	Waiting list.	MFT was associated with a decline in internet addiction. This was associated with satisfaction of the participants' psychological needs and improved parent-adolescent communication and closeness.
Ma et al. (2018)	Quasi-experimental.	Two half-day psychoeducational talks, sometimes medication.	MFT was associated with parents perceiving their children's symptoms as being less serious and pathological, and with improved parent-child relationships, parenting stress, parental efficacy, hope, and perceived social support.
Ma et al. (2021)	Quasi-experimental.	Two workshops on relaxation at a three-month interval, schedule similar to MFT.	No significant difference was found between the MFT and control condition regarding parental and family functioning. MFT was associated with a reduction in psychological distress.
McDonald et al. (2006)	RCT.	Eight weekly mailings of behaviorally oriented parenting skills booklets and a follow-up phone call.	MFT was associated with improved academic performance and classroom behaviors, including aggression and social skills.

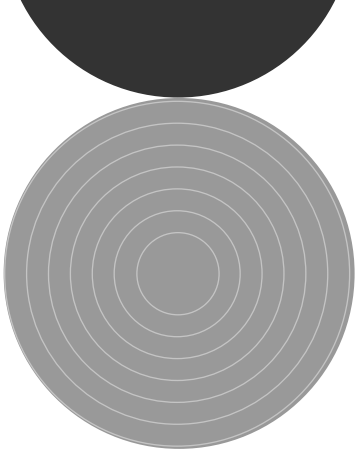
Table C. *Continued*

Study	Study design	Control condition	Main findings concerning impact of MFT
McDonald et al. (2012)	RCT.	Waiting list.	MFT was associated with improvements in child anxiety, child social skills, and family adaptability. No changes were found in externalizing behavior or family cohesion.
McFarlane et al. (2015)	Risk-based allocation study.	Community care. Monthly monitoring through phone assessment. Sometimes medication.	MFT was associated with improvements in positive, negative, disorganized and general symptoms, global assessment of functioning, and work and school participation.
McKay et al. (1999)	Quasi-experimental.	Individual or family therapy within outpatient child mental health center.	MFT was associated with decreases in disruptive behavior, conduct problems, learning difficulties, hyperactivity, and impulsivity.
Morris et al. (2014)	Prospective cohort study.	Access to a range of different school-based interventions, including mentors, parent groups, and children's groups. Access to local generic services.	MFT was associated with improvements in children's social, emotional and behavioral functioning. Family functioning remained relatively stable.
Pérez-García et al. (2020)	RCT.	Standard therapy: individual therapy/CBT approach, clinical psychologist usually monthly, depended on symptoms. With or without pharmacological treatment; psychiatry specialist every two or three months	No significant difference was found between MFT and the control condition. The analysis of main factors suggests that MFT is associated with greater improvements in internalizing behavior, and standard treatment was associated with greater improvements in externalizing behavior, particularly in verbal aggression and depression.
Poole et al. (2018)	RCT.	Eight two-hour sessions of treatment as usual (PAST: manualized treatment including supportive counseling, general psychoeducation and support group options).	MFT was associated with reductions in parental stress and depressive symptoms. Youth in both conditions showed similar levels of improvement in depressive symptoms.
Rosenblum et al. (2017)	RCT.	Weekly mailings of parenting information.	MFT was associated with improvements in mental health and parenting stress.
Rossberg et al. (2010)	Naturalistic follow-up study.	Standard treatment protocol; those who refused to participate and those who were not asked. Sometimes medication.	MFT was associated with lower drop-out rates. MFT was associated with less improvement in positive and excitative symptoms and longer duration of psychotic symptoms.
Satin et al. (1989)	RCT.	No specific intervention, medical care.	MFT was associated with more positive perceptions of being? a "teenager with diabetes" and improved diabetes care. Adolescents participating in smaller family groups demonstrated improvements in blood sugar levels.
Schmitter-Edgecombe and Dyck (2014)	RCT.	Standard care: routine physician visits, monitoring of disease progression, maintenance of active lifestyle, sometimes medication.	MFT was associated with improvements on everyday functioning and memory for the mild cognitive impairment participants, and coping behaviors of the care-partners. No differences were found for psychological functioning.
Valencia et al. (2010)	RCT.	Monthly 20-minute customary pharmacological outpatient treatment.	MFT was associated with improvements of adherence to medication, attendance at appointments, symptoms, social functioning, relapse, and re-hospitalization.

Table C. *Continued*

Study	Study design	Control condition	Main findings concerning impact of MFT
Wysocki et al. (2006)	RCT.	1) Diabetes care reflecting prevailing clinical practices at each site. Quarterly visits with pediatric endocrinologist or qualified clinician and certified diabetes education. 2) Behavioral family systems therapy for diabetes.	MFT was associated with improvements in blood sugar levels.

Abbreviations: CBT = cognitive behavioral therapy; MFT = multiple family therapy; PAST = Parenting Adolescents Support Training; RCT = randomized controlled trial.



3

Family Empowerment (FAME): Study protocol for a pilot implementation and evaluation of a preventive multi-family programme for asylum-seeker families

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ABSTRACT

Background

Families applying for asylum have often experienced multiple potentially traumatic events and continue to face stressors during their resettlement. Studies have indicated that traumatic events can negatively impact parenting behaviour and child development. A secondary preventive multi-family intervention programme, called Family Empowerment, was developed. Family Empowerment aims to strengthen parenting skills and prevent exacerbation of emotional problems in asylum-seeker families. This study protocol aims to evaluate the feasibility, acceptability, and potential effectiveness of Family Empowerment to reduce parental mental health problems and improve family functioning.

Methods

An uncontrolled pre-test-post-test design will be conducted, using a mixed-methods approach. Approximately 60 families living at asylum centres and family locations with children aged 0–18 will be included. All participants will be invited to take part in seven sessions of Family Empowerment. Measurements take place at baseline, during implementation of Family Empowerment and 1week post-Family Empowerment. Demographic data, the quality of the parent-child interaction, family functioning, parental symptoms of depression and anxiety, and participants' feedback on progress and the therapeutic alliance will be assessed. A programme integrity list will be filled out during each session. Semi-structured interviews at baseline and post-Family Empowerment will be used to evaluate Family Empowerment.

Discussion

This is the first study to provide a pilot implementation and evaluation of Family Empowerment. The current study will inform us on how to improve programme elements and the implementation of Family Empowerment. Limitations are discussed.

Trial registration

Dutch Trial Register, TC = NTR6934. Registered on January 8, 2018.

Keywords

Asylum-seekers, Families, Multi-family Therapy, Family Empowerment

BACKGROUND

In 2017, approximately half of all refugees worldwide were minors below 18 years of age. Most of these minors arrived in the country of resettlement with at least one parent or caregiver. These refugee families have been forced to flee their homes as a result of persecution, violence, or conflict (UNHCR, 2018). Many of them have been exposed to multiple potentially traumatic events prior to and during their flight, such as the loss of loved ones, war-related events, and physical violence. Furthermore, studies indicate that the continuous stressors refugees are exposed to during resettlement, including social and economic insecurities and long and complex asylum procedures, affect their psychological functioning (Fazel et al., 2012; Li et al., 2016). Table 1 describes the placement procedure of refugees applying for asylum in the Netherlands.

Table 1. *Placement of Refugee Families in the Netherlands*

Refugees applying for asylum in the Netherlands first report to an 'application centre' where they receive shelter, medical care, and guidance. During the first phase of the asylum procedure, they are accommodated in a 'process reception centre'. Asylum-seeker families are then placed in an asylum centre that provides them with basic needs, such as food and a roof over their heads, until their asylum application is granted or rejected. Children under the age of 18 have the right to shelter when their asylum application has been rejected. If the application is rejected and the family does not leave the Netherlands within 28 days, families are placed in a 'family facility', where they are prepared for deportation. In these centres, families have access to a limited level of facilities (COA, 2019). When the children turn 18, their right to shelter ends. As a result of the circumstances in family facilities, including limited financial resources, freedom-restricting measures, and insecurity concerning deportation, an increased level of distress can be expected here (COA, 2018; Mooren & Bala, 2016).

The accumulation of disruptive events and circumstances before and during the flight and the stressors inextricably linked with migration and resettlement can affect the psychological functioning of asylum-seeker families (Fazel et al., 2012; Weine et al., 2014). Although studies indicate that most refugees do not develop mental health disorders, a substantial minority develops adverse emotional reactions and stress-related complaints, such as difficulty concentrating, sleeping problems, and irritability (Fazel & Betancourt, 2018; Fazel et al., 2005). Such complaints can impact the daily lives of refugee children, including their educational achievements, social functioning, and family interactions (Almqvist & Broberg, 2003; Fazel & Betancourt, 2018).

Asylum-seeker children cannot be seen in isolation from the context and environment in which they grow up. Their parents often have to deal with their own distressing experiences, losses, and continuous stressors. As a result, they are at risk of developing stress-related complaints, which can undermine their parenting skills. For example, they can be less emotionally available, less structuring, and less supporting towards their children (Van Ee et al., 2014). Additionally, exposure to traumatic situations can disrupt the parents' and child's capacity to mentalize, which refers to the ability to reflect upon and understand the state of mind of yourself and the other (Allen et al., 2008; Fonagy & Bateman, 2006). A reduced

capacity to mentalize may negatively affect the development of healthy attachment relationships between parents and their children and consequently affect the overall development of the child (Allen et al., 2008). However, clinical experience suggests that the detrimental impact of stress-related complaints on parenting skills can be counteracted by focusing on social and psychological support to help families adapt after distressing events (Fazel & Betancourt, 2018; Mooren & Bala, 2016). A recent review showed that studies focusing on preventive programmes addressing asylum-seeker families have been scarce so far (Fazel & Betancourt, 2018).

Multi-family therapy (MFT) has been developed by Laqueur et al. (1964) in order to improve family functioning and strengthen social support. MFT has since been adapted to meet the needs of various groups, including patients who suffer from symptoms of anorexia, schizophrenia, depression, and conduct disorder (Gelin et al., 2018; Lemmens et al., 2009). MFT is a psychosocial intervention for a group of at least two families including at least two family members from different generations (O'Shea & Phelps, 1985). Since its development, MFT has been conducted with a variety of theoretical models, illnesses, disorders, and populations (Asen, 2002). The frequency, duration, and number of sessions differ across settings and populations. Activities are adapted for each specific setting and population. MFT focuses on issues or concerns that families have in common and that are directly or indirectly related to family interactions. Sessions focus on strengthening interfamilial relations. For over 10 years, MFT has been provided to refugee families at the Foundation Centrum '45, a Dutch centre for specialist diagnostics and treatment of people with complex psychotrauma complaints.

At the Foundation Centrum '45, MFT has, so far, mainly been offered to families with severe mental health problems and impaired family functioning. The main principles underlying MFT can also be applied in a preventive programme. Accordingly, therapists and researchers at the Foundation Centrum '45 developed a secondary preventive programme for asylum-seeker families based on MFT: Family Empowerment (FAME). FAME addresses families who live under stressful circumstances in asylum centres and family facilities and who may experience the impact of stress-related complaints on parenting, individual mental health, and family functioning. The programme addresses families with diverse cultural backgrounds. As described in more detail below, during FAME, a varying number of five to eight families gather in one room in weekly sessions of approximately 2–3 h for seven consecutive weeks. The aim is to reinforce parenting skills and social support, to improve family functioning and to prevent further development of emotional problems. FAME focuses on activating the families' own resources and knowledge and allows families to exchange their perspectives, feedback, support, and knowledge. Skills can be developed and practised in a safe environment. Mentalization plays an important role in FAME, as the programme aims to stimulate reflection on one's own and others' thought processes and emotions (Mooren & Bala, 2016).

Although FAME has previously been offered at a family facility, the effects of the

programme have not yet been evaluated systematically (Mooren & Bala, 2016). Weine (2011) proposed a cycle for developing and evaluating preventive programmes for refugee families based on empirical evidence. This cycle encompasses five steps, namely step 0, foundational activities; step 1, template preparation; step 2, situation-specific adaptation; step 3, intervention trial; and step 4, new situations. The development of the FAME manual is in line with both the foundational activities (step 0) and the template preparation (step 1) (Mooren & Bala, 2016). The manual describes programme elements that have been developed based on empirical evidence and clinical experience with refugees and MFT (Mooren & Bala, 2016). Step 2, situation-specific adaption, was conducted as the programme elements were adapted to fit the needs of asylum-seeker families living in asylum centres and family facilities. The resulting FAME programme adheres to the principles and approaches as described in the manual and incorporates situation-specific adaptations. The aim of the current study is to realize step 3 of the cycle proposed by Weine (2011): performing a pilot intervention trial, to demonstrate programme characteristics such as feasibility (whether the preventive programme is doable), acceptability (whether families and trainers accept the programme), and potential effectiveness (whether the programme coincides with positive changes in key outcomes). This precedes the final step (step 4), namely 'new situations', which includes conducting intervention trials at other sites and in other contexts.

Objectives

The current pilot study aims to evaluate the feasibility, acceptability, and potential effectiveness of FAME to reduce parental mental health problems and improve family functioning. As families living in family locations might suffer from increased levels of distress, we expect these families to have more difficulties concerning the parent-child relationship, parental symptoms, and family functioning than families living in asylum centres. Therefore, baseline distress levels of both categories of families will be compared. Specifically, the objectives are to determine:

1. Whether it is feasible to offer FAME to families living in Dutch asylum centres and family facilities.
2. Whether FAME is acceptable to asylum-seeker families.
3. Whether undergoing FAME coincides with a reduction in parental symptoms of anxiety and depression and improvement in family functioning.
4. Baseline differences and similarities in the parent-child relationship, parental symptoms of anxiety and depression, and family functioning between families living in asylum centres and families living in family facilities.

METHODS/DESIGN

Trial Design

An uncontrolled, two-group pre-test-post-test design will be conducted, using a mixed-methods approach. Standardized questionnaires, semi-structured interviews, an observational scale, and a (self-constructed) programme integrity list will be used. The programme, including measurements, will take approximately 10 weeks per group.

Participants

Study participants will be recruited from the asylum-seeker family population in the Netherlands. Families will be selected through convenience sampling. Eligible families must meet the following criteria: (1) at least one caregiver participates in FAME, (2) at least one child aged 0–18 participates, and (3) the family lives in an asylum centre or family facility. Participants who are not able to function in a group, as reported by health teams of the family facility or asylum centre, are not eligible for this study. For example, participants who are likely to experience difficulties communicating in a group setting as a result of severe psychiatric illness, such as psychosis, will be excluded. Families with psychiatric problems, such as posttraumatic stress disorder or depression, who are likely to be able to benefit from FAME are included in the study. This will be discussed with the health teams prior to inviting the families to take part in the information session about FAME. Each group will include approximately five to eight families. Families will be divided over the groups based on the age of their child (0–5, 6–12, 13–18). However, this division cannot be followed strictly, for example, because some families have children in more than one age category. Therefore, the division will be used merely as a guideline. If there are multiple children in a family, parents are asked with which child they experience most difficulties and will be allocated to the age group of that child. All children of the family are invited to take part in the programme.

As this is a pilot implementation and evaluation of a programme that has not been studied previously, it was not considered appropriate to conduct a reliable sample size calculation. We aim to include approximately five living locations. In each location, we will recruit two groups of approximately six families. This will result in a total sample size of approximately 60 families ($5 \times 2 \times 6$). One or two parents and approximately one to two children of each family will take part, resulting in a total number of approximately 90 parents and 90 children.

Intervention

FAME is offered to families living in family locations and asylum centres. FAME encompasses seven sessions. Apart from the introduction session and final evaluation session, each session has a similar structure. The sessions start with an energizing activity to warm up the participants and promote positive group interactions. Subsequently, the main activity,

representing the central theme of the session, takes place. The themes and activities of FAME are based on the metaphor 'the bucket and the treasure chest'. The bucket is a metaphor for the number of stressful factors and problems families are exposed to. The bucket is filled with soluble and insoluble problems. The treasure chest represents the sources of support the families have. During the programme, families and trainers will focus on questions such as: 'What are sources of stress in the bucket, and what are sources of support in the treasure chest?' The bucket and treasure chest can be found in the manual of FAME (Mooren & Bala, 2016). The role of the trainer can be described as an 'eagle', as he or she walks around the room and zooms in on important positive or problematic interactions that arise. The family members function as 'consultants' for each other, as they can offer and receive feedback and support. The sessions are ended by reflecting on what the families have discussed and learned. A manual on FAME for families with children aged six to twelve has been published in Dutch (Mooren & Bala, 2016). The programme was further adapted to fit the other age groups addressed in this study. Trainers who offer FAME are therapists working at Centrum '45, who have ample experience in working with refugees and asylum-seekers and in working with FAME. Table 2 lists the sessions, themes, and aims of FAME.

Table 2. *Sessions of FAME*

Session	Theme	Aims
1. Introduction	Introduction of FAME, participants, and therapists	Parents know the aim of FAME. Mutual expectations are identified. Methods and framework of FAME are explicated. Parents are introduced to the study. Parents and children feel motivated to take part in the group.
2. Bucket and treasure chest	Stressors and sources of support	Parents are aware of the impact of difficulties on thoughts, behaviour, emotions and relationships. Parents recognize difficulties and risk factors. Parents can distinguish between soluble and insoluble problems. Parents experience mutual recognition. Parents start to develop the following insight: you can do something to decrease stress (locus of control). Families have a positive experience.
3. Impact	Parent-child relationship and the impact of difficulties	Parents are more aware of their own stress reactions. Parents can differentiate between different stress reactions (e.g. rumination, sadness, sleeping problems). Parents are aware of the impact of their stress on the parent-child relationship. Parents realize how they can aid their children. Parents develop an understanding of what they and their children need to facilitate positive development.
4. Tools	Resources and coping strengths within the family	Parents gain insight in how to deal with difficulties, and how they are already dealing with difficulties. Parents increase and improve their coping strategies, learn from each other. Parents experience positive interactions with each other. Parents know what helps them to control their own emotions.

Table 2. *Continued*

Session	Theme	Aims
5. Discovering	Resources and coping, strengths within the family	Parents become aware of the impact of their own emotions on their child. Parents become aware of how their children perceive the world and emotions of their child.
6. Treasure map	Social support	Parents obtain insight in how they can ask for help. Parents obtain insight in how they can offer help. Parents become more aware of their self-worth.
7. Closing session	Concluding FAME, leave-taking	Looking back: What did you learn? Looking forward: How will you use the things you learned during FAME in the future? Self-confidence of participants is stimulated. Participants develop ideas on how to hold onto and use acquired insights.

Overview of themes and aims for all age groups

Procedure

Families in both living conditions follow the same procedure. In cooperation with health teams at family facilities and asylum centres throughout the Netherlands, asylum-seeker families will be invited to take part in an introduction session. Participants will be informed about this initial introduction session through flyers and verbal information offered by local partners and researchers. The aim of the introduction session is to explain certain aspects of the programme, such as the structure, number, and duration of the sessions, and to clarify expectations. Families are given the opportunity to ask any questions they might have. During the week after the introduction session, families that have stated their interest in taking part in the programme will be visited. During this visit, any further questions can be answered. Participants who want to take part in the study are then asked to fill in a written informed consent. Parents fill in an informed consent for their children under the age of 16. Minors over 12 years of age fill in an informed consent as well.

Families who agree to take part in the study are subjected to pre-test measures (t_1). One of the researchers will either visit them at home or arrange a quiet room. A professional (telephone) interpreter will be provided. During this visit, parents will be asked to fill out questionnaires (see the 'Measurements' section), and a semi-structured interview with the parents will take place. If the participants agree, their semi-structured interviews will be audio-recorded. If the family members agree to take part in videotaping, the parent-child relationship will subsequently be assessed by videotaping the interaction between parent and child for approximately 20 min. Pre-test measures will last approximately 90 min for the parents, and 20 min for the children.

As noted, FAME involves seven weekly 2–3-h sessions. One or two official interpreters will be provided in each group. At the end of each session, the participants are asked to fill in scales measuring their distress and how they rate the session (t_2). The scales will be explained by the trainer, who is aided by the interpreters. Moreover, during the sessions, a researcher will evaluate programme integrity using a predetermined programme integrity

list. The final assessment (t_3) takes place in the week after the last session of FAME. The participants will be visited at home or a private room will be arranged. A (telephone) interpreter will be provided. The parents and children aged five and over will take part in individual semi-structured interviews. Parents will fill in questionnaires. Post-test measures will last approximately 65 min for the parents and 30 min for the children. See Table 3 for the schedule of enrolment, intervention, and assessment.

Table 3. *Schedule of Enrolment, Intervention, and Assessment*

	Parents				Children		
Time point	Enrolment	t_1	t_2	t_3	t_1	t_2	t_3
Enrolment							
Eligibility screen	X						
Informed consent	X						
Information session	X						
Assessments							
SCORE-15		X		X			
PHQ-4		X		X			
Semi-structured interview		X		X			X
Demographics		X					
EAS		X			X		
((Y)C)ORS			X			X	
((Y)C)SRS			X			X	
Programme integrity list			X			X	

Note. t_1: pre-FAME, t_2: weekly assessments during FAME, t_3: post-FAME. EAS = Emotional Availability Scales; PHQ-4 = Patient Health Questionnaire for Depression and Anxiety; SCORE-15 = Systematic Clinical Outcome and Routine Evaluation; ((Y)C)ORS = ((Young) Child) Outcome Rating Scale; ((Y)C)SRS = ((Young) Child) Session Rating Scale

Measurements

Quantitative

Parents. Family functioning will be measured using the Systemic Clinical Outcome and Routine Evaluation (SCORE-15; Stratton et al. (2010)). The SCORE-15 is a 19-item self-report questionnaire that can be used to monitor and report indicators of progress in systemic therapy. It offers an overall measure of family functioning as well as sub-scale scores on the dimensions: strength and adaptability, overwhelmed by difficulties, and disrupted communication. The validity of the SCORE-15 as an index of therapeutic change has been established. The questionnaire demonstrates good test-retest reliability, construct validity, and responsiveness in terms of clinical and reliable change (Hamilton et al., 2015; Stratton et al., 2010).

Parental symptoms of depression and anxiety will be assessed using the 4-item Patient Health Questionnaire for Depression and Anxiety (PHQ-4; Löwe et al. (2010)). The PHQ-4 has been validated in the general population. The total score is an index of anxiety and

depression severity (Kroenke et al., 2009).

The following demographics of the participating family members will be collected: age, gender, country of origin, time spent in the Netherlands, number and age of family members, and educational level.

Parents and Children. Parents and children are subjected to an observational measurement. Quality of the parent-child relationship will be measured using the Emotional Availability Scales (EAS) developed by Biringen (2008). They described emotional availability as 'the capacity of a dyad to share an emotionally healthy relationship' (p. 114; Biringen et al. (2014)). When conducting the EAS, a parent-child dyad is asked to interact as they would usually do for approximately 20 min. These interactions are videotaped and consequently scored on the EAS by certified objective observers with ample experience in working with refugees. EAS measures four caregiver components: sensitivity, structuring, non-intrusiveness, and non-hostility. The child components measured by the EAS are the child's responsiveness to the caregiver and the child's involvement with the caregiver. A score on a Likert scale of 1–7 on each component is used for data analysis. A score of 7 suggests that the participant displays optimal behaviours on that scale, a score of 4 indicates inconsistent behaviour, and a score of 1 indicates that the participant displays non-optimal behaviour. Studies suggest that the EAS is universally applicable, and cross-cultural validity has been established in various countries (Biringen et al., 2014; Selin, 2013).

To monitor participants' feedback on progress, a self-report scale will be used: the ((Young) Child) Outcome Rating Scale (((Y)C)ORS). The ((Y)C)ORS has four single-item subscales: individual, relational, social, and general. Sample questions of the CORS include 'How am I doing?' and 'How are things in my family?'. To assess therapeutic alliance, the ((Young) Child) Sessions Rating Scale (((Y)C)SRS) will be used. The four single-item subscales of the ((Y)C)SRS include relationship, goals and topics, approach and method, and overall. Both the ((Y)C)ORS and the ((Y)C)SRS are visual and analogue. Both scales have demonstrated adequate validity, solid reliability, and high feasibility (Duncan et al., 2003; Miller et al., 2003).

Programme Integrity. To evaluate whether the programme is feasible and can be executed as intended, we developed a programme integrity list. This checklist is based on the four dimensions of programme integrity (Carroll et al., 2007): (1) Adherence, the specified components of the programme; (2) Exposure, the extent to which family members are exposed to the programme, by monitoring presence and duration (presence is measured by registering the number of minutes each family is present and duration by monitoring the duration of each session in minutes); (3) Quality of delivery, therapeutic skills and competence, measured by scoring items such as 'zoomed in on problematic interactions' and 'allowed participants to practise with learned behaviours'; (4) Participant responsiveness, measured by assessing reactions during the session, including positive interactions (e.g.

laughter) and active participation. Additional questions about participant responsiveness will be asked during the semi-structured interview (t_3). We aim to observe all FAME sessions offered during this study. All assessors will be trained in using the programme integrity list. Two independent assessors will be present during several sessions to fill in the programme integrity list. Inter-rater reliability will be calculated.

Qualitative

Parents and Children. To further investigate the feasibility and acceptability of FAME, semi-structured interviews with parents are held at t_1 and t_3. During t_1, we aim to assess (1) whether participants feel that distressing experiences before, during, and after the flight have impacted their parenting skills and the parent-child relationship, (2) social support, (3) how participants cope with stressors, and (4) expectations concerning FAME. During t_3, we aim to (1) study participants' evaluations of the programme in terms of usefulness; (2) evaluate programme outcomes: social support, coping strategies, and the parent-child relationship; and (3) evaluate participant responsiveness. Open-ended questions will be posed to the family members. Subsequently, family members score their answers on a 5-point Likert scale. For example, the open-ended question "Which component of the programme was most helpful to you, and why?", is followed by scoring the question "How helpful was this component?" on a 5-point Likert scale (1 *not helpful* to 5 *very helpful*). The topic list is based on brainstorm sessions with researchers and developers of the FAME programme.

Statistical Analysis

Analysis of Quantitative Data

Quantitative data-analysis will be conducted using SPSS 23 (IBM Statistics). Descriptive statistics of demographic data, the programme integrity list, and the rating scales will be presented for all participants. For continuous variables, means, standard deviations, medians, and ranges will be reported. For categorical variables, numbers and percentages will be reported.

To test the hypothesis that families living at family facilities have more problems concerning the parent-child relationship and family functioning and higher parental symptoms of anxiety and depression than families living at asylum centres, pre-test scores on the EAS, PHQ-4, and SCORE-15 will be compared between these two groups using independent t tests.

To evaluate whether undergoing FAME coincides with a reduction in parental symptoms of anxiety and depression and improvement in family functioning, differences between the pre- and post-test scores on the SCORE-15 and PHQ-4 will be calculated. If more than 40 participants have completed the pre- and post-test measures, a mixed-design ANOVA will be executed. However, if there is a large amount of missing data, or if less than 40 participants have completed pre-test and post-test measures, two independent t tests will be executed. In addition to statistical significance, it is important to report any meaningful

clinical change when studying the impact of an intervention. Calculating the Reliable Change Index (RCI), as proposed by Jacobson and Truax (1992), allows us to do so. Using the RCI, we will calculate whether the differences in the scores between t_1 and t_3 are greater than the measurement error. A calculated RCI larger than |1.96| indicates a clinically reliable change with 95% certainty. The RCIs allow us to determine the numbers of participants improved, unchanged, and worsened from t_1 to t_3.

Analysis of Qualitative Data

All audio-recorded interviews will be transcribed verbatim. Data of the semi-structured interviews will be analysed using the qualitative data analysis software programme MAXQDA 10. The current study uses the General Inductive Approach as proposed by Thomas (2006). The approach is often used in qualitative data analysis. Data analysis is guided by the evaluation objectives. Using the General Inductive Approach for analysing qualitative evaluation data, the following five steps will be conducted: (1) initial reading of the text, (2) identifying specific text fragments related to the research questions, (3) labelling fragments to create categories, (4) reducing overlap and redundancy, and (5) describing the most important categories. These steps will result in three to eight outcome categories capturing the key aspects of the most important themes. Reliability of the qualitative data analysis will be assessed by independent parallel coding by two researchers during step 3 and 5.

Integrating Quantitative and Qualitative Data

Quantitative and qualitative data from each family will be combined in one document. Findings regarding the evaluation of FAME derived from qualitative and quantitative data will be integrated for each family by analysing whether (1) qualitative and quantitative findings lead to similar or different conclusions and (2) qualitative findings can provide more in-depth information to the quantitative findings. In addition, we will compare the qualitative and quantitative findings of all families that took part in the study and analyse whether any differences or similarities exist.

Data Management

Each family will be linked to an administration number. The data will be saved under the administration numbers on the protected IT environment of the Foundation Centrum ‘45. The data analysis will be performed at the Foundation Centrum ‘45. The handling of personal data complies with the General Data Protection Regulation.

DISCUSSION

The current study is designed to evaluate the feasibility, acceptability, and potential effectiveness of FAME, a preventive programme for asylum-seeker families. Moreover, potential baseline differences in the parent-child relationship, parental symptoms of anxiety and depression, and family functioning between families living in asylum centres and families living in family facilities are investigated. Although a large body of research supports the idea that family processes, the parent-child relationship, and the community play a central role in the development and well-being of the child, these processes received little attention in preventive interventions developed for these at-risk families (Fazel & Betancourt, 2018). Moreover, no studies have yet evaluated FAME (Mooren & Bala, 2016). This study will inform us on how to improve programme elements and the implementation of FAME.

FAME aims to strengthen and support potential resources within and outside of the families. The current study will indicate whether FAME is a feasible and acceptable programme when offered in a naturalistic setting. An important strength of this study is the inclusion of qualitative data, in addition to various quantitative measures. Conducting semi-structured interviews with the participants enables us to hear the voices of the participants about how they experience the programme and whether they feel it has helped them to deal with the consequences of previous and current stressors.

When executing the proposed study, several barriers can be anticipated. For example, when working with asylum-seeker families, we have to keep into account the many relocations the families are faced with. Families living in asylum centres are often placed in another centre or move away from the centre after the asylum has been granted. Families living at family locations risk deportation. These replacements can result in heightened levels of dropout. Moreover, asylum-seekers are faced with post-migration stressors concerning acculturation and resettlement, such as financial issues, language barriers, and facing an insecure future. These continuous stressors might make it difficult to prioritize preventive programmes such as FAME (Fazel & Betancourt, 2018; Li et al., 2016). To deal with these issues concerning recruitment and inclusion, trainers will collaborate with local health teams in order to reach families, inform them about FAME, and remind them of the sessions as best as possible. To further inform families, the initial information session will focus on disclosing the aim of FAME and the study and clarify mutual expectations. Finally, in order to overcome barriers, FAME is offered at the living locations of the families, diminishing travelling costs and time spent travelling. Nevertheless, the current study will not be able to eliminate dropout as a result of factors such as relocation. These barriers underline the need for studying the feasibility of FAME.

The current study holds several limitations. Because of the small sample size and convenience sampling, the results and their generalizability should be interpreted with caution. Moreover, concerning our objective to establish the potential effectiveness of FAME, we will be unable to attribute any potential effects to FAME as a result of the lack of a

control group. However, in line with the developmental cycle proposed by Weine (2011), the scope of the current study is not to provide such an extensive evaluation, but to take a next step in the development of a recently developed programme. Possibly, the study will allow us to determine important parameters to estimate the sample size and detectable effect sizes for potential future, larger studies assessing the effectiveness and implementation of FAME.

In conclusion, this is the first study examining the feasibility, acceptability, and preliminary effectiveness of the secondary preventive programme FAME. Our aim is to contribute to the still limited knowledge on preventive programmes for asylum-seeker families. By developing a programme designed to prevent further development of emotional reactions and to improve family functioning, we aim to support these at-risk families preparing for resettlement in a new country, or those facing deportation.

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REFERENCES

Allen, J. G., Fonagy, P., & Bateman, A. W. (2008). *Mentalizing in clinical practice*. American Psychiatric Pub.

Almqvist, K., & Broberg, A. G. (2003). Young children traumatized by organized violence together with their mothers–The critical effects of damaged internal representations. *Attachment & Human Development*, *5*(4), 367-380.

Asen, E. (2002). Multiple family therapy: An overview. *Journal of Family Therapy*, *24*(1), 3-16.

Biringen, Z. (2008). *The emotional availability (EA) scales and the emotional attachment & emotional availability (EA2) clinical screener: Infancy/ early childhood version; middle childhood/youth versions; therapist/interventionist manual; couple relationship manual*. http://emotionalavailability.com

Biringen, Z., Derscheid, D., Vliegen, N., Closson, L., & Easterbrooks, M. A. (2014). Emotional availability (EA): Theoretical background, empirical research using the EA Scales, and clinical applications. *Developmental Review*, *34*(2), 114-167.

Carroll, C., Patterson, M., Wood, S., Booth, A., Rick, J., & Balain, S. (2007). A conceptual framework for implementation fidelity. *Implement Science*, *2*(40). https://doi.org/10.1186/1748-5908-2-40

Duncan, B. L., Miller, S. D., Sparks, J. A., Claud, D. A., Reynolds, L. R., Brown, J., & Johnson, L. D. (2003). The Session Rating Scale: Preliminary psychometric properties of a "working" alliance measure. *Journal of Brief Therapy*, *3*(1), 3-12.

Fazel, M., & Betancourt, T. S. (2018). Preventive mental health interventions for refugee children and adolescents in high-income settings. *The Lancet Child & Adolescent Health*, *2*(2), 121-132. https://doi.org/10.1016/s2352-4642(17)30147-5

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*(9812), 266-282. https://doi.org/10.1016/s0140-6736(11)60051-2

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet*, *365*(9467), 1309-1314.

Fonagy, P., & Bateman, A. W. (2006). Mechanisms of change in mentalization-based treatment of BPD. *Journal of Clinical Psychology*, *62*(4), 411-430.

Gelin, Z., Cook-Darzens, S., & Hendrick, S. (2018). The evidence base for Multiple Family Therapy in psychiatric disorders: a review (part 1). *Journal of Family Therapy*, *40*(3), 302-325.

Hamilton, E., Carr, A., Cahill, P., Cassells, C., & Hartnett, D. (2015). Psychometric properties and responsiveness to change of 15-and 28-item versions of the SCORE: A family assessment questionnaire. *Family Process*, *54*(3), 454-463.

Jacobson, N. S., & Truax, P. (1992). Clinical significance: a statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology 59*(1), 12-19.

Kroenke, K., Spitzer, R. L., Williams, J. B., & Löwe, B. (2009). An ultra-brief screening scale for anxiety and depression: the PHQ-4. *Psychosomatics*, *50*(6), 613-621.

Laqueur, H. P., Laburt, H., & Morong, E. (1964). Multiple family therapy. *Current Psychiatric Therapies*, *4*, 150-154.

Lemmens, G. M., Eisler, I., Buysse, A., Heene, E., & Demyttenaere, K. (2009). The effects on mood of adjunctive single-family and multi-family group therapy in the treatment of hospitalized patients with major depression. *Psychotherapy and Psychosomatics*, *78*(2), 98-105.

Li, S. S., Liddell, B. J., & Nickerson, A. (2016). The relationship between post-migration stress and psychological disorders in refugees and asylum seekers. *Current Psychiatry Reports*, *18*(9), 1-9.

Löwe, B., Wahl, I., Rose, M., Spitzer, C., Glaesmer, H., Wingenfeld, K., Schneider, A., & Brähler, E. (2010). A 4-item measure of depression and anxiety: validation and standardization of the Patient Health Questionnaire-4 (PHQ-4) in the general population. *Journal of Affective Disorders*, *122*(1-2), 86-95.

Miller, S. D., Duncan, B., Brown, J., Sparks, J., & Claud, D. (2003). The outcome rating scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy*, *2*(2), 91-100.

Mooren, G. T. M., & Bala, J. (2016). *Goed ouderschap in moeilijke tijden: Handleiding voor meergezinsgroepen met vluchtelingen*. Pharos.

O'Shea, M. D., & Phelps, R. (1985). Multiple family therapy: Current status and critical appraisal. *Family Process*, *24*(4), 555-582.

Selin, H. (2013). *Parenting across cultures: Childrearing, motherhood and fatherhood in Non-Western Cultures* (Vol. 7). Springer Science & Business Media.

Stratton, P., Bland, J., Janes, E., & Lask, J. (2010). Developing an indicator of family function and a practicable outcome measure for systemic family and couple therapy: the SCORE. *Journal of Family*

Therapy, *32*(3), 232-258.

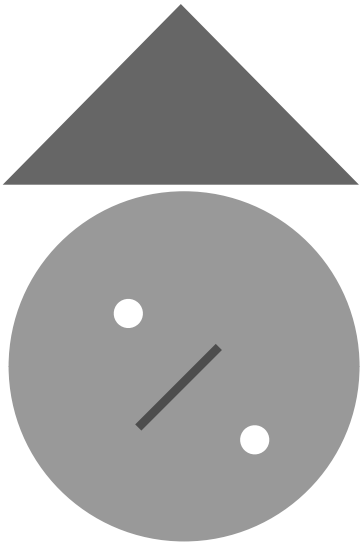
Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, *27*(2), 237-246.

UNHCR. (2018). *Global trends: forced displacement in 2017*.

Van Ee, E., Hein, I. M., Bala, J., & Mooren, T. (2014). Multifamily therapy met vluchtelingengezinnen: van oorlog naar veiligheid. *Kind & Adolescent*, *35*(3), 205-215.

Weine, S., Ware, N., Hakizimana, L., Tugenberg, T., Currie, M., Dahnweih, G., Wagner, M., Polutnik, C., & Wulu, J. (2014). Fostering resilience: Protective agents, resources, and mechanisms for adolescent refugees' psychosocial well-being. *Adolescent Psychiatry*, *4*(3), 164-176.

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



4

Family Empowerment (FAME): A feasibility trial of preventive multifamily groups for asylum seeker families in the Netherlands

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ABSTRACT

This study evaluated the feasibility of Family Empowerment (FAME), a preventive multifamily program for asylum seeker families in the Netherlands. FAME aims to reinforce the parent–child relationship, family functioning, and social support. We used an uncontrolled pre-test–post-test design, embedded in a mixed-methods approach. FAME was offered to 46 asylum seeker families, mostly originating from Eritrea, Armenia, or Syria. Twenty-seven parents gave consent to participate in this study. Program integrity and evaluations of participating parents and trainers were assessed. Family functioning and parental symptoms of depression and anxiety were measured pre- and post-FAME. Six participants completed all assessments. Most participants valued gathering with multiple families. Although FAME might coincide with decreases in anxiety and depression, the program had a limited impact on family functioning. Possibly, the aims of FAME did not align with some families' current needs. Lessons learned and recommendations to further improve interventions for refugee families are discussed.

INTRODUCTION

In January 2020, over 27,000 refugees and asylum seekers resided in reception centers, asylum centers, and family locations in the Netherlands. Approximately a quarter of this group were minors under the age of 18, the majority of whom arrived in the Netherlands with at least one parent (Centraal Orgaan opvang asielzoekers, 2020). The lives of these families can be put under considerable pressure as a result of adverse past events in combination with continuous stressors linked to the post-migration environment, such as insecurities concerning status, family reunification, social isolation, finances, and finding housing (Fazel et al., 2012; Utržan & Wieling, 2020).

A refugee is defined by the United Nations High Commissioner for Refugees (UNHCR) as "any person who owing to 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/her nationality and is unable or, owing to such fear, is unwilling to avail him/herself of the protection of that country; or who, not having a nationality and being outside the country of his/her former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it" (p. 121), whereas an asylum seeker is defined as "an individual who is seeking international protection. In countries with individualized procedures, an asylum-seeker is someone whose claim has not yet been finally decided on by the country in which the claim is submitted" (p. 118) (UNHCR, 2013). In 2019, approximately 30,000 persons applied for asylum in the Netherlands, most of whom originated from Syria (18%), Eritrea (8%), and Nigeria (7%) (Immigration & Naturalisation Service, 2019). In the Netherlands, asylum seeker families are located in asylum centers until their asylum application is granted or rejected. If the application is rejected, families are placed in a family location, where they are prepared for deportation.

The adjustment of children after adverse events can be influenced by the parent–child relationship (El-Khani et al., 2020; Fazel & Betancourt, 2018). Refugee and asylum seeker parents are at risk of developing stress-related symptoms, and mental health problems can undermine their parenting skills, the parent–child relationship, and family functioning (Sangalang et al., 2017; Van Ee et al., 2016). Moreover, these parents are often forced to leave their social support networks behind, causing feelings of loneliness and isolation (Stewart et al., 2015). A well-functioning parent–child relationship, family system, and social support system can play an important protective role in families' adjustment after hardship (Betancourt & Khan, 2008; El-Khani et al., 2020; Fazel & Betancourt, 2018).

Family interventions can be an important means to prevent the negative impact of resettlement-related adversity. However, studies in this area have been scarce (Slobodin & de Jong, 2015). There is some evidence that family-focused interventions for families exposed to trauma and displacement can have a positive impact on mental health utilization, social support, family hardiness, parental involvement, children's problem behavior, emotion regulation, and family functioning (Asen, 2002; Ballard et al., 2017; El-Khani et al.,

2020; Weine et al., 2003, 2008). However, the scarcity of studies evaluating family-focused interventions limits the possibility to draw clear conclusions on their effectiveness (Slobodin & de Jong, 2015). The studies that have been conducted emphasized the importance of cultural and contextual adaptations when offering programs to families in the context of trauma and resettlement. For instance, by offering programs by facilitators who are refugees themselves (Weine et al., 2008) or by using examples relevant to the context of the participating families (El-Khani et al., 2020).

To prevent the occurrence or deterioration of mental health problems and to reinforce the parent–child relationship, family functioning, and social support for families, the secondary preventive multifamily program Family Empowerment (FAME) was developed (Mooren & Bala, 2016). FAME was developed specifically for families residing in asylum centers and living locations in the Netherlands.

The development of FAME is based on 10 years of experience with offering multifamily groups for refugee families at a psychotrauma center. Experiences with offering FAME at an asylum center have been used to strengthen the manual (Mooren & Bala, 2016). The development of the FAME manual has been in line with the cycle for developing and evaluating preventive programs for refugee families as proposed by Weine (Van Es et al., 2019; Weine, 2011).

During FAME, multiple families facing similar difficulties are brought together, allowing families to share experiences, to offer and receive mutual support and feedback, and to learn about different perspectives. FAME aims to strengthen parental competence and resilience. A key concept is mentalization, the ability to reflect upon and understand the state of mind of yourself and the other (Allen et al., 2008; Bateman & Fonagy, 2013). Although opinions about the parent–child relationship, parenting styles, and family functioning are often culturally bound, several universal ideas concerning the importance of sensitivity and responsiveness exist. For example, being attentive and responsive to the needs of a child is considered as beneficial to children worldwide (Mooren & Bala, 2016; Rohner, 2004; Van IJzendoorn & Sagi-Schwartz, 2008). FAME aims to address such universal concepts in a culturally sensitive way.

During FAME, families gather for approximately eight weekly sessions. Each session has a similar structure: an energizing activity, activities focused on the main theme of that session, and closure, for example by reflecting on the session and/or practicing with relaxation exercises. The program protocol is described in detail elsewhere (Mooren & Bala, 2016; Van Es et al., 2019).

Deviations from the protocol often occur when an intervention program is applied in a naturalistic setting (Kösters et al., 2017). Program integrity, the extent to which the program is implemented as intended, can affect the treatment outcome (Kösters et al., 2017; Carroll et al., 2007). The current study aims to evaluate the feasibility of FAME when delivered in a naturalistic setting by studying (a) four dimensions of program integrity (adherence to the intervention, exposure to the intervention, quality of delivery, and participant

responsiveness); (b) evaluations of FAME by participants and trainers; and (c) whether FAME coincided with decreases in symptoms of anxiety and depression, and improvements in family functioning. This pilot intervention study is an important step in the development of FAME before conducting trials at other locations and in other contexts (Weine, 2011).

METHODS

Design

The current study is a mixed-methods pre-test–post-test feasibility trial. A self-constructed program integrity list, semi-structured individual and group interviews, a focus group, and standardized questionnaires were used. The study protocol has been published in a peer-reviewed journal (Van Es et al., 2019). Ethical approval was obtained from the Medical Research Ethics Committee of the Leiden University Medical Centre (P17.268).

Participants

Trainers offered FAME at one Dutch asylum center and two family locations between November 2018 and July 2019. Per location, two treatment groups were started (six groups in total). Families were excluded from participation in FAME if a family member was not able to function in a group or was unlikely to benefit from participation, for example, as a result of severe psychiatric illness (e.g., psychosis). No one met this exclusion criterion. All parents who took part in at least one session of FAME were invited to participate in the study.

Procedure

Asylum centers and family locations were selected based on convenience sampling. Families with a similar cultural background and language were invited for an introduction session of FAME through flyers. In addition, researchers and/or local professionals visited families to offer information on FAME and to invite them to an introduction session. During this session, trainers explained several aspects of FAME, such as the frequency and the structure of sessions and mutual expectations of trainers and families. An overview of themes and aims for each session of FAME can be found in the study protocol (Van Es et al., 2019). Finally, researchers offered verbal and written information on the study.

Parents who were interested in taking part in the study were invited for an appointment at their home or in a quiet room for the completion of pre-test measures (t_1, see Table 1). Written informed consent was obtained. After the final session of FAME, the final assessment took place (t_3). If it was not possible to make individual appointments, researchers handed out questionnaires to the group of families and conducted semi-structured group interviews. Interviews were audio-taped and transcribed verbatim or minutes were taken. During each assessment, a researcher and a (telephone) interpreter were present.

Table 1. *Assessment Schedule of FAME Feasibility Trial*

		Time point		
	Respondent	t_1	t_2	t_3
Demographics	Parent	X		X
Feasibility				
Program integrity list	Researcher		X	
Semi-structured interview	Parent	X		X
Therapeutic alliance (CSRS)	Parent		X	
Focus group	Trainer			X
Family Functioning & Distress				
Family functioning (SCORE-15)	Parent	X		X
Depression and anxiety (PHQ-4)	Parent	X		X

Note: t_1: Pre-FAME, t_2: During FAME, t_3: Post-FAME.
Abbreviations: CSRS = Child Session Rating Scale; PHQ-4 = Patient Health Questionnaire for Depression and Anxiety; SCORE-15 = Systemic Clinical Outcome and Routine Evaluation.

Before each session of FAME, trainers visited the families to remind them of the session. The groups were open, meaning that when appropriate, a new family could join the group. Professional interpreters were present at each session. Program integrity lists were filled in by researchers or students during each session of FAME (t_2). All assessors were trained in administering the program integrity list.

After all FAME groups were completed, (co-)trainers took part in a focus group. They gave verbal consent for the audio-recording and use of the focus group data for the study. The audio-recording was transcribed verbatim.

Several adaptations were made to the study protocol published earlier (Van Es et al., 2019). Firstly, the Emotional Availability Scale (EAS), an observational instrument assessing the quality of the parent–child relationship at baseline (Biringen, 2008), was not used. As parents were hesitant to give permission to record a videotape, it was decided not to conduct this measurement in order to reduce attrition. Secondly, the proposed measurements with children proved unworkable as children often did not attend the sessions. Thirdly, we noticed that, due to the language barrier, the adult version of the Session Rating Scale (SRS) and the Outcome Rating Scale took a lot of time and effort to fill in. Therefore, we decided to use the child version of the SRS (CSRS), which is a more visual measure for therapeutic alliance.

Team and Team Resources

Our team of trainers consisted of three lead trainers and two co-trainers. At one location, local professionals followed a 1-day FAME-course provided by the leading trainers to become co-trainers. One local professional and one researcher functioned as co-trainers and, as such, delivered parts of FAME together with the lead trainers. Each session was prepared based on the FAME protocol and reflected on afterward. Trainers took part in several supervision sessions led by a trained therapist who had experience with multifamily

therapy, during which challenges faced when implementing FAME and possible solutions were discussed.

Measures

The scheduling of assessments is displayed in Table 1.

Demographics

Researchers registered the following demographics of the participants: age, gender, country of origin, time since arrival in the Netherlands, and number of family members. Demographics were collected prior to FAME or post-FAME if a participant did not participate in pre-FAME measurements.

Program Feasibility

Program feasibility was studied by using a program integrity list, the CSRS, interviews, a focus group, and standardized questionnaires. To evaluate program integrity, a list was constructed and completed by a researcher during each FAME session (t_2). It was based on four dimensions of program integrity (Carroll et al., 2007): (a) Adherence: assessors rated components of the protocol as executed (yes) or not executed (no), and the percentage of activities that was executed according to protocol was calculated; (b) Exposure: the presence of families, the total number of sessions, and the duration of each session; (c) Quality of delivery: during each session, assessors rated whether trainers applied therapeutic skills and competences specific to FAME (yes, sometimes, no, or not applicable); and (d) Participant responsiveness: during each session, assessors rated the approximate percentage of time that positive interactions (e.g., laughter) took place and rated active participation for each participant on a scale of 0 (not active) to 100 (very active).

To assess therapeutic alliance, the visual analogue Child version of the SRS was filled in by parents. The four single-item subscales of the CSRS include: (a) respect and understanding; (b) relevance of goals and topics; (c) client–practitioner fit; and (d) overall alliance. The subscales scores range from 0 to 10, and the total score is calculated by adding up the subscale scores (range 0–40). A higher score indicates a better therapeutic alliance. A total score below 36, or a score below nine on a scale, indicates a perceived problem in the therapeutic alliance. The SRS has adequate validity and high feasibility (Duncan et al., 2003). Duncan et al., (2003) reported a Cronbach's coefficient alpha of .88 for six administrations to 70 participants (N = 420) randomly selected from an outpatient mental health counseling agency.

Semi-structured interviews were used to explore parents' evaluations of FAME. Prior to FAME (t_1), expectations concerning FAME were explored. After FAME (t_3), participants' evaluations of the usefulness and acceptability of the program were evaluated. Furthermore, we explored whether participants felt that FAME had impacted the parent–child relationship, social support, and coping strategies. Finally, a focus group interview with FAME (co-)trainers

took place after all groups were completed (t_3), during which program integrity, usefulness, and acceptability of FAME were discussed.

Family Functioning and Distress

To further understand the acceptability of FAME, we investigated whether FAME coincides with an improvement in family functioning and decreases in symptoms of anxiety and depression in participating parents. The Dutch version of the Systemic Clinical Outcome and Routine Evaluation (SCORE-15) (Stratton et al., 2010) was used to measure family functioning. This self-report questionnaire includes 15 items (e.g., "When one of us is upset they get looked after within the family"). Scores can be calculated on three dimensions (strength and adaptability, overwhelmed by difficulties, and disrupted communication); the total score offers an index of overall problems concerning family functioning. The questionnaire has good construct validity and is sensitive to change (Hamilton et al., 2015; Stratton et al., 2014).

To measure the severity of parental symptoms of depression and anxiety, the four-item Patient Health Questionnaire for Depression and Anxiety (PHQ-4) was used. Each item (e.g., "Feeling down, depressed, or hopeless") is rated on a scale from 0 (*not at all*) to 3 (*nearly every day*). The total score ranges from 0 to 12, with categories of psychological distress being none (0–3), mild (3–5), moderate (6–8), and severe (9–12). In addition, anxiety and depression subscale scores can be calculated. On each subscale, a score of ≥3 is considered positive for screening purposes. The PHQ-4 is a very brief and well-validated questionnaire. It is considered suitable for a diverse group of refugees (Kliem et al., 2016). As the SCORE-15 and PHQ-4 are not translated to all languages, professional interpreters translated the questionnaire and answered any questions that arose.

Data Analysis

Qualitative Data

Minutes and transcriptions of the semi-structured interviews and focus group were analyzed using MAXQDA 10 (VERBI). The data were analyzed using the General Inductive Approach (Thomas, 2003). Specific text fragments that were linked to the study aims were identified and labeled to create categories. Subsequently, overlap between and redundancy of the categories were reduced, and the remaining categories were described. This procedure was conducted independently by two researchers (CvE and TM) and subsequently discussed to increase the reliability of the analysis. The analysis resulted in outcome categories that represent the most important themes.

Quantitative Data

Descriptive statistics of the four program integrity dimensions were calculated using SPSS 23 (IBM Statistics). To investigate whether participants showed significant improvements on the PHQ-4 and SCORE-15, the Reliable Change Index (RCI), as proposed by Jacobson and Truax (1992), was calculated. The following formula was used: $\frac{t_3 - t_1}{S_{diff}}$. S_{diff} is calculated using

the intraclass correlation coefficient of the questionnaires and the standard deviation of the pre-FAME scores. The intraclass correlation coefficient of the SCORE-15 is .91 (Hamilton et al., 2015), and the intraclass correlation coefficient of the PHQ-4 is .83 (Kim et al., 2021). A calculated RCI larger than |1.96| indicates a clinically reliable change with 95% certainty.

In line with the manual, we allowed one missing item on the SCORE-15. If one item was missing, the subscales and total scores were calculated by multiplying the average score of the other items with the number of items on the subscale or total score. No missing items were allowed on the PHQ-4. As not all participants filled in all questionnaires and questions, the number of respondents varies throughout the study. When percentages are reported, they apply to the number of participants answering that specific question or questionnaire.

RESULTS

Descriptive Statistics

Six groups of FAME were conducted, including one group with participants from Armenia (Armenian speaking), two groups with participants from Eritrea and Ethiopia (Tigrinya/Amharic speaking), one group with participants from Syria and Iran (Arabic), and two groups with participants from North Africa (English, French, and Arabic speaking). The latter group was conducted by the trainer in English and French and translated to Arabic by an interpreter. In total, 46 families (42 mothers, 6 fathers, and 43 children) joined at least one session of FAME. Of the 48 parents, 27 gave consent for participating in the study. This study presents the data of the parents who gave consent. Reasons for not participating were diverse (see Table 2). For example, families consisting of a mother and a baby were not able to answer all questions concerning family functioning. Two groups did not participate in post-FAME measurements because the groups did not continue after the introduction session. Local professionals did not give permission to interview the participants to explore why they did not want to continue. They explained that the participants experienced too much stress concerning their asylum procedure and living situation, and they did not want to add to their burden. Table 3 reports the demographics of the participants. Six participants completed pre- as well as post-FAME measurements. The qualitative and quantitative data of these participants are described in detail in the “Evaluation by Participants” section.

Table 2. *Reasons for Not Partaking in Measurements*

	n
Took part in ≥ 1 session(s) of FAME	48
Reasons for not partaking in study (n=21)	
Not being able to schedule an appointment	7
Group ended prematurely	6
Participant relocated	4
Only joined one session	3
Other	1
Total participation (written consent)	27
Reasons for not partaking at t_1 (n=13)	
Group did not partake in t_1 measures	8
Not being able to schedule an appointment	3
Late enrolment	2
Reasons for not partaking at t_3 (n=8)	
Group ended prematurely	6
Not being able to schedule an appointment	1
Participant relocated	1

Note: FAME = Family Empowerment.

Table 3. *Demographics of Study Participants (N=27)*

Variable*	***n* (%)**	**M (SD)**	**Range**
Gender (*n*=27)			
Female	22 (81.5)	-	-
Male	5 (18.5)	-	-
Age (years) (*n*=26)		34.6 (8.8)	21 – 56
Country of origin (*n*=27)			
Eritrea	10 (37.0)	-	-
Armenia	7 (25.9)	-	-
Syria	3 (11.1)	-	-
Other	5 (18.5)	-	-
Missing	2 (7.4)		
Number of children in family (*n*=19)		2.16 (1.4)	1– 6
Time since arrival in Netherlands (months) (*n*=18)		47.8 (38.0)	2 – 108
Living location (*n*=27)			
Asylum center	20 (74.1)	-	-
Family location	7 (25.9)	-	-
Partner (*n*=25)			
Yes	13 (52.0)	-	-
No	12 (48.0)	-	-

* Number of participants for whom data were available are in parentheses

Table 4 reports the group means and standard deviations of the PHQ-4 and SCORE-15 at baseline. The anxiety subscale score suggests an increased risk of anxiety. The total score indicates that, on average, participants who completed the baseline assessment experienced moderate levels of psychological distress. The SCORE-15 scores indicate few problems with “Strengths and adaptability” and “Disrupted communication” and some problems with “Overwhelmed by difficulties.” The total score indicates that families reported few problems concerning family functioning.

Table 4. *Baseline Measurements on Depression, Anxiety, and Family Functioning*

	n	M (SD)
PHQ-4 Anxiety[a]	14	4.1 (2.1)
PHQ-4 Depression[a]	14	2.9 (2.3)
PHQ-4 Total	14	7.0 (4.2)
SCORE-15 Strengths and adaptability	10	10.6 (5.6)
SCORE-15 Overwhelmed by difficulties	9	14.3 (5.4)
SCORE-15 Disrupted communication	9	10.1 (5.0)
SCORE-15 Total	9	35.2 (15.3)

Abbreviations: PHQ-4 = Patient Health Questionnaire for Depression and Anxiety; SCORE-15 = Systemic Clinical Outcome and Routine Evaluation.
[a]Cut-off score (positive for screening purposes) = 3.

Program Feasibility

Program Integrity

Program integrity aspects are summarized in Tables 5 and 6. On average, trainers adhered to 60% of the protocol. Deviations from the protocol occurred, for example, as a result of not being able to conduct certain activities because no children attended the group or in order to address themes brought up by participants.

Table 5. *Program Integrity: the Extent to Which the Program was Implemented as Intended*

	M (SD)	Range
Adherence (%)	60.0 (22.8)	6.7 – 93.8
Exposure		
Number of sessions	5.3 (3.0)	1 - 8
Duration of sessions (minutes)	91.6 (16.7)	60 – 120
Number of families present	5.0 (3.3)	1 – 14
Responsiveness		
Positive interactions (0-100)	59.5 (20.4)	20 - 90
Active participation (0-100)	78.0 (7.9)	59 – 90
Child Session Rating Scale (CSRS)[a]		
Respect and understanding (0-10)	9.3 (1.2)	2.0 – 10.0
Relevance of the goals and topics (0-10)	9.5 (0.5)	8.0 – 10.0
Client-practitioner fit (0-10)	9.2 (1.1)	4.7 – 10.0
Overall alliance (0-10)	8.9 (1.5)	4.6 – 10.0
Total (0-40)	36.8 (3.4)	23.9 – 40.0

[a]Filled in by 12 participants

Table 6. *Quality of Delivery: the Percentage to Which Trainers Applied Therapeutic Skills and Competence Specific to FAME*

	% Yes	% Sometimes	% No	% N/A
Introducing activities	100	0	0	0
Organizing subgroups	29.0	22.6	0	48.4
Taking distance	51.6	29.0	3.2	16.1
Continuously being on the move between families	74.2	19.4	0	6.5
Zooming in on interactions	54.8	16.1	6.5	22.6
Asking about perspectives/reflections	90.3	3.2	0	6.5
Letting parents take responsibility for children	22.6	45.2	3.2	29.0
Practicing with new behavior	13.3	33.3	33.3	20.0
Emphasizing link between group and home	93.5	0	0	6.5

Note: N/A = not applicable

Concerning exposure, four groups of FAME consisted of seven or eight sessions. Two groups were terminated after the introduction session and measurements, as families indicated that they did not want to continue FAME. Sessions lasted 92 min on average, and an average of five families (at least one family member) participated in each session.

Participant responsiveness varied between sessions. Positive interactions varied between 20% and 90% per session (M = 60%). Variations occurred mostly because some sessions included serious themes, whereas, in other sessions, icebreakers and playing with the children resulted in more positive interactions. Overall, participants participated actively in the sessions (M = 78%). Twelve participants filled in the CSRS. Participants evaluated the subscales "respect and understanding," "relevance of the goals and topics," and "client-practitioner fit" as well as the "overall CSRS score" as satisfactory. The average score on "overall alliance" indicated room for improvement.

The scores for quality of delivery varied widely from 100% (introducing activities) to 13% (practicing with new behavior). During several sessions, the components "organizing subgroups" and "letting parents take responsibility for children" were not applicable, as no children attended the respective sessions.

Evaluation by Trainers

Factors Promoting Feasibility

Four of the five trainers, who together were present in all sessions offered, took part in the focus group. They reported several factors promoting the feasibility of FAME, including collaboration with local professionals. Although the manual of FAME facilitated its feasibility, trainers highlighted the importance of flexibility and deviating from the protocol to address specific group needs. Trainers reported that the structure (icebreaker, activity focused on theme, and closure) and core themes of the program (mentalization, recognition of problems, and parental resilience) were useful.

Trainer: The theoretical background of this program is different from parenting programs that focus more on rewarding, ignoring and punishing, and this is really about mentalizing.

Factors Interfering with Feasibility

Trainers reported several factors that interfered with the feasibility of FAME. It was not always possible to carry out all activities, for example, when participating families had limited time because of other obligations. Moreover, as a result of issues such as relocations, sometimes, only one or two families attended the session. Finally, trainers stated that there were difficulties with organizing a suitable location, as two different rooms had to be available in order to offer separate activities to parents and children.

Another factor limiting the feasibility concerned difficulties in recruiting and motivating families to take part in FAME. It was often difficult to prioritize FAME when families were faced with pressing issues, such as concerns linked to the asylum procedure.

Although offering FAME to parents as well as children allows families and trainers to

work with interactions coming up during FAME sessions, it was difficult to address topics such as harsh parenting and daily stressors when children were present. In addition, the presence of children sometimes caused stress for parents as children walked in and out of the room and asked for their attention during the session. Moreover, adolescents did not want to join FAME together with their parents. Trainers noted that, to increase the feasibility, it might help to decide together with the parents whether children should take part in FAME. One trainer noted that it is important to explain in more depth why children are invited to the group, as illustrated by the following quote:

> *Trainer: How I imagined it at the start, I thought: OK, the group is a sort of reflection of daily life, children are always there. Whether you're stressed or not, whether you're having fun or not, they're present. So as much as possible [...] you have to be available, and how do you do that. And that is what you practice within the group. But I wonder if parents are aware of this and if they know what they're working on at that time.*

Evaluation by Participants

Complete pre- and post-FAME measurements were available for six participants. For illustrative purposes, their qualitative and quantitative evaluations are described below.

Strengths of FAME

Four participants found FAME useful. Most participants (n = 4) stated coming together with other families allowed for sharing perspectives, ideas, and experiences. For example, participants explained that they learned how others deal with similar problems. Several participants found the concrete exercises and advice offered during FAME helpful. For example, one mother felt relieved after writing down her problems and throwing them in the metaphorical "bucket" (defining insolvable and solvable problems). A father added that the metaphor of the treasure chest helped him to find solutions for his problems. A mother emphasized that FAME increased her awareness of the impact of stress on her children and of the importance of protecting them from stress-related reactions, as illustrated by the following quote:

> *I did see a lot of changes. Especially what I learned during the course: if I feel stress, that's not a good sign for my daughter, and I can't take care of my daughter that well. [...]. If I don't have a lot of stress I can take better care of my baby. And also that I show the stress less to my daughter. So that I go away from her if I have stress, and not show her.*

Weaknesses of FAME

Two participants did not find FAME useful. Both stated that although important subjects

were addressed, there was insufficient time to discuss these subjects in depth, and too much time was spent on subjects that did not concern parenting and on problems that could not be solved. In addition, several participants (*n* = 3) reported that although they felt supported by the other families and trainers during FAME, they did not experience a change in social support outside the group. Two participants added that their future was too insecure and/or there were no solutions offered for (continuous) stressors. A mother added:

> *[Nothing changed.] This is due to my procedure. Four families have been deported from the asylum center. This causes a lot of stress, I cannot control it. This isn't going any better now.*

Impact of FAME

Several participants (*n* = 4) reported an impact of FAME. For example, some experienced a decrease in worrying, feelings of helplessness, stress, or anger. Others noted that they were more patient or calm. Moreover, a mother explained that FAME increased her understanding of her children's perspectives.

Family Functioning and Distress

Table 7 shows the mean total PHQ-4 and SCORE-15 scores for each participant at t_1 and t_3. The participants who filled in the pre- as well as the post-FAME questionnaires took part in most sessions of FAME. Two of the six participants who completed the PHQ-4 measurements reported improvements in depression and anxiety scores from t_1 to t_3, as indicated by the RCI. The other four participants reported no significant change in depression and anxiety scores. One of the five participants who completed the SCORE-15 reported an improvement in family functioning from t_1 to t_3. The other four participants reported no significant change in family functioning.

Table 7. *Reliable Change Indexes on PHQ-4 and SCORE-15 Scores per Participant (N=6) from t_1 to t_3*

Participant no	PHQ-4 t_1 (M)	PHQ-4 t_3 (M)	RCI PHQ-4 t_1-t_3	SCORE-15 t_1 (M)	SCORE-15 t_3 (M)	RCI SCORE-15 t_1-t_3
1	2	4	0.83	-[a]	-	-
2	6	5	-0.41	27	33	0.96
3	9	6	-1.24	36	30	-0.96
4	9	7	-0.83	21	26	0.80
5	12	5	-2.89*	59	46	-2.07*
6	12	7	-2.07*	54	46	-1.21

Abbreviations: PHQ-4 = Patient Health Questionnaire for Depression and Anxiety; SCORE-15 = Systematic Clinical Outcome and Routine Evaluation; RCI: reliable change index.
[a]Data on the SCORE-15 are missing as the family only consisted of mother and baby.
*Clinically significant decrease.

DISCUSSION

This study is the first to investigate the feasibility of FAME, a preventive multifamily program for asylum seeker families.

Program Integrity

We found that several deviations to the program protocol occurred. Two groups were discontinued after the introduction session. As a result, exposure to FAME differed per family, as the number of families attending the sessions, and the number of sessions per group varied widely. Overall, families participated actively in the program. According to the trainers, factors promoting the feasibility of FAME included collaborating with local professionals and using the FAME manual. Factors limiting feasibility included constraints in time, attendance, and physical space.

Evaluations, Family Functioning, and Distress

A small group of participants took part in all measurements. Several participants stated that they had appreciated gathering with multiple families. Although not all participants noted an impact of FAME, some had developed new coping strategies and were more aware of the impact of stress on their child(ren). The quantitative results offer an indication that FAME might coincide with a decrease in anxiety and depression. However, only one of the participants reported a statistically significant improvement in family functioning. This might be an indication that FAME, in its current form, has a limited impact on the improvement of family functioning in asylum seeker families.

Methodological Challenges

Several methodological challenges arose during the implementation and evaluation of FAME. As challenges in the recruitment, inclusion, and retention of families were anticipated, several measures were planned to limit the impact of these challenges, as described in the published study protocol (Van Es et al., 2019). For example, an introduction session was offered to inform families about FAME and to exchange mutual expectations, as suggested by Asen and Scholz (2010). In addition, trainers and interpreters went door to door to invite families to take part prior to each session. Researchers visited the living locations on multiple occasions to offer participants several opportunities to take part in the measurements. However, some challenges could not be overcome, such as participants facing deportation, families relocating, and new families moving into the center.

Implementation Challenges

Trainers noted that they found it difficult to compromise between adhering to the study protocol and deviating from the protocol to adjust to the families' needs. Although higher program adherence is expected to lead to better outcomes, several studies have indicated

that some adaptions to a program can lead to more positive program evaluations and better outcomes possibly because trainers adapt the program to the participants needs (Kösters et al., 2017; Durlak & DuPre, 2008). Studying program integrity as well as program outcomes could shed light on whether adaptations have led to more positive evaluations and outcomes (Perepletchikova & Kazdin, 2005; Perepletchikova et al., 2009). Unfortunately, this study does not allow for drawing any conclusions on the impact of program integrity on program outcomes because of the small sample size and low response rate.

Deviations from the protocol in this study were mostly due to the absence of children and trainers taking time to address themes brought up by participants. Parents and trainers were often hesitant to discuss certain sensitive topics in the presence of the children. Other studies describing multifamily therapy have addressed this issue by conducting separate groups for parents and children, for example, only including the children at the start and end of each session (Fristad et al., 2009). Calvo et al., (2014) noted that it is more suitable to offer parallel groups to adolescents and their parents, as adolescents face developmental challenges such as differentiation from their parents. Therefore, a clear explanation should be offered on why children are invited, worries that parents have concerning the attendance of their children should be addressed, and parents should be involved in deciding whether or not to invite the children.

Asylum seeker families face several continuous stressors, such as uncertainty, concerning their asylum status and financial difficulties. Fazel and Betancourt (2018) stated that, as a result, it might be difficult to prioritize other concepts such as mental health. Although several participants found FAME useful, some added that FAME could not address these important continuous stressors, as the program does not offer any practical solutions. This finding highlights the importance of managing expectations (FAME does not offer practical solutions) and offering clear psycho-education (FAME aims to offer ways to cope with worries and stress caused by the problems). When offering a program to refugee families, it is important to assess whether key elements of the program match the needs of the families (Weine, 2011). FAME addresses families' needs in a culturally sensitive, flexible manner. However, for some families, FAME might not be offered at the right time, as other priorities, such as moving house and asylum procedures, require their attention.

Limitations

Several limitations of the study must be noted. Firstly, because of the small sample and low response rate, we cannot draw conclusions about the effectiveness of FAME. Secondly, we were not able to explore why two groups discontinued after the introduction session. Thirdly, social desirability bias may have occurred due to (co-)trainers conducting the follow-up interviews/focus groups. Finally, to our knowledge, no standardized and culturally appropriate measures exist to assess family functioning in the wide range of cultural backgrounds of the study participants. There is a need for the development of culturally sensitive assessments of family processes (Weine et al., 2008).

Recommendations

When planning an intervention in the context of trauma and resettlement, several challenges will exist. As Weine (2011) stated: "The required efforts would be substantial, but then so would the pay-offs" (p. 426). Our findings indicate several implications and recommendations for the implementation of FAME. Firstly, we recommend collaborating with local professionals, who can offer information on how to address families, can aid with inviting and motivating families to join the introduction session, and can be trained to offer FAME themselves. Moreover, to improve the feasibility of FAME, several conditions should preferably be met when selecting locations, including sufficient space, time, and a minimum number of participating families. Attendance rates can be improved by ensuring that there is a match between the needs of the asylum seeker families and the aims of FAME. The implementation of FAME can be improved by putting more emphasis on psycho-education and explaining more clearly why a certain group is invited to participate, why FAME is offered, and why parents as well as children are asked to participate. Finally, flexibility in meeting families' needs will likely contribute to higher retention.

Recommendations for future research include flexibility in research methods to accommodate challenges inextricably linked to the conducting research with asylum seekers in the setting of asylum centers. We made several adaptations to the original research protocol to increase the feasibility of the study. Because of the language barrier, we preferred using the more visual child version of the SRS for studying parents' evaluations of therapeutic alliance. We also decided not to use videotapes, as participants might be hesitant to give their permission to use these measurements. In addition, the feasibility of a pre–post-test design is highly impacted by offering an open group where families can join FAME in a later session or have to stop early because of relocations. Offering a program to a group of culturally diverse refugee families in resettlement calls for modifications in response to learned lessons and contextual changes (Weine, 2011). Future studies should include qualitative measures in order to give room to participants' voices and increase our understanding on whether and how FAME addresses their needs. By using qualitative data, researchers can explore whether other factors asylum seeker families are faced with, such as news concerning the asylum procedure or stress concerning relocations, have an impact on the outcomes.

Conclusion

Few studies have focused on the evaluation of multifamily programs for asylum seekers families (Slobodin & de Jong, 2015), and to our knowledge, this is the first to evaluate the feasibility of a multifamily program designed specifically for asylum seeker families in the Netherlands. Several challenges to the feasibility of the implementation and evaluation of FAME were encountered. When offering a preventive family-focused program, we advise to (a) invest in the practical organization of the group whilst also allowing flexibility to address families' specific needs; (b) offer clear expectation management and psycho-education; and

(c) evaluate the group in an accessible manner, allowing flexibility in the assessments, as it concerns a preventive, open group that is prone to contextual changes.

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REFERENCES

Allen, J. G., Fonagy, P., & Bateman, A. W. (2008). *Mentalizing in clinical practice*. American Psychiatric Publisher.

Asen, E. (2002). Multiple family therapy: An overview. *Journal of Family Therapy, 24*(1), 3–16. https://doi.org/10.1111/1467-6427.00197

Asen, E., & Scholz, M. (2010). *Multi-family therapy: Concepts and techniques*. Routledge.

Ballard, J., Wieling, E., & Forgatch, M. (2017). Feasibility of implementation of a parenting intervention with Karen refugees resettled from Burma. *Journal of Marital and Family Therapy, 2*(44), 220–234. https://doi.org/10.1111/jmft.12286

Bateman, A., & Fonagy, P. (2013). Mentalization-based treatment. *Psychoanalytic Inquiry, 33*(6), 595–613. https://doi. org/10.1080/07351690.2013.835170

Betancourt, T. S., & Khan, K. T. (2008). The mental health of children affected by armed conflict: Protective processes and pathways to resilience. *International Review of Psychiatry, 20*(3), 317–328. https://doi.org/10.1080/09540 260802090363

Biringen, Z. (2008). *The emotional availability (EA) scales and the emotional attachment & emotional availability (EA2) clinical screener: Infancy/ early childhood version; middle childhood/youth versions; therapist/interventionist manual; couple relationship manual.* http://emotionalavailability.com

Calvo, A., Moreno, M., Ruiz-Sancho, A., Rapado-Castro, M., Moreno, C., Sánchez-Gutiérrez, T., Arango, C., & Mayoral, M. (2014). Intervention for adolescents with early-onset psychosis and their families: A randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 53*(6), 688–696. https://doi. org/10.1016/j.jaac.2014.04.004

Carroll, C., Patterson, M., Wood, S., Booth, A., Rick, J., & Balain, S. (2007). A conceptual framework for implementation fidelity. *Implementation Science, 2,* 40. https://doi.org/10.1186/1748-5908-2-40

Centraal Orgaan opvang asielzoekers. (2020). *Jaarverslag 2019*. Centraal Orgaan opvang asielzoekers.

Duncan, B. L., Miller, S. D., Sparks, J. A., Claud, D. A., Reynolds, L. R., Brown, J., & Johnson, L. D. (2003). The Session Rating Scale: Preliminary psychometric properties of a "working" alliance measure. *Journal of Brief Therapy, 3*(1), 3–12.

Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology, 41*(3-4), 327–350. https://doi.org/10.1007/s10464-008-9165-0

El-Khani, A., Maalouf, W., Baker, D. A., Zahra, N., Noubani, A., & Cartwright, K. (2020). Caregiving for children through conflict and displacement: A pilot study testing the feasibility of delivering and evaluating a light touch parenting intervention for caregivers in the West Bank. *International Journal of Psychology, 55*, 26–39. https:// doi.org/10.1002/ijop.12591

Fazel, M., & Betancourt, T. S. (2018). Preventive mental health interventions for refugee children and adolescents in high income settings. *The Lancet Child & Adolescent Health, 2*(2), 121–132. https://doi.org/10.1016/s2352-4642(17)30147-5

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(*9812), 266–282. https://doi.org/10.1016/ s0140-6736(11)60051-2

Fristad, M. A., Verducci, J. S., Walters, K., & Young, M. E. (2009). Impact of multifamily psychoeducational psychotherapy in treating children aged 8 to 12 years with mood disorders. *Archives of General Psychiatry, 66*(9), 1013– 1021. https://doi.org/10.1001/archgenpsychiatry.2009.112

Hamilton, E., Carr, A., Cahill, P., Cassells, C., & Hartnett, D. (2015). Psychometric properties and responsiveness to change of 15-and 28-item versions of the SCORE: A family assessment questionnaire. *Family Process, 54*(3), 454– 463. https://doi.org/10.1111/famp.12117

Immigration and Naturalisation Service (2019). *Asylum trends—Monthly reports on asylum applications in The Netherlands*. https://ind.nl/Documents/AT_2019.pdf

Jacobson, N. S., & Truax, P. (1992). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*(1), 12–19. https://doi. org/10.1037/0022-006X.59.1.12

Kim, H. W., Shin, C., Lee, S. H., & Han, C. (2021). Standardization of the Korean version of the patient health questionnaire-4 (PHQ-4). *Clinical Psychopharmacology and Neuroscience, 19*(1), 104–111. https://doi.org/10.9758/ cpn.2021.19.1.104

Kliem, S., Moessle, T., Klatt, T., Fleischer, S., Kudlacek, D., Kröger, C., Brähler, E., Beutel, M. E., & Wiltink, J. (2016). Psychometric evaluation of an Arabic version of the PHQ-4 based on a representative survey of Syrian refugees. *Psychotherapie,*

Psychosomatik, Medizinische Psychologie, 66(9–10), 385–392.

Kösters, M. P., Chinapaw, M. J., Zwaanswijk, M., Van der Wal, M. F., Utens, E. M., & Koot, H. M. (2017). Friends for life: implementation of an indicated prevention program targeting childhood anxiety and depression in a naturalistic setting. *Mental Health & Prevention, 6,* 44–50.

Mooren, G. T. M., & Bala, J. (2016). *Goed ouderschap in moeilijke tijden: Handleiding voor meergezinsgroepen met vluchtelingen*. Pharos.

Perepletchikova, F., Hilt, L. M., Chereji, E., & Kazdin, A. E. (2009). Barriers to implementing treatment integrity procedures: Survey of treatment outcome researchers. *Journal of Consulting and Clinical Psychology, 77*(2), 212. https://doi.org/10.1037/a0015232

Perepletchikova, F., & Kazdin, A. E. (2005). Treatment integrity and therapeutic change: Issues and research recommendations. Clinical Psychology: *Science and Practice, 12*(4), 365–383. https://doi.org/10.1093/clipsy.bpi045

Rohner, R. (2004). The parental "acceptance-rejection syndrome": Universal correlates of perceived rejection. *American Psychologist, 59*(8), 830. https://doi.org/10.1037/0003-066X.59.8.830

Sangalang, C. C., Jager, J., & Harachi, T. W. (2017). Effects of maternal traumatic distress on family functioning and child mental health: An examination of Southeast Asian refugee families in the US. *Social Science & Medicine, 184*, 178–186. https://doi.org/10.1016/j.socscimed.2017.04.032

Slobodin, O., & de Jong, J. (2015). Family interventions in traumatized immigrants and refugees: A systematic review. *Transcultural Psychiatry, 52*(6), 723–742. https://doi.org/10.1177/1363461515588855

Stewart, M., Dennis, C.-L., Kariwo, M., Kushner, K. E., Letourneau, N., Makumbe, K., Makwarimba, E., & Shizha, E. (2015). Challenges faced by refugee new parents from Africa in Canada. *Journal of Immigrant and Minority Health, 17*(4), 1146–1156. https://doi.org/10.1007/s10903-014-0062-3

Stratton, P., Bland, J., Janes, E., & Lask, J. (2010). Developing an indicator of family function and a practicable outcome measure for systemic family and couple therapy: The SCORE. *Journal of Family Therapy, 32*(3), 232–258. https:// doi.org/10.1111/j.1467-6427.2010.00507.x

Stratton, P., Lask, J., Bland, J., Nowotny, E., Evans, C., Singh, R., Janes, E., & Peppiatt, A. (2014). Detecting therapeutic improvement early in therapy: Validation of the SCORE-15 index of family functioning and change. *Journal of Family Therapy, 36*(1), 3–19. https://doi.org/10.1111/1467-6427.12022

Thomas, D. R. (2003). A general inductive approach for qualitative data analysis. *American Journal of Evaluation, 27*, 237.

UNHCR. (2013). *UNHCR global appeal 2013 update*. https://www.UNHCR.org/50a9f81ca.pdf

Utržan, D. S., & Wieling, E. A. (2020). A phenomenological study on the experience of Syrian asylum-seekers and refugees in the United States. *Family Process, 59*(1), 209–228. https://doi.org/10.1111/famp.12408

Van Ee, E., Kleber, R. J., Jongmans, M. J., Mooren, T. T., & Out, D. (2016). Parental PTSD, adverse parenting and child attachment in a refugee sample. *Attachment & Human Development, 18*(3), 273-291.

Van Es, C. M., Mooren, T., Zwaanswijk, M., Te Brake, H., & Boelen, P. A. (2019). Family Empowerment (FAME): study protocol for a pilot implementation and evaluation of a preventive multi-family programme for asylum-seeker families. *Pilot and Feasibility Studies, 5*(1), 1-9.

Van IJzendoorn, M. H., & Sagi-Schwartz, A. (2008). Cross-cultural patterns of attachment: Universal and contextual dimensions. In J. C. P. R. Shaver (Ed.), Handbook of attachment: Theory, research, and clinical applications (pp. 880–905). The Guilford Press.

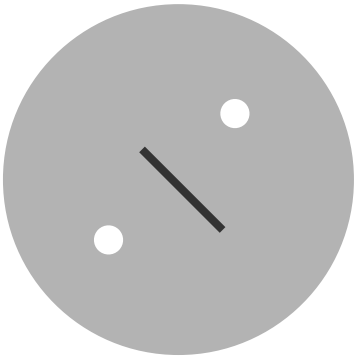
Weine, S. M. (2011). Developing preventive mental health interventions for refugee families in resettlement. *Family Process, 50*(3), 410–430. https://doi.org/10.1111/j.1545-5300.2011.01366.x

Weine, S., Kulauzovic, Y., Klebic, A., Besic, S., Mujagic, A., Muzurovic, J., Spahovic, D., Sclove, S., Pavkovic, I., Feetham, S., & Rolland, J. (2008). Evaluating a multiple-family group access intervention for refugees with PTSD. *Journal of Marital and Family Therapy, 34*(2), 149–164. https://doi.org/10.1111/j.1752-0606.2008.00061.x

Weine, S. M., Raina, D., Zhubi, M., Delesi, M., Huseni, D., Feetham, S., Kulauzovic, Y., Mermelstein, R., Campbell, R. T., Rolland, J., & Pavkovic, I. (2003). The TAFES multi-family group intervention for Kosovar refugees: A feasibility study. *The Journal of Nervous Mental Disease, 191*(2), 100–107. https://doi.org/10.1097/01.NMD.00000 50938.06620.D2

PART II

Unaccompanied Refugee Minors



5

Eritrean unaccompanied refugee minors in transition: A focused ethnography of challenges and needs

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ABSTRACT

In the Netherlands, the largest group of unaccompanied refugee minors originates from Eritrea. These minors have been exposed to several distressing events and face psychosocial challenges and drastic changes within their social-ecological environment upon arrival in the Netherlands. The current study explored challenges and needs of Eritrean unaccompanied refugee minors and their caregivers. We conducted a focused ethnography among Eritrean minors (N = 18) and their professional caregivers (N = 15). A thematic content analysis revealed the following themes to be central in the daily lives of Eritrean unaccompanied refugee minors: (a) relationships, (b) psychological stress, (c) preparation for independent living, (d) spirituality, and (e) leisure activities. Each theme was linked to key challenges, including minors finding their way without their parents, family reunification, and worries about the wellbeing of their relatives. These uncovered themes provide implications for future research and policy to improve the guidance, care, and support for these minors. The current study suggests that to promote their development and functioning, future training and programs should aim to strengthen the relationship of unaccompanied refugee minors and their professional caregivers.

Keywords

Unaccompanied Refugee Minors; Eritrea; Challenges; Needs; Focused Ethnography; Relationships; Psychological Stress; Preparation for Independent Living; Spirituality; Leisure Activities.

INTRODUCTION

Every year, thousands of unaccompanied refugee minors (URMs)—children and adolescents who have been separated from their parents and relatives—flee their home country (Separated Children in Europe Programme, 2004). In 2016, the largest group of URMs in the Netherlands originated from Eritrea, making up approximately one-third of all 5678 URMs resettled in the Netherlands (Pharos, 2017). The United Nations have documented gross violations of human rights in Eritrea, including an open-ended military service and torture in prisons (United Nations General Assembly, 2016). As a result of the current situation in Eritrea, the majority of the asylum applications of Eritrean refugees (96.1%) are granted by the Dutch government (VluchtelingenWerk Nederland, 2017). Several healthcare professionals have expressed their concerns about the societal functioning and health of Eritrean minors (Sleijpen, Van Es, Te Brake, & Mooren, 2018; Van Beelen, 2016).

Previous to arriving in their host country, most Eritrean URMs have experienced many distressing events that have altered their lives drastically. For example, they often depend on human traffickers during their flight and are prone to sexual violence and torture (Ministry of Foreign Affairs, 2015; Van Beelen, 2016; Van Reisen, 2016). Moreover, URMs are subject to a dramatic change within their social-ecological context, including changes of school, church, and political and cultural environment (Betancourt & Khan, 2008; Bronfenbrenner, 1979). When resettling in a new country, URMs can be faced with several stressors and psychosocial challenges. For example, they are confronted with acculturation hassles, such as problems with communicating in a new language, discrimination, and economic strains (Keles, Friborg, Idsøe, Sirin, & Oppedal, 2018). Additionally, the adverse experiences refugee minors have been exposed to before and during their flight can undermine their trust in other people. Moreover, they face an insecure future, which might result in feelings of powerlessness (Sleijpen, Mooren, Kleber, & Boeije, 2017).

Population-based quantitative studies carried out in Europe suggest that URMs are at an increased risk of developing internalizing problems and traumatic stress reactions (Bean, Derluyn, Eurelings-Bontekoe, Broekaert, & Spinhoven, 2007a; Derluyn, Mels, & Broekaert, 2009). Huemer et al. (2009) concluded, based on a review on mental health issues in URMs, that these minors form a highly vulnerable group with a higher level of posttraumatic stress symptoms than the general population. An explanation for this increased risk is that in addition to having experienced disruptive events, URMs have been separated from their parents and other caretakers and relatives (Derluyn & Broekaert, 2008). There is evidence that an absent or negative parent–child relationship can have a detrimental impact on the wellbeing of children and adolescents exposed to distressing experiences (Bean et al., 2007a; Luthar & Goldstein, 2004; Pine, Costello, & Masten, 2005).

It is important to study needs of URMs as they adjust to their new lives and how support systems and living arrangements can meet these needs (Carlson, Cacciatore, & Klimek, 2012). Studies indicate that the postimmigration living situation of URMs has an impact on

the wellbeing of these minors (Derluyn & Broekaert, 2008; Kalverboer et al., 2017).

Although URMs in the Netherlands are subjected to the same asylum procedure as adult refugees, they have additional rights to education and guidance. The Nidos Foundation, a family guardian organization, appoints a guardian to the URMs. These guardians act in loco parentis and seek to ensure that the URMs receive the care, upbringing, and education they need. In the Netherlands, URMs are often placed in a children's living group. Such groups house approximately 12 URMs, age 14–18. They are supervised 24 hours a day by mentors who support the youths in their activities of daily living such as cooking and going to school. As the living arrangement in which the URMs are placed likely affects their wellbeing, it is of interest to explore how their needs can be met by professional caregivers, such as mentors and guardians.

Many studies on refugees and URMs to date have focused predominantly on mental health problems (e.g., Fazel, Reed., Panter-Brick, & Stein, 2012; Huemer et al., 2009). There is limited knowledge about other aspects of their functioning, such as their societal participation and relationship with others. Several authors promote moving away from mental health problems as the primary focus (Betancourt & Khan, 2008; Huber et al., 2011, 2016; Sleijpen, Ter Heide, Mooren, Boeije, & Kleber, 2013). Accordingly, during this study we aim to follow the direction of the participants by applying the participatory learning and action approach (Kindon, Pain, & Kesby, 2007). In this approach, all participants are regarded as collaborators in research and are allowed to control the direction of the focus groups. Moreover, the questions asked during this study focus on a broader understanding of functioning, based on the domains of positive health defined by Huber et al. (2016). Finally, to obtain a broader and more informative understanding of the lives of URMs, we include multiple informants (Bean et al., 2007a; Bean, Eurelings-Bontekoe, & Spinhoven, 2007b). We interpret the findings in light of the social-ecological context of the URMs (Betancourt & Khan, 2008; Bronfenbrenner, 1979). The social-ecological model allows us to understand the dynamic relations between different factors playing a role in the lives of URMs, including individual factors, relationships with the immediate environment such as their guardians and mentors, family networks outside the Netherlands, and cultural and societal factors.

The current study focused not only on psychopathology but employed a broader perspective on the lives of Eritrean URMs housed in children's living groups as they integrate into Dutch society. The aim of this study was to explore how these youths are best supported to improve their lives in the Netherlands, specifically by (a) identifying key challenges faced by Eritrean URMs living in a children's living group in the Netherlands and (b) exploring their needs to overcome these challenges. This information will increase our knowledge on how to improve the guidance, care, and living conditions for these youths during their transition to adulthood. Moreover, this study emphasizes the need for culturally sensitive approaches to education, and mental health care addressing the highly specialized mental health issues of these URMs. We present the perspectives of both minors and their caregivers to determine differences and similarities in their concerns. To

achieve the study aims, we held focus groups with URMs and individual interviews with their mentors and guardians.

METHODS

Participants

Nidos selected, from throughout the Netherlands, children's living groups with more than five Eritrean URMs. Eritrean URMs between 14 and 18 years of age were included. Exclusion criteria were (a) cognitive impairment preventing the participant from comprehending the procedure and (b) resistance by the URM, as defined by the code of conduct involving minors (Central Committee on Research involving Human Subjects, 2002). Two locations with male minors and one location with female minors were selected. A total of 18 Eritrean minors between 16 and 17 years old took part in the focus groups. The native language of all Eritrean minors was Tigrinya.

Mentors and guardians who were appointed to the Eritrean minors in the study were asked to participate in individual interviews concerning their experiences with Eritrean URMs. Seven mentors and eight guardians took part in the individual interviews. See Table 1 for the demographic characteristics of the URMs and their mentors and guardians.

Table 1. *Demographic Characteristics of URMs and their Caregivers*

Variable		
Age in years (range (*M*))	Mentors	24–48 (35.4)
	Guardians	28–37 (32.1)
	Eritrean URMs	16–17*
Sex (% female)	Mentors	57%
	Guardians	75%
	Eritrean URMs	39%
Months of work experience (range (*M*))	Mentors	5–180 (53.6)
	Guardians	3–42 (12.5)
Months of work experience with Eritrean URMs (range (*M*))	Mentors	5–24 (12.4)
	Guardians	3–24 (8.8)
Number of pupils (range (*M*))	Mentors	7–12 (9.2)
	Guardians	17–22 (20.3)

Note. The guardians and mentors worked 24–36 hours a week.
*Although we confirmed that all URMs were 16 or 17 years of age, we did not register the age of each individual.

Method

To develop a clear understanding of the perspectives of this specific group of minors, guardians, and mentors, researchers carried out a focused ethnography. Focused ethnographies aim to study a subcultural group in a specific context, drawing from intensive methods of data collection, such as interviews, focus groups, and observations (Roper

& Shapira, 2000; Wall, 2014). The topic guide for the focus groups and the interviews in this study was drawn from the definition of health by Huber et al. (2016), which entails six dimensions: bodily functions, mental functions and perception, spiritual/ existential dimension, quality of life, social and societal participation, and daily functioning. Questions for the minors included "Do you have any physical issues or complaints?" and for the caregivers "What role does religion/spirituality play in the lives of these URMs?"

The topic guide was adapted further after a literature search and brainstorm sessions with participating researchers, resulting in the final topic guide. Added questions for the minors included "What challenges do you face?" and "How do you deal with these challenges?" and questions for the caregivers included "What is going well in your work with Eritrean URMs?" and "What helps you in building a trusting relationship with Eritrean URMs?" During the focus groups and individual interviews the researcher allowed participants to control the direction of the discussion while using the topic guide to inquire about issues that had not been raised.

The focus groups with the minors were based on the participatory learning and action approach, which aims to involve refugees who are considered hard to reach in qualitative research (Kindon et al., 2007). The first questions for the minors in the focus group were: "What do you do during a day?" and "What activities do you enjoy doing?" The purpose of these broad, open questions was to allow minors to have control over the direction of the focus groups. Cultural mediators—Eritrean men and women close to the minors in age and experience, and familiar with Dutch as well as Eritrean society and culture—were selected and trained to work with URMs by researchers. They not only aided in translating to and from Tigrinya, but also substantially aided in bridging the cultural gap.

Semi-structured interviews with mentors and guardians were conducted. Firstly, demographic information was collected. Subsequently, the caregivers were asked to describe an average day of work as a guardian or mentor. Similar to the focus groups with the minors, the caregivers controlled the direction of the interview.

Procedure

The interviews, the transcription, and the data analysis took place between May 2016 and January 2017. To assure data integrity and compliance to ethical and juridical aspects, the study protocol was submitted to the accredited Medical Ethics Committee of the University Medical Center Utrecht (protocol number 16-257/C). This committee judged that the study did not fall under the scope of the Medical Research Involving Human Subjects Act as the current study does not threaten the psychological or physical integrity of the minors.

Managers, guardians, and mentors of three children's living groups were offered written and oral information about the study. All granted permission to approach the URMs. Next, all URMs received written and oral information and were asked to take part in the focus group. It was explained that participation was voluntarily and that all information would be handled anonymously. All of the approached minors consented to take part in the study, and written

informed consent was obtained.

In total, nine focus groups—three focus group sessions for each of the three children's living groups—took place in the living room of the minors. An average of five minors took part in each group. Each session lasted approximately three hours. The aim of the first session was to get acquainted with the minors and ask about their daily lives. The second and third sessions were meant to elaborate upon topics that emerged during the first session and to ask the minors about challenges and how they cope with these challenges. During the third session, member-checking was conducted by presenting the themes we uncovered in the focus groups, written on a poster in Tigrinya and Dutch. We presented our conclusions and asked whether the minors agreed on our findings, and whether we had missed anything. For example, one group stated they agreed with our conclusions, however they emphasized the importance of sports. The focus groups were led in Dutch or English by two of the current authors CvE and MS. Consequently, the questions were translated to Tigrinya by a cultural mediator. Minors answered the questions in Tigrinya, which was then translated to Dutch or English by the cultural mediator. A note-taker carefully took minutes and field notes during the focus groups. The focus groups were not audio-recorded to avoid that URMs felt inhibited in speaking freely.

In total, 15 individual interviews were conducted. Seven mentors were asked to take part in individual interviews that took place at the children's living group. Eight guardians participated in interviews over the telephone. Informed consent of the guardians and mentors was obtained. Semi-structured interviews were conducted in Dutch by a researcher and lasted approximately one hour. All interviews were tape-recorded and transcribed.

The focus groups and individual interviews were conducted by European, white researchers with experience working with refugee minors and trained in cross-cultural work. However, the background of the researchers might have caused bias in the formulation of the research questions and the conclusions made based on the gathered data. In order to deal with this potential bias and focus on a Western perspective, we included researchers and cultural mediators from Eritrea in the process of defining the research questions and interpreting the research data.

Data Analysis

Identifiable information in the transcripts, minutes, and field notes, such as names and cities, was substituted for codes. The data were imported into MAXQDA 10 (VERBI). Researchers used thematic content analysis (Burnard, 1991; Burnard, Gill, Stewart, Treasure, & Chadwick, 2008) in this study, beginning simultaneously with the start of the data collection.

First, one of the authors (CvE) performed open coding. This involved reading the transcripts and minutes thoroughly and coding the data line by line, resulting in a list of codes and memos with ideas and reflections concerning the study. A second coder (MS) independently open-coded three interviews of the minors, mentors, and guardians. The two researchers (CvE and MS) discussed the list of codes until they reached consensus on

a list of codes.

Second, brainstorm sessions with four researchers (CvE, MS, TM and HtB) focused on organizing the codes (text fragments). Based on these sessions, different themes were distinguished. Finally, each transcript was worked through, and text fragments were allocated to the themes, resulting in an organized dataset.

After interviewing six guardians, six mentors and conducting focus groups with 11 minors, data saturation was achieved, indicated by key concepts recurring during interviews and focus groups with no new themes emerging.

RESULTS

Based on the focus groups with the URMs and the interviews with the caregivers, five main themes emerged: (a) relationships, (b) psychological stress, (c) preparation for independent living, (d) spirituality, and (e) leisure activities. Following is a discussion of the themes from the perspectives of the URMs and their caregivers. Challenges and needs identified by the URMs and their caregivers are summarized in Table 2.

Table 2. *Challenges and Needs of Eritrean URMs and their Caregivers*

Themes		
Relationship	*Challenges*	Distrust; language barrier; uncertainty about roles of caregivers
	Needs	Continuity in contact; information concerning decision-making; possibility to call in a cultural mediator
Psychological stress	*Challenges*	Experienced distressing events; worries about family and family reunification procedure; financial situation; stress-related complaints; barriers to mental health care
	Needs	Clarity concerning the family reunification procedure; expertise around screening, monitoring, and referring to mental health care
Preparation to independent living	*Challenges*	Little contact with Dutch people; language barrier; cultural inclination toward being shy; tight community; limited time until age 18
	Needs	Expanding of the social network in the Netherlands; care after turning 18
Spirituality	*Challenges*	Friction between URMs and caregivers concerning religion; spirit possession; cultural gap
	Needs	Healthy balance between religious activities and other activities; knowledge of Eritrean culture; information and education for the minors about Dutch culture and difficult topics (e.g., sexuality and stress) corresponding with their perceptions and culture reference framework
Leisure activities	*Challenges*	Few organized activities; little motivation for partaking in activities and little own initiative; lack of financial resources
	Needs	Attunement concerning activities; tips for motivating the minors to participate in organized activities; knowledge of possibilities to increase the available budget

Note. There is interaction and overlap between the themes.

Relationships

URMs

When asked about building a trusting relationship with their caregivers, the youths identified several challenges: (a) sparse contact moments with their guardians, (b) not feeling heard or helped by their caregivers, (c) uncertainty about whom to turn to with their questions, as they often were referred to another caregiver, (d) the language barrier, and (e) lack of insight into the decision-making process of their caregivers. For example, several URMs explained that they often heard that URMs in other living groups had privileges such as being able to join a sports club.

Most youths added that they also had difficulty trusting other people in general, and they had few or no social contacts outside the Eritrean community. They stated they were shy and not used to make appointments with friends, which complicated engaging in social contact with Dutch peers. Moreover, the youths often had issues trusting interpreters as they thought the interpreters were not translating well.

> *A good mentor answers all your questions, or if they do not have the answer, they let you know who they are going to ask the questions to and try to get an answer to your questions in this way. Some mentors give us short answers and try to push away what we ask of them. That is not good. (Eritrean URM)*

> *We do not trust the interpreters. When a guardian asks about a document and we say we are not able to obtain it, the interpreter will tell us we have to obtain it. If we try to explain to the interpreters that we are not able to obtain the documents, they tell us: Nidos says you should get it, so you should. They do not explain Nidos what we are saying, so the guardian does not hear what we have to say. (Eritrean URM)*

Caregivers

Although eight caregivers encountered challenges in establishing a trusting relationship with Eritrean URMs, eight others felt they had developed a trusting relationship with the youths, as the youths increasingly involved them in their lives. Mentors described multiple ways to establish a trusting relationship, such as doing something for the youths (n = 4) and displaying genuine interest (n = 2). Guardians emphasized the importance of doing what you say and saying what you do (n = 6). Many guardians (n = 6) used Whatsapp to keep in touch with the youths between appointments. Most caregivers (n = 9) stated the language barrier challenged communication with the youths. Some guardians (n = 4) had the impression that interpreters did not translate adequately.

The caregivers addressed their needs, explaining the necessity of knowledge on Eritrean culture, for example through a training focusing on this subject or aided by cultural mediators. Moreover, several caregivers emphasized the necessity of transferring

knowledge on important themes, such as sexuality and stress, to the youths.

> *If you see your pupil for the first time, I think the only thing you can do is to show you keep to your agreements, so you can build trust, and the practical issues that are important to them at that time, to fix those and to show you can do that. And to keep to your word, then trust comes naturally and if you have trust you can talk about other things. (Guardian)*

Psychological Stress

URMs

All youths described several current sources of stress. Family reunification procedure was their biggest source of stress, as they often found the procedure unclear, they had to wait for long periods of time, it was difficult to obtain documents required for the procedure, and they had little time to discuss the procedure with their guardian. Moreover, a lack of financial resources caused distress on many levels. For example, youths were unable to distribute money to loved ones or human traffickers. Youths also expressed their worries about the wellbeing of their family members. They found it difficult to inform their family about the family reunification procedure and added that they were afraid their family members would flee their country upon hearing bad news about the procedure. They explained that they considered the flight from Eritrea as extremely dangerous and distressing.

As a result of these stressors, most youths suffered from mental health complaints, including difficulties with sleeping and emotion-regulation. For example, one youth stated he acted aggressive toward his guardian after hearing negative news concerning the family reunification procedure. Moreover, most youths said that stress caused problems at school, including trouble concentrating. When asked how they dealt with these stressors, most youths cited the following coping strategies: religion and praying, talking to friends they trust, and staying in bed. Some youths said that walking, playing sports, working, and listening to music helped them cope with stress.

> *I: Don't you have stress about yourself or other things?*
> *P: No, only about our families. Why would we stress about ourselves; we are here and can take care of ourselves. (Eritrean URM)*

> *The school does not really give us stress. But because we have to think about so many things, it is difficult to pay attention and process everything. [...] Since I am here, nothing changed about the situation, since then I have not been making the progress I did before. My ability to memorize, remember and recall is less good. If someone tells me something, I forget it quickly. (Eritrean URM)*

Caregivers

The caregivers named similar sources of stress, such as family reunification (*n* = 12), worries about family members in Eritrea or those who embarked on their flight (*n* = 11), and money (*n* = 6). Almost all caregivers (*n* = 14) stated that in addition to current stressors, URMs probably have experienced traumatic events, for example, during their flight from Eritrea to the Netherlands. Caregivers noted that because of distressing events and circumstances, youths developed sleeping issues (*n* = 6), problems at school (*n* = 4), and aggression (*n* = 3).

When asked if Eritrean URMs would benefit from trauma-focused treatment, eight caregivers said they felt that would help the youths. Nevertheless, an equal number of caregivers observed barriers to treatment, such as taboos concerning health care and the probability that Western health care would not correspond with their needs and culture.

> *Concerning family reunification. It is very unclear to us, something changes every week. […] If it is unclear to us, then it is unclear to the youngsters for sure, then you can't explain it properly. (Guardian)*

Preparation for Independent Living

URMs

All youths highly valued school and learning the Dutch language, and they explained that this was important to be able to live independently. All youths tried to participate in Dutch society by undertaking activities, such as sports. The youths cited barriers to engaging with Dutch youths including the language barrier, culture differences, and their living circumstances, taking into account that they lived and went to school with other refugees.

All youths said that activities of daily living, such as cooking and going to school, were going well. The youths were worried about living independently without their parents when they would turn 18, and they were unable to indicate what they needed to live independently at that age.

> *I: Do you find it difficult to live in the Netherlands, with all its authorities and rules?*
> *P: If we learn the language well, I don't think it's that difficult. (Eritrean URM)*

> *I: Do you participate in the Dutch society?*
> *P: Not yet. It is difficult to get in touch with Dutch people. Sometimes they even ignore an outstretched hand.*
> *I: And in school?*
> *P: There's only refugees. (Eritrean URM)*

Caregivers

Seven caregivers said this group of Eritrean youths valued school, with several caregivers describing the youths as disciplined. Most of the caregivers described the youths as independent concerning activities of daily living, such as cooking, cleaning, and going to school, but stated that the youths had more difficulty with tasks such as planning and keeping appointments. Caregivers added that because of this and the language barrier, most youths needed support after turning 18, which currently is not offered in the Netherlands.

Both mentors and caregivers stated that the Eritrean URMs form a tight community in which only Tigrinya is spoken, resulting in difficulties integrating. Half of the caregivers explained that most Syrian minors came from more developed areas than minors from Eritrea. As a result, minors from Eritrea were more likely to have difficulties concerning learning the Dutch or English language, contacting their parents and adapting to the Dutch society. Nine caregivers stated that some URMs did take part in the Dutch society on a limited scale, for example, by doing (volunteer) work and by celebrating Dutch festivities.

> *Some youngsters only arrived in the Netherlands when they were 17 years old. To learn the Dutch language, learn how the Dutch society works, and learn how all the organizations work, that is too much. (Guardian)*

Spirituality

URMs

For most of the youths, their religion, the Eritrean-Orthodox Tewahedo Church, was the most important thing in their lives, apart from their family. Some described religion as their only source of hope. Many indicated that they now were spending more time on religion than they did in Eritrea. They explained that they now were older, unable to rely on their parents anymore, and experiencing more stress than in Eritrea. The youths mentioned two main stressors concerning religion: (a) high traveling expenses to go to church and (b) restrictions to carrying out their religion. Several youths stated that their caregivers argued that they were spending too much time on religion, while other youths said it was unclear to them why their time spent on religion was limited.

The topic of spirits was approached by most youths. While some youths believed in spirits but did not have any experience with spirits in their group, others indicated that some of them were possessed. These youths added that when someone is possessed, it helps to read the Bible to them. Some youths addressed the topic of sexuality, stating they did not talk about this subject in their social environment.

> *When we have problems, we pray, because He is the only one who can help us. (Eritrean URM)*

> *I: Do you pray more now than before?*

P: When we were with our parents we did not have any problems, our parents took care of us. Here we have too many problems. I did not go to the church there, but I do here. (Eritrean URM)

Caregivers

Religion played a crucial role in the lives of the youths, according to almost all caregivers (*n* = 14). They noted that the youths pray and go to the church frequently. Several caregivers explained advantages of religion, as it serves as a source of support (*n* = 6) and brings the group together (*n* = 3). An important disadvantage cited by eight caregivers, however, was that the youths spent a great deal of time on religion, interfering with other activities such as learning the Dutch language.

Several caregivers (*n* = 5) had experience with belief in spirit possession. They interpreted this to be a consequence of the youths' traumatic experiences.

I understand that your religion is important, and we really want to support that [...] but to sit in your room all day to write Biblical texts in Tigrinya, that is not the intention. (Mentor)

Leisure Activities

URMs

In their free time, the youths liked to engage in several types of sports such as soccer, cycling, and swimming. Some youths added that during their free time, they watch television, listen to music, or work. Although the youths described several leisure activities, all of them felt they were undertaking too few activities. Three important barriers to undertaking activities were identified: (a) a shortage of money, (b) few activities were organized by the caregivers, and (c) they experienced too much stress to engage in activities.

We slept all summer, because we did not have money and nobody organized anything. (Eritrean URM)

Yes, I like it [doing sports], but if I have stress because of my family or something, I don't want to do sports. (Eritrean URM)

Caregivers

A few guardians undertook activities with the youths, such as going for ice cream, as this allowed them to engage with the youths in a less formal setting. All mentors stated that the youths engaged in sports. Additionally, they described activities they undertake with the youths, such as soccer (*n* = 4) and attending Dutch festivities (*n* = 3). Most mentors (*n* = 5) reported, however, that the youths' lack of motivation to take part in activities functioned as a barrier. They struggled to motivate the youths to join activities they had organized.

Moreover, caregivers indicated that experiencing stress, a shortage of money, and time spent on religion were barriers to engaging in activities.

> *They told us, we do so little, we are at home a lot, but then we organized something and they wouldn't join us. So you stop doing that after a while. (Mentor)*

DISCUSSION

The current study aimed to identify key challenges Eritrean URMs living in children's living groups face and what resources they consider important in dealing with these challenges. The analyses indicated five main themes: (a) relationships, (b) psychological stress, (c) preparation for independent living, (d) spirituality, and (e) leisure activities. Key difficulties and needs were found within these themes. During the study, several strengths of the youths stood out. For example, Eritrean URMs highly value education and learning the Dutch language. Moreover, the youths were independent concerning activities of daily living and formed an important source of social support for one another.

The results suggest that finding their way in Dutch society without their parents, the complex family reunification procedure, and worries about the wellbeing of their parents and relatives are among the most important challenges in the lives of Eritrean URMs. These challenges are exacerbated by several issues, such as language and cultural barriers, and the lack of financial resources. The results indicate that drastic changes in the social-ecological system of Eritrean URMs, and particularly the separation from their parents, has affected their wellbeing (Bean et al., 2007a; Huemer et al., 2009; Vervliet, Lammertyn, Broekaert, & Derluyn, 2014).

The wellbeing of Eritrean URMs is inextricably linked to the socio-ecological system in the Netherlands as well as in Eritrea, as illustrated by the following example: hearing bad news from relatives in Eritrea might lead to stress-related complaints such as aggression and concentration issues, consequently affecting the youths' relationships with others as well as their functioning in school. Moreover, feelings of uncertainty that most likely were initiated during distressing events in their past appear to be aggravated further in the children's living groups. For example, the youths appeared to have limited control in the decision-making process of their caregivers, time they spend on religion, and the organization of activities.

Concerning relationships, prior research emphasized that URMs who are placed in a highly supportive environment, fare best (Kalverboer et al., 2017; Ní Raghallaigh, 2013). This study confirms the need of these youths for supportive and committed care. In addition, the youths added that they need a caregiver who offers them additional guidance, including helping them with practical issues, investing time, and offering continuity. Concerning

psychological stress, in line with prior studies, this study found that these URMs have been exposed to distressing events as well as continuous stressors, and most have developed consequent mental health issues, such as symptoms of traumatic stress (Carlson et al., 2012; Ehntholt & Yule, 2006; Fazel et al., 2012; Huemer et al., 2009; Vervliet et al., 2014). In agreement with earlier research on mental health services for refugee youth, caregivers noted several barriers to psychological interventions similar to those reported in earlier studies, such as the idea that Western approach to trauma-focused interventions may not correspond to the needs of these youngsters (Ellis, Miller, Baldwin, & Abdi, 2011; Majumder, O'Reilly, Karim, & Vostanis, 2015).

URMs in the Netherlands face an abrupt end to childhood and the support of guardians and mentors when they turn 18. These URMs have limited time to develop skills of independent living. Therefore, it is not surprising that these youths experience a great amount of distress concerning their future and living independently at age 18. Similarly, Webb et al. (2017) indicate that young people leaving care can experience environmental and emotional instability, and a lack of support during their transition to adulthood and independence.

Spirituality and religion is considered a common approach to coping with distress in refugee minors (Ní Raghallaigh & Gilligan, 2010; Sleijpen et al., 2017), and Eritrean refugees specifically (Araya, 2001). Some minors noted they spend more time on religion and pray more since they arrived in the Netherlands as a result of the psychosocial challenges they face and the distress they currently experience. Finally, the emphasis placed on leisure activities by the minors and their caregivers is in line with several studies that highlight leisure activities, such as sports, as coping strategies (Cardoso, 2018; Iwasaki, 2003).

The study focused on several perspectives, giving a voice to guardians and mentors, as well as to the minors. Although the various groups roughly shared similar concerns, important differences in perspectives were identified. For example, youths explained that religion offered them considerable support and they often felt limited in carrying out their faith in the Netherlands. Caregivers, however, stated they were searching for a balance between religion and other activities, as they were aware of the importance of religion but realized it limited the time the youths spent on other important activities, such as learning the Dutch language. This example confirms the importance of having multiple informants (Bean et al., 2007a, 2007b) and emphasizes the need for attunement based on mutual intercultural understanding such as offering education for caregivers as well as youngsters to improve intercultural competence (Bates et al., 2005).

According to both the youngsters and their caregivers, Eritrean minors have difficulties trusting others. A possible explanation for this may lie in their past as studies indicate that separation from parents at a young age can have a negative impact on functioning (Bean et al., 2007a; Luthar & Goldstein, 2004; Pine et al., 2005). Several studies have stated that Eritrean children often are separated from their father because of military service (Van Beelen, 2016). Moreover, URMs have been separated from their parents at a young age and can be

exposed to extremely distressing events without being able to rely on their previous network. Studies indicate that problems in the parent–child relationship are associated with several difficulties, including behavioral problems such as aggression and lower social competence (e.g., Erickson, Sroufe, & Egeland, 1985; Jacobsen & Hofmann, 1997; Lyons-Ruth, 1996). Future studies can shed light on this issue by retrospectively studying the (attachment) relationship between URMs and their parents, and how this issue can be addressed.

To expand our knowledge on the functioning of Eritrean URMs, looking beyond mental health problems, we allowed the participants to control the direction of the focus groups and interviews. Moreover, the topic list was based on the definition of health by Huber et al. (2016), which covers dimensions such as quality of life and social participation. By doing so, this study did not only indicate the needs of these youths concerning mental health issues, but also provided a broader understanding of the challenges, needs, and resources of these youths in their daily lives. For example, this offered us insight into their challenges and needs concerning building a trusting caregiver–child relationship.

If the uncovered challenges are not addressed, this can have a negative impact on the integration and functioning of Eritrean URMs in their current context. Therefore, several implications are suggested. Firstly, Eritrean URMs face great challenges concerning their preparation for independent living. In line with Mendes and Snow (2016) we suggest that these vulnerable minors can benefit from residential support and guardianship beyond the age of 18. However, professional caregivers are often limited by the Dutch care system and asylum procedure (Sirriyeh, & Ní Raghallaigh, 2018). This limitation emphasizes the importance of adequate training and supervision of professional caregivers to support the transition of Eritrean URMs into adulthood.

Secondly, the current study underlines the need for culturally sensitive approaches to education. The importance of education for URMs is stressed by several authors (Bates et al., 2005; Bean et al., 2007b), and described as a “passport out of poverty” for care leavers (McNamara, Harvey, & Andrewartha, in press). Education aids the minors in learning the Dutch language, which the minors themselves cite as a prerequisite for living independently in the Netherlands. Improving language competence can result in improved economic integration and access to social resources, and promotes successful integration (Hou & Beiser, 2006).

A third implication concerns the need for more focused attention to the highly specialized mental health issues of Eritrean URMs. The current study emphasizes the importance of transferring knowledge on screening, monitoring, and referring to current caregivers. Moreover, it highlights the need for culturally sensitive interventions that focus on prior distressing experiences as well as continuous stressors. A review of interventions with URMs highlights the importance of teaching and strengthening coping strategies, and suggest this might positively affect mental health (Demazure, Gaultier, & Pinsault, 2017). As very little is known about (preventive) interventions for URMs, future research can provide knowledge on this issue (Demazure et al., 2017; Unterhitzenberger et al., 2015).

Limitations

In this study, focus groups informed our understanding of the youths' perceptions. Although focus groups enabled the discussions to take place, it was difficult for the researchers to discuss certain delicate topics. For example, Eritrean CMs and researchers explained there was a cultural taboo concerning discussing sexuality. To obtain more insight into these issues, it would be of interest to speak to these youngsters individually.

Moreover, the current study focused on Eritrean URMs living in children's living units. As refugee minors in the Netherlands represent more than 100 countries of origin and therefore form a culturally heterogeneous group (Bean et al., 2007a), this focus restricts the generalizability of the findings. To examine if the identified challenges and needs apply to other URMs, it is important to focus future research on URMs with other nationalities and other living conditions.

In addition, the current study did not evaluate individual aspects, such as gender differences, although many individual differences exist even within the Eritrean group of minors. For example, minors from cities may have a higher level of education and more familiarity with modern society than minors from towns; therefore, the former group may have fewer issues adapting to the Dutch (school) system (Van Beelen, 2016; Weine et al., 2013). This finding emphasizes the need for attention on the specific challenges and needs of individuals.

Conclusion

The current study identified themes wherein challenges and needs of Eritrean URMs became apparent. Key challenges included worries about the wellbeing of parents and relatives, the complex family reunification procedure, and concerns about living independently without their caregivers at age 18. As a consequence of exposure to negative events and continuous daily stressors, it is only to be expected that these youths face difficulties adapting to their lives in the Netherlands. To foster optimal development, without ignoring the challenges the youths face, future training and programs should aim to strengthen the caregiver–URM relationship.

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REFERENCES

Araya, B. (2001). *Counseling in an Eritrean context*. Asmara, Eritrea: The Red Sea Press.

Bates, L., Baird, D., Johnson, D. J., Lee, R. E., Luster, T., & Rehagen, C. (2005). Sudanese refugee youth in foster care: The "lost boys" in America. *Child Welfare, 84*, 631–648. Retrieved from http://ovidsp.tx.ovid.com/sp-3.24.1b/ovidweb.cgi?&S= ECADFPMDDKDDECGMNCHKABFBCLMFAA00&Complete+Reference=S.sh.21% 7c1%7c1

Bean, T., Derluyn, I., Eurelings-Bontekoe, E., Broekaert, E., & Spinhoven, P. (2007a). Comparing psychological distress, traumatic stress reactions, and experiences of unaccompanied refugee minors with experiences of adolescents accompanied by parents. *Journal of Nervous and Mental Disease, 195*, 288–297. doi:10.1097/01.nmd.0000243751.49499.93

Bean, T. M., Eurelings-Bontekoe, E., & Spinhoven, P. (2007b). Course and predictors of mental health of unaccompanied refugee minors in the Netherlands: One year follow-up. *Social Science and Medicine, 64*, 1204–1215. doi:10.1016/j.socscimed.2006.11.010

Betancourt, T. S., & Khan, K. T. (2008). The mental health of children affected by armed conflict: Protective processes and pathways to resilience. *International Review of Psychiatry, 20*, 317–328. doi:10.1080/09540260802090363

Bronfenbrenner, U. (1979). Contexts of child rearing: Problems and prospects. American Psychologist, 34, 844–850. doi:10.1037/0003-066X.34.10.844 Burnard, P. (1991). A method of analysing interview transcripts in qualitative research. *Nurse Education Today, 11*, 461–466. doi:10.1016/0260-6917(91)90009-Y

Burnard, P., Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Analysing and presenting qualitative data. *British Dental Journal, 204*, 429–432. doi:10.1038/sj. bdj.2008.292

Cardoso, J. B. (2018). Running to stand still: Trauma symptoms, coping strategies, and substance use behaviors in unaccompanied migrant youth. *Children and Youth Services Review, 92*, 143-152. doi:10.1016/j.childyouth.2018.04.018

Carlson, B. E., Cacciatore, J., & Klimek, B. (2012). A risk and resilience perspective on unaccompanied refugee minors. *Social Work, 57*, 259–269. doi:10.1093/sw/sws003

Central Committee on Research involving Human Subjects. (2002). *Manual for the review of medical research involving human subjects* [Manual]. Retrieved from http://www.ccmo.nl/attachments/files/code-of-conduct-minors.pdf doi:10.1044/1059-0889(2002/er01)

Demazure, G., Gaultier, S., & Pinsault, N. (2017). Dealing with difference: A scoping review of psychotherapeutic interventions with unaccompanied refugee minors. *European Child & Adolescent Psychiatry, 27*, 447–466. doi:10.1007/s00787-017-1083-y

Derluyn, I., & Broekaert, E. (2008). Unaccompanied refugee children and adolescents: The glaring contrast between a legal and a psychological perspective. *International Journal of Law and Psychiatry, 31,* 319–330. doi:10.1016/j.ijlp.2008.06.006

Derluyn, I., Mels, C., & Broekaert, E. (2009). Mental health problems in separated refugee adolescents. *Journal of Adolescent Health, 44*, 291–297. doi:10.1016/j. jadohealth.2008.07.016

Ehntholt, K. A., & Yule, W. (2006). Practitioner review: Assessment and treatment of refugee children and adolescents who have experiences war-related trauma. *Journal of Child Psychology and Psychiatry, 47*, 1197–1210. doi:10.1111/j.1469-7610.2006.01638.x

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

Erickson, M. F., Sroufe, L. A., & Egeland, B. (1985). The relationship between quality of attachment and behavior problems in preschool in a high-risk sample. *Monographs of the Society for Research in Child Development, 50*, 147–166. doi:10.2307/3333831

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. *Lancet, 379*, 266–282. doi:10.1016/S0140-6736(11)60051-2 174

Hou, F., & Beiser, M. (2006). Learning the language of a new country: A ten-year study of English acquisition by South-East Asian refugees in Canada. *International Migration, 44*, 135–165. doi:10.1111/imig.2006.44.issue-1

Huber, M., Knottnerus, J. A., Green, L., Van der Horst, H., Jadad, A. R., Kromhout, D., ... Smid, H. (2011). How should we define health? *BMJ.* doi:10.1136/bmj.d4163

Huber, M., Van Vliet, M., Giezenberg, M., Winkens, B., Heerkens, Y., Dagnelie, P. C., & Knottnerus, J. A. (2016). Towards a 'patient-centred' operationalisation of the new dynamic concept of health: A mixed methods study. *BMJ Open, 5*. doi:10.1136/

bmjopen2015-010091

Huemer, J., Karnik, N. S., Voelkl-Kernstock, S., Granditsch, E., Dervic, K., Friedrich, M. H., & Steiner, H. (2009). Mental health issues in unaccompanied refugee minors. *Child and Adolescent Psychiatry and Mental Health, 3,* 13. doi:10.1186/1753-2000-3-13

Iwasaki, Y. (2003). The impact of leisure coping beliefs and strategies on adaptive outcomes. *Leisure Studies, 22*, 93–108. doi:10.1080/026143603200058777

Jacobsen, T., & Hofmann, V. (1997). Children's attachment representations: Longitudinal relations to school behavior and academic competency in middle childhood and adolescence. *Developmental Psychology, 33*, 703–710. doi:10.1037/0012-1649.33.4.703

Kalverboer, M., Zijlstra, E., Van Os, C., Zevulun, D., Brummelaar, M., & Beltman, D. (2017). Unaccompanied minors in the Netherlands and the care facility in which they flourish best. *Child & Family Social Work, 22*, 587–596. doi:10.1111/cfs.12272

Keles, S., Friborg, O., Idsøe, T., Sirin, S., & Oppedal, B. (2018). Resilience and acculturation among unaccompanied refugee minors. *International Journal of Behavioral Development, 42*, 52–63. doi:10.1177/0165025416658136

Kindon, S., Pain, R., & Kesby, M. (2007). *Participatory action research approaches and methods: Connecting people, participation and place.* New York, NY: Routledge.

Luthar, S. S., & Goldstein, A. (2004). Children's exposure to community violence: Implications for understanding risk and resilience. *Journal of Clinical Child and Adolescent Psychology, 33*, 499–505. doi:10.1207/s15374424jccp3303_7

Lyons-Ruth, K. (1996). Attachment relationships among children with aggressive behaviour problems: The role of disorganized early attachment patterns. *Journal of Consulting and Clinical Psychology, 64*, 64–73. doi:10.1037/0022-006X.64.1.64

Majumder, P., O'Reilly, M., Karim, K., & Vostanis, P. (2015). 'This doctor, I not trust him, I'm not safe': The perceptions of mental health and services by unaccompanied refugee adolescents. *International Journal of Social Psychiatry, 6,* 129–136. doi:10.1177/ 0020764014537236

McNamara, P., Harvey, A., & Andrewartha, L. (in press). Passports out of poverty: Raising access to higher education for care leavers in Australia. *Children and Youth Services Review*. doi: 10.1016/j.childyouth.2017.07.015

Mendes, P., & Snow, P. (Eds.). (2016). *Young people transitioning from out-of-home care: International research, policy and practice.* London: Palgrave Macmillan.

Ministry of Foreign Affairs (2015, July). *Algemeen ambtsbericht Eritrea* [Official report]. Retrieved from: https://www.rijksoverheid.nl/documenten/ambtsberichten/2015/07/30/eri trea-2015-07–30

Ní Raghallaigh, M. (2013). The causes of mistrust amongst asylum seekers and refugees: Insights from research with unaccompanied asylum-seeking minors living in the Republic of Ireland. *Journal of Refugee Studies, 27*, 82–100. doi:10.1093/jrs/fet006

Ní Raghallaigh, M., & Gilligan, R. (2010). Active survival in the lives of unaccompanied minors: Coping strategies, resilience, and the relevance of religion. *Child & Family Social Work, 15*, 226–237. doi:10.1111/j.1365-2206.2009.00663.x

Pharos. (2017). *Factsheet alleenstaande minderjarige vreemdelingen (amv's)*. Utrecht, The Netherlands: Author.

Pine, D. S., Costello, J., & Masten, A. (2005). Trauma, proximity, and developmental psychopathology: The effects of war and terrorism on children. *Neuropsychopharmacology: Official Publication of the American College of Neuropsychopharmacology, 30*, 1781–1792. doi:10.1038/sj.npp.1300814

Roper, J. M., & Shapira, J. (2000). *Ethnography in nursing research* (Vol. 1). Thousand Oaks, US: Sage. Separated Children in Europe Programme, (2004). Statement of good practice [Statement]. Retrieved from http://www.unhcr.org/4d9474399.pdf

Sirriyeh, A., & Raghallaigh, M. N. (2018). Foster care, recognition and transitions to adulthood for unaccompanied asylum seeking young people in England and Ireland. *Children and Youth Services Review*

Sleijpen, M., Mooren, T., Kleber, R. J., & Boeije, H. R. (2017). Lives on hold: A qualitative study of young refugees' resilience strategies. *Childhood (Copenhagen, Denmark), 24*, 348–365. doi:10.1177/0907568217690031

Sleijpen, M., Ter Heide, F. J. J., Mooren, T., Boeije, H. R., & Kleber, R. J. (2013). Bouncing forward of young refugees: A perspective on resilience research directions. *European Journal of Psychotraumatology, 4*, 20124. doi:10.3402/ejpt.v4i0.20124

Sleijpen, M., Van Es, C., Te Brake, H., & Mooren, T. (2018). *Toolkit voor de begeleiding van Eritrese alleenstaande minderjarigen in Nederland*. Diemen, The Netherlands: Arq Psychotrauma Expert Groep.

United Nations, General Assembly (9 May 2016). *Report of the commission of inquiry on human rights in Eritrea*. Geneva. Retrieved from: https://www.ohchr.org/en/hrbodies/hrc/ coieritrea/pages/reportcoieritrea.aspx

Unterhitzenberger, J., Eberle-Sejari, R., Rassenhofer, M., Sukale, T., Rosner, R., & Goldbeck, L. (2015). Trauma-focused cognitive behavioral therapy with un-

accompanied refugee minors: A case series. *BMC Psychiatry, 15*. doi:10.1186/s12888-015-0645-0

Van Beelen, N. (2016). *Van ver gekomen. Een verkenning naar het welzijn en de gezondheid van Eritrese vluchtelingen.* Utrecht, The Netherlands: Pharos.

Van Reisen, M. (2016, 2 June). *The involvement of unaccompanied minors from Eritrea in human trafficking* [report]. Retrieved from http://www.eepa.eu/wcm/dmdocuments/publi cations/the_Involvement_of_unaccompanied_minors_in_ht.pdf

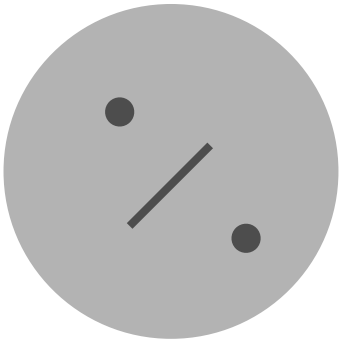
Vervliet, M., Lammertyn, J., Broekaert, E., & Derluyn, I. (2014). Longitudinal follow-up of the mental health of unaccompanied refugee minors. *European Child & Adolescent Psychiatry, 23*, 337–346. doi:10.1007/s00787-013-0463-1

VluchtelingenWerk Nederland (2017, 10 July). *Vluchtelingen in getallen 2017* [report]. Retrieved from https://www.vluchtelingenwerk.nl/sites/public/u152/Vluchtelingeningetallen2017compleet-1.pdf

Wall, S. (2014). Focused ethnography: A methodological adaptation for social research in emerging contexts. *Forum: Qualitative Social Research, 16*. Retrieved from http://nbnresolving.de/urn:nbn:de:0114-fqs150111

Webb, L., Cox, N., Cumbers, H., Martikke, S., Gedzielewski, E., & Duale, M. (2017). Personal resilience and identity capital among young people leaving care: Enhancing identity formation and life chances through involvement in volunteering and social action. *Journal of Youth Studies, 20*, 889–903. doi:10.1080/13676261.2016.1273519

Weine, S. M., Ware, N., Tugenberg, T., Hakizimana, L., Dahnweih, G., Currie, M., ... Levin, E. (2013). Thriving, managing, and struggling: A mixed methods study of adolescent African refugees' psychosocial adjustment. *Adolescent Psychiatry, 3*, 72. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3816789



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Overcoming barriers to mental health care: Multimodal trauma-focused treatment approach for unaccompanied refugee minors

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ABSTRACT

Background

This study evaluated the feasibility of a short-term, multimodal trauma-focused treatment approach adapted specifically for unaccompanied refugee minors (URMs) in the Netherlands. This approach aims to overcome barriers to mental health care and to reduce symptoms of posttraumatic stress disorder (PTSD) and depression.

Methods

An uncontrolled study was conducted, evaluating the main request for help, treatment integrity and feasibility, and the course of symptoms of PTSD (Children's Revised Impact of Event Scale-13) and depression (Patient Health Questionnaire modified for Adolescents).

Results

In total, 41 minors were included in the study. Most participants were male ($n=27$), predominately from Eritrea (75.6%) with a mean age of 16.5 (SD = 1.5). Minors mostly reported psychological problems, such as problems sleeping, and psychosocial problems, including worries about family reunification. Deviations from the approach were made to meet the current needs of the minors. Factors limiting the feasibility of the approach were often related to continuous stressors, such as news concerning asylum status.

Conclusions

The results provide a first indication that this approach partly overcomes barriers to mental health care and emphasize the added value of collaborating with intercultural mediators and offering outreach care.

Trial registration

The study was registered in the Netherlands Trial Register (NL8585), 10 April 2020, Retrospectively registered, https://www.trialregister.nl/trial/8585.

BACKGROUND

Tailored psychosocial support for vulnerable groups, such as unaccompanied refugee minors (URMs), is of great importance. URMs are refugee children and adolescents under the age of 18, who have been separated from their primary caregivers (UNHCR, 1994). In 2017, approximately 6000 URMs were under guardianship in the Netherlands, with the majority coming from Eritrea, Afghanistan, or Syria. In general, refugee minors are exposed to a variety of stressors before and during their flight, such as forced migration and other dangerous circumstances. After migration, these minors often continue to experience hardships, such as resettlement in a new and strange environment, racial discrimination, isolation, and insecurities concerning family reunification and their refugee status. The potentially traumatic events before and during the flight, as well as the continuous stressors related to the post-migration context can affect the mental health of these refugee minors (Drožđek et al., 2014b; Laban et al., 2005a; Unterhitzenberger et al., 2019a). URMs are considered one of the most vulnerable groups of refugees (UNHCR, 2004). Studies indicate that, compared to accompanied minors, many URMs were exposed to more adverse events, such as sexual assault and violence (Bean et al., 2007; UNHCR, 2004). The vulnerability of URMs might be further enhanced by the separation from their caregivers and the lack of support that parental and family care can offer (Derluyn & Broekaert, 2008).

Altogether, URMs are at greater risk of developing mental health problems than accompanied minors. A substantial group of URMs develop symptoms of posttraumatic stress disorder (PTSD) and/or depression, which may become chronic (Jensen et al., 2019). As mental health problems during childhood and adolescence can be long-lasting, it is crucial to address these problems promptly (Fazel et al., 2012b). Furthermore, the continuous stressors URMs face are likely to maintain their mental health complaints (Jensen et al., 2019; Vervliet, Lammertyn, et al., 2014). For example, Eritrean URMs and their caregivers in the Netherlands stated that continuous stressors, such as worries about their family members, the complex family reunification procedure, and a lack of financial resources, highly affected their psychological functioning. URMs and their caregivers suggested that, as a result, URMs developed, or experienced an exacerbation of, sleeping problems, difficulties concentrating, and other health issues (Van Es et al., 2021).

Although URMs have an elevated risk of developing mental health complaints, few studies have focused on interventions and programmes targeting these complaints. Most of these studies were qualitative or based on case descriptions (Demazure et al., 2018; Unterhitzenberger et al., 2015). To our knowledge, only one randomized controlled trial (RCT) was conducted. This study showed that a trauma-focused group intervention for URMs, drawing on cognitive behavioural principles, improved self-reported symptoms of PTSD and depression, but not caregiver-reported symptoms (Pfeiffer et al., 2018). Moreover, a case study and an uncontrolled pilot study on trauma-focused cognitive behavioural therapy (TF-CBT) yielded preliminary evidence that this therapy is feasible and may effectively reduce

PTSD symptoms in traumatized URMs (Unterhitzenberger et al., 2015; Unterhitzenberger et al., 2019a). Finally, a recent pilot study suggested it is feasible to implement Narrative Exposure Therapy (NET) for URMs (Pfeiffer et al., 2018; Said & King, 2020).

One possible reason for the lack of intervention studies is the number of barriers faced when offering trauma-focused interventions to URMs. One study indicated that although approximately 60% of the participating URMs reported a need for professional support, only 11.7% had actually received this help (Bean et al., 2006). Barriers to the provision of adequate mental health care include individual barriers—such as linguistic differences, taboos concerning mental health care, lack of knowledge of the mental health system and mental health disorders, as well as a fear of stigma—and structural barriers—such as a lack of financial coverage for treatment and interpreters, and poor access to services (Bean et al., 2006; Demazure et al., 2018; Derluyn & Broekaert, 2008; Majumder et al., 2015; Ni Raghallaigh, 2013; Van Es et al., 2019). We therefore face the challenge of diminishing these barriers and offering culturally sensitive and accessible interventions to this group of minors.

To overcome barriers to mental health care, we developed a short-term (approximately eight-session) multimodal trauma-focused treatment approach, specifically adapted for URMs. This approach, described in more detail below, includes CBT interventions to target continuous stressors and to alleviate symptoms of depression and (traumatic) stress. The treatment approach aims to overcome individual as well as structural barriers by (a) offering the treatment at the living location of the minors or another location of the minor's choice, (b) collaborating with intercultural mediators (ICMs), who aided in understanding cultural and language differences between the minor and the therapist, and (c) conducting a flexible, multimodal treatment approach that allows the treatment sessions to focus on the minors' current request for help.

This paper describes a pilot study designed to evaluate this trauma-focused treatment approach for URMs. Specifically, we explored (a) the main request for help among URMs in the Netherlands referred to the treatment approach; (b) the treatment integrity (the extent to which we were able to apply the approach as intended) and feasibility (whether the approach can be implemented successfully), and (c) the course of symptoms of PTSD and/or depression. The information collected during this pilot study was meant to help us in refining the treatment approach to meet the needs of URMs in the Netherlands adequately. The findings will also inform future efforts in studying treatment programmes for URMs.

METHODS

Participants

Participants were URMs referred to the multimodal treatment approach by their legal guardian or general practitioner. Inclusion criteria were being (a) a URM living in the Netherlands under the guardianship of Nidos (the national guardianship institution for unaccompanied

and separated children under the age of 18 in the Netherlands); (b) younger than 19 years old at referral; (c) from Eritrea, Syria or Afghanistan; and (d) with symptoms of PTSD and/or depression as reported by the legal guardian/general practitioner. Minors were excluded when pharmacological treatment or crisis intervention was required for acute suicidality or psychosis, as these issues were beyond the scope of the multimodal treatment approach. In these cases therapists or youth care professionals aided in finding adequate help.

As some URMs receive extended youth care after they turn 18, minors up to 19 years old could be referred for treatment. It was chosen to offer the treatment to minors from Eritrea, Syria or Afghanistan because the majority of URMs in the Netherlands came from these countries (Pharos, 2019) and professionals working at Nidos perceived that minors from these countries experienced barriers to accessing regular mental health care. ICMs from Eritrea, Syria and Afghanistan were therefore trained to offer the treatment approach. Finally, as the treatment aims to address symptoms of PTSD and/or depression, only minors with reported symptoms were referred. No power analysis was conducted to estimate the number of participants as the aims of the current study were exploratory. Recruitment and inclusion ran from October 2017 until March 2020.

Procedure

Guardians were informed about the intervention by youth care professionals working at Nidos. Guardians identified minors who experienced symptoms of PTSD and/or depression in addition to barriers to regular mental health care, such as low motivation for treatment, long waiting lists, and the idea that Western health care would not correspond with the URM's needs and culture. The minors were consequently referred for the multimodal trauma-focused treatment approach. Next, a therapist and ICM visited the minor at their living location or another location of the minor's choice, for an intake interview. The trauma-focused treatment approach then started. Assessments of psychological complaints and potentially traumatic events were carried out during the session following the intake interview (t_1). Post-measurements of psychological complaints were conducted during the last session (t_3). After each session, therapists filled in a list assessing elements of programme integrity (t_2). After all treatments had been completed, all ICMs and therapists were asked to fill in a questionnaire to evaluate the trauma-focused treatment approach. The questionnaires were conducted online or over the telephone due to restrictions related to COVID-19.

To assure data integrity and compliance with ethical and juridical aspects, the study was reviewed by the Medical Ethics Committee of the Leiden University Medical Centre. The Committee stated the study did not require ethical approval as it intended to improve care as usual. Minors received verbal information on the study and provided verbal or written informed consent. For minors below 16 years of age, legal guardians also gave verbal or written consent. The assessments with the minors were part of the treatment evaluation and also used for clinical purposes. Participating therapists and ICMs gave online consent for the use of their data for research purposes.

Measurements

All assessments of the minors were administered with help from an ICM. The Children's Revised Impact of Event Scale-13 (CRIES-13) is available in several languages (www.childrenandwar.org). The Patient Health Questionnaire-9, modified for adolescents (PHQ-A) is available in English. When a minor spoke another language, the questionnaires were translated into this language by an ICM.

Demographic Information

The following demographic information was collected: gender, age, country of origin, whether the minor came from a city or town, and whether the minor had any family members in the Netherlands.

Request for Help

To map how URMs define their main problem and request for help, minors were asked to formulate their main problem.

Life Events

During the second treatment session, therapists identified positive life events, adverse life events, and losses of loved ones the minors had been exposed to. They did so by laying down a lifeline, as is described in the Narrative Exposure Therapy for the treatment of traumatized children and adolescents' protocol (KIDNET; described in more detail in the 'Treatment and Therapist' section). Minors were asked for their permission to share information concerning their treatment sessions, including the lifeline, with the researchers.

Programme Integrity

To assess whether the treatment approach was performed as intended, two components of programme integrity, based on the conceptual framework of Carroll et al. (2007) were assessed: exposure and adherence. Exposure was operationalized as the number of sessions per client and minutes per session. Adherence was operationalized as the extent to which therapists adhered to the specific components of the approach. The programme integrity list was completed by the therapist after each session. In addition, the programme integrity list included questions on the duration of the treatment approach, how therapists evaluated the collaboration with the ICM, the main theme of each session, whether a module protocol was used, whether the therapist deviated from the treatment approach, and why they deviated from the treatment approach.

Feasibility

After finishing all sessions, the therapists and ICMs involved in the study were asked to evaluate the multimodal trauma-focused treatment approach by filling in an online questionnaire. The questionnaire was based on a brainstorming session in which the

researchers discussed the evaluation aims. It consisted of mostly open-ended questions focusing on positive aspects of the intervention and elements that could be improved or changed. Therapists and ICMs were also asked to arrange aspects of the approach according to their importance, based on their experience.

Symptoms of Posttraumatic Stress

All minors completed the CRIES-13, a 13-item tool measuring symptoms of posttraumatic stress in children aged 8 and older. The scale includes three subscales: intrusion, avoidance, and arousal. Items are rated on a 4-point scale rating 0 = *not at all*, 1 = *rarely*, 3 = *sometimes*, and 5 = *often*. A total score of ≥ 30 suggests an increased risk of PTSD (Perrin et al., 2005). The CRIES-13 is a valid measure of posttraumatic stress that has been used extensively among children exposed to war and with different cultural backgrounds (Perrin et al., 2005; Smith et al., 2003). The Cronbach's alpha in this study was good (0.81).

Symptoms of Depression

To measure symptoms of depression, the PHQ-A (Johnson et al., 2002) was used. The PHQ-A is a modified version of the PHQ-9. For example, 'reading the newspaper' in the PHQ-9 questionnaire was changed to 'schoolwork and reading' in the PHQ-A. The PHQ-A includes nine items rated from 0 (not at all) to 3 (nearly every day) with a time period of the past 7 days. In line with the PHQ-9, a total score of ≥ 10 was considered as the cut-off score for detecting depression (Manea et al., 2012). Despite a few differences, the measure is mostly consistent with DSM-5 criteria for a major depressive disorder. The PHQ-9 is a validated, frequently used instrument measuring depression in adolescents (Richardson et al., 2010). The last question of the PHQ-A is on self-harm and suicidality. All therapists were licensed and trained to explore suicidality, and suicidality was also included in the training for ICMs. If a minor was suicidal, it was explained to the URM that their guardian and/or mentor would be informed. If needed, a child and youth psychiatrist could be consulted. Although the reliability and validity of the PHQ-A for refugee minors from different backgrounds have, to our knowledge, not yet been established, the PHQ-A has been shown to have acceptable psychometric properties when completed by Arabic-speaking adolescent refugees (Al Amer et al., 2020). The Cronbach's alpha in this study was acceptable (0.79).

Treatment and Therapists

Before starting the present study, we performed a non-systemic evaluation of the multimodal trauma-focused treatment approach (Van Es et al., 2019). After offering the treatment to 33 Eritrean URMs, the therapists and researchers reviewed the approach. They noted that it focused mainly on traumatic events in the past, however, they emphasized the importance of tailoring the treatment to meet the minor's individual needs, for example by focusing more on current, ongoing stressors. The approach was therefore adapted to allow for more flexibility. Moreover, the importance of involving the direct context of the URM (e.g., guardian

and mentor) was emphasized by the involved professionals.

The procedure is presented in Fig. 1. URMs were offered the multimodal, culturally sensitive, trauma-focused treatment approach. The approach started with a clinical intake interview. During the intake, confidentiality and mutual expectations were discussed. During the following session, psychoeducation about PTSD symptoms and trauma-focused treatment were offered. As URMs are often unfamiliar with such treatments, and differences in explanatory models between the therapist and the minors might exist, considerable time was spent on psychoeducation. For example, therapists normalized symptoms by explaining how complaints might be linked to traumatic experiences in the past and continuous stressors. Additionally, the treatment rationale and potential side effects of the treatment approach were explained. Finally, the minors' lifeline (as derived from KIDNET) was laid out, either by drawing or by laying down a rope and placing flowers for their positive experiences and stones for their negative experiences. Next, it was decided which intervention module suited the minor best. This was done during multidisciplinary consultation based on the request for help and complaints as reported by the minor. Each session lasted approximately 90 min. The final session focused on leave-taking. If more help was needed, the therapist discussed with the minor and the guardian what was needed and, if necessary and suitable, the therapist provided this. If therapists were not able to offer this support, they assisted the URM and their guardian to find suitable help. For example, therapists helped finding suitable mental health care nearby.

The treatment approach included different modules, including CBT interventions and elements of KIDNET (the lifeline) and Eye Movement Desensitization and Reprocessing (EMDR), to address continuous stressors, and symptoms of depression and (traumatic) stress. Culturally sensitive adaptations of the modules included collaborating with ICMs before and during the sessions. Before the sessions, how to offer psychoeducation in a culturally sensitive way was discussed, for example by using suitable metaphors. The core components of the treatment modules were not adapted.

NET

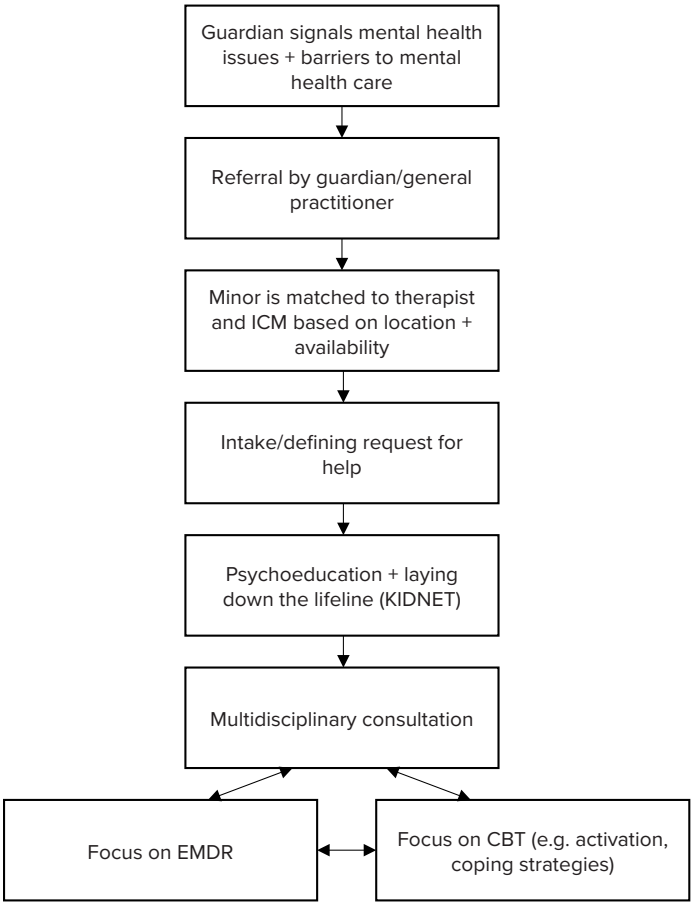
The lifeline was construed based on KIDNET (Neuner et al., 2008) and served as a way to identify key adverse life events, positive life events, and losses of loved ones. Moreover, the lifeline provided insight into the link between complaints and traumatic events (a case conceptualization). NET is conditionally recommended by the American Psychological Association (APA) for the treatment of PTSD (American Psychological Association, 2017).

EMDR

URMs who had developed traumatic stress reactions as a result of a clearly defined traumatic incident received EMDR to address these issues. EMDR is a frequently used psychotherapeutic treatment (Shapiro & Maxfield, 2002) focused on weakening negative and strengthening positive cognitions associated with the traumatic event. A key element of

EMDR is a dual attention task. Whilst the client focuses on an image of the traumatic memory, bilateral, rhythmic stimulation, for example evoking saccadic eye movements, is offered (De Roos et al., 2017). Oras et al. (2004) suggested that EMDR is an effective treatment for traumatized refugee children and the guidelines of the National Institute for Health and Care Excellence (NICE) cited EMDR as a promising treatment for children and adolescents (Diehle et al., 2015; NICE, 2005). After discussions with ICMs, therapists, professionals with experience working in Eritrea, and EMDR experts, it was decided to offer EMDR, because during EMDR minors do not have to verbalize all of their traumatic experiences, which is more often the case in other trauma-focused treatments, such as KIDNET. URMs might be unfamiliar with talking about their experiences and therefore might be hesitant to do so.

Figure 1. *Treatment Approach Procedure*



Note. CBT = Cognitive Behavioural Therapy; EMDR = Eye Movement Desensitization and Reprocessing; ICM = intercultural mediator; KIDNET = Narrative Exposure Therapy for Children.

CBT

NICE recommends CBT for the treatment for depression (NICE, 2019). During the intervention, CBT was offered, for example, by supporting URMs in increasing activities and improving social connections (Cohen et al., 2012).

Therapists

The trauma-focused treatment approach was performed by therapists working at various mental health care institutions throughout the Netherlands. Therapists were recruited based on the network of the project team involved in designing the treatment approach. Therapists were all licensed mental health care workers and trained EMDR-therapists with multiple years of experience with minors from different cultural backgrounds. Therapists took part in multidisciplinary consultation as part of their regular work, as well as multidisciplinary consultation and supervision as part of the multimodal treatment approach. The motivation for therapists to take part in offering the treatment approach included the collaboration with ICMs, being part of a network of experienced psychologists, and working together to increase the understanding of what works for URMs in the Netherlands.

ICMs

ICMs were persons close to the URMs in cultural background and experience, who aimed to facilitate communication between the therapist and the minor. They interpreted language and offered information on the cultural background of the URMs. All ICMs followed a training focused on trauma, stress, and selfcare before providing the approach and were given the opportunity to participate in intermediate supervision sessions.

Analysis

Main Request for Help

After an initial assessment of the main requests for help of the minors their requests were categorized into psychological problems, psychosocial problems, and somatic problems. All requests for help were related to these categories. In addition, a previous study indicated that URMs in the Netherlands often report psychosocial stressors and psychological complaints (Van Es et al., 2019). Moreover, refugees often present somatic symptoms (Rohlof et al., 2014).

Treatment Integrity and Feasibility

To evaluate programme integrity, exposure, and adherence were computed. Missing items were allowed on the programme integrity list. When percentages are reported, they apply to all questions that have been completed. Adverse events were categorized following the subsequent categories, in line with the World Health Organization World Mental Health Surveys (Stein et al., 2010): natural and man-made disasters and accidents; combat, war, and refugee experiences; sexual and interpersonal violence; witnessing or perpetrating

violence; and death of a loved one. Being captured or held against one's will was added as a category as more than 25% of minors reported experiencing this adverse event.

Data from the online questionnaires were analysed using the general inductive approach for analysing qualitative evaluation data (Thomas, 2006) in the following steps. All steps were conducted in parallel (CvE and MeV). First, the text was read thoroughly. Second, specific text fragments related to the research questions were identified and labelled to create categories. Third, overlap and redundancy were reduced. Finally, the most important categories were identified. The categories were discussed among the two raters until a consensus was reached. During this process, an ongoing discussion was maintained with the rest of the research team.

Course of Symptoms

Data of the pre- and post-treatment assessments of the CRIES-13 and PHQ-A were analysed using SPSS (version 27, IBM Statistics). For the CRIES-13, in line with Verlinden et al. (2015), data were counted as missing if more than one item on a subscale was missing. For the PHQ-A, in line with prior studies on the PHQ-9 (Kroenke et al., 2010), data were counted as missing if more than two items were missing. Missing values on the PHQ-A were replaced by the mean of the completed items of the PHQ-A, as suggested by Kocalevent et al. (2013) and missing items on the CRIES-13 were replaced by the mean of the completed items of the same subscale. A Chi-square test and independent t-test were conducted to evaluate whether any differences related to demographic information and baseline scores on the CRIES-13 and PHQ-A existed between participants who completed the questionnaires and participants who did not. To assess whether any changes occurred in symptoms of depression and PTSD, paired t-tests and Wilcoxon-signed rank tests were conducted. To evaluate clinical significance of change, we calculated the Reliable Change Index (RCI) for changes in symptoms of depression and PTSD, using the formula $\frac{t_3-t_1}{S_{diff}}$ (Jacobson & Truax, 1991), with t_3 referring to post-treatment assessments of the PHQ-A and CRIES-13, t_1 referring to pre-treatment assessments of the PHQ-A and CRIES-13, and S_{diff} being calculated using the test–retest reliability coefficient of the questionnaires and the standard deviation of the pre-treatment scores. The test–retest coefficient of the CRIES-13 is 0.85 (Verlinden et al., 2014). Kroenke et al. (2001) found that the test–retest reliability of the PHQ-9 was 0.84. A calculated RCI larger than |1.96| indicated a clinically reliable change, with 95% certainty. The RCI resulted in numbers of minors improved, unchanged, and worsened from t_1 to t_3. In addition to the RCI, clinically significant change was further evaluating by assessing whether clients had obtained a score of <30 on the CRIES-13, and a score of <10 on the PHQ-A after the treatment approach.

RESULTS

In total, 61 minors were referred to the treatment approach. Fifteen did not start with the approach for a variety of reasons, including: not being able to contact the guardian and/or minor (*n*=3), not being motivated for treatment (*n*=3), no longer having a request for help because family reunification took place (*n*=2), and starting treatment at another facility whilst placed on the waitlist (*n*=2). In addition, four minors did not give consent to taking part in the study. Ultimately, 41 minors participated in the study. Three participants dropped out immediately after intake, for the following reasons: moving house, needing another form of support because of current threat of deportation, and placement in a secure psychiatric facility. A flowchart is provided in Fig. 2. Demographic characteristics of the URM participants are listed in Table 1. Moreover, all therapists (*n*=9) and all but one of the ICMs (*n*=8) completed the online questionnaires. The ICM who did not complete the questionnaire was contacted several times but did not reply to the requests of the researchers.

Figure 2. *Flowchart of Participants*

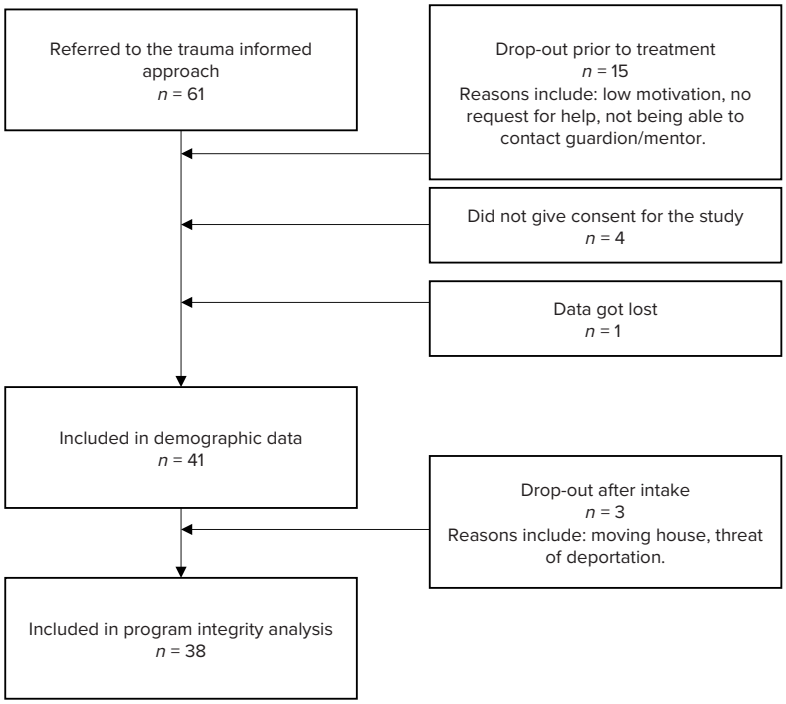


Table 1. *Demographics of Study Participants (N=41)*

Variable*	*n* (%)	M (SD)	Range
Gender (*n*=41)			
Female	14 (34.1)	-	-
Male	27 (65.9)	-	-
Age (years) (*n*=41)		16.5 (1.5)	12-19
Country of origin (*n*=41)			
Eritrea	31 (75.6)	-	-
Syria	9 (22.0)	-	-
Afghanistan	1 (2.4)	-	-
Grew up in town or city (*n*=15)			
Town	11 (73.3)	-	-
City	4 (26.7)	-	-
Family members in the Netherlands? (*n*=19)			
Yes	7 (36.8)	-	-
No	12 (63.2)	-	-

* Number of participants for whom data were available are in parentheses

Request for Help

Most participants (95.1%) reported psychological problems, such as difficulties sleeping and concentrating, flashbacks, and feelings of depression. Moreover, psychosocial problems, such as worries concerning family members and problems with housing, were reported by 27 participants (65.9%). Finally, six participants (14.6%) stated that they experienced somatic complaints, such as headaches and incontinence.

Programme Integrity

The data of minors who attended at least one session after intake were included in analyses based on the programme integrity list (*n*=38). Participants were offered 8 sessions on average (range 4–17), which lasted approximately 80 min. Three minors dropped out after 2 or 3 sessions for the following reasons: wanting to focus on their future and preparing for their asylum interview, not being able to find motivation for treatment, and experiencing too much stress after receiving negative news concerning their asylum status.

Therapists collaborated with ICMs during 93% of the sessions. The main reasons for collaboration with ICMs reported by the therapists included ICMs bridging the cultural and/or language gap (53.7%), that collaboration with ICMs is part of the protocol (16.6%), and ICMs helping in creating a connection with the minors (13.2%). Therapists sometimes worked with professional interpreters (3.3%), or without an ICM or interpreter (3.7%), mostly when the ICM was not able to join a session due to practical reasons. During the majority of the sessions, therapists rated their collaboration with ICMs positively (96.4%), stating for example that they 'understand the culture', and that they promote the building of a trusting relationship. In a few cases therapists said the collaboration could be improved—this was mostly when the ICM joined the session online or via telephone as a result of restrictions due to COVID-19.

The sessions focused primarily on continuous stressors (27.1%), trauma (21.9%), laying

the lifeline (20.8%), getting to know each other (11.5%), saying goodbye (8.7%), and psychoeducation (7.3%). During 56% of the sessions, therapists followed a treatment module protocol. In these sessions, therapists primarily offered EMDR (47.2% of the sessions) and the lifeline derived from KIDNET (40.3% of the sessions). In other sessions where a protocol of a treatment module was followed, therapists used CBT (11.9% of the sessions following a protocol), or specific protocols, for example focused on stabilization or dealing with anger.

Therapists documented several deviations from the treatment approach. For example, they deviated to address the current needs of the minor, which often concerned dealing with continuous stressors (e.g. worries about family members, problems concerning school and housing), and news the minors had received (e.g. concerning asylum status, family reunification, death of a loved one). Moreover, therapists noted that they sometimes needed to take extra time for psychoeducation, explaining EMDR, building trust, laying down the lifeline and translation. The circumstances due to COVID-19 resulted in several deviations from the approach for approximately a third of the minors. For example, two of the minors received all sessions online/over the telephone. In addition, several minors were contacted online or via telephone by their therapist between sessions for continuity. These sessions resulted in several challenges, including arranging devices, a secure internet connection, and adequate space for the minors. Furthermore, the focus of these sessions sometimes shifted to dealing with social isolation and restrictions. Therapists reported they took time to involve the direct context of the minors, for example by having a guardian or mentor attend the intake interview, and by talking to a guardian or mentor concerning the minors' continuous stressors. In addition, therapists sometimes deviated from the EMDR protocol because minors reported they did not want to continue, for example because their arousal was too high or because they had an extreme headache.

Therapists described many differences between the participating minors. For example, whereas some minors were very motivated and wanted to talk about their experiences, others had difficulties developing a trusting relationship. One minor stated he did not want to continue with EMDR as it reminded him of magic. In some cases, treatment was mostly focused on motivating the minor to receive mental health care. Treatment termination took place for different reasons. Most minors felt the treatment had helped them overcome their problems (75.1%), some minors were referred to another mental health facility (11.4%), and others wanted to focus on their future/current worries rather than therapy (8.6%).

Evaluation by Therapists

The therapists' experience with offering the treatment approach varied widely. For example, three therapists had treated one minor, and two others had seen approximately 20 minors. All therapists found the approach useful and wanted to continue offering it. According to the therapists the most important elements of the approach included outreach work, working on a mutual established goal, and working with an ICM with a similar cultural background to the minor. They also valued the flexibility of the approach and being able to deviate

to suit the needs of the minor. Some therapists experienced difficulties whilst explaining EMDR to the minors, and some thought that EMDR did not always suit the minors' needs. Several stated that the protocol could be improved by some adaptations, for example by allowing for more flexibility, and by adding more psychoeducation, CBT exercises relaxation exercises, and homework exercises to the protocol. Finally, they underlined the importance of local professionals throughout the Netherlands offering the approach, and of sharing knowledge and expertise.

> *Therapist: 'We reach minors that wouldn't normally be reached. We try to adapt to fit to the needs of the minor, instead of the minor adapting to the mental health care institution.'*

Evaluation by ICMs

Eight ICMs took part in the evaluation. Their experience with the approach varied from one treatment to more than ten treatments. The majority of ICMs were involved in more than four treatments. Seven ICMs found the approach useful and all ICMs wanted to continue to offer the approach. The ICM who did not find the approach useful stated that more time should be invested in getting to know each other, and that the therapists as well as the ICM should share more personal stories with the minors. ICMs especially valued that the treatment approach could be adapted to fit the minors' needs better. ICMs rated the KIDNET lifeline, the outreach work, and the engaged approach by the therapist and ICMs as the most important elements of the approach. Most ICMs felt their work was an important addition to the approach. For example, one ICM explained that ICMs can assist in formulating certain questions. Some ICMs added that the approach could be improved by offering more psychoeducation, and spending time on building trust. Several ICMs stated their work could be improved by receiving more training focused on their role in the treatment approach, and some ICMs stated that the communication between therapist and ICM could be improved. Finally, the ICMs highlighted the importance of involving the patient's context and added that this could be improved.

> *ICM: 'Before the therapy begins, the ICM and therapist should spend more time with the minor. Otherwise, you can't build trust. My experience is that when more time is invested in the beginning, the outcomes are better.'*

Course of Symptoms

Most participants did not complete the questionnaires. Twelve participants completed the pre- and post-measurements of the PHQ-A, and 17 completed the pre- and post-measurements of the CRIES-13. Obstacles in obtaining complete measurements included drop-out; limited time to conduct the assessments; restrictions due to COVID-19 (in some cases, therapists and ICMs were not able to explain the questionnaires online or

over the telephone); a lack of motivation to fill in the questionnaires; and difficulties with understanding the questions. Another reason for non-completion was that therapists were afraid to burden the minors by asking questions about their mental health.

Based on an independent t-test and a Chi-square test, we found no differences in demographic information (age, gender, country of origin, whether they came from a town or city) or baseline scores on the PHQ-A and CRIES-13 between minors who completed the questionnaires and minors who did not complete the questionnaires. Most participants who filled in the CRIES-13 pre-treatment (24 out of the 29, 82.8%) had developed heightened symptoms of PTSD, and approximately half (12 out of 21, 57.1%) reported moderate to severe symptoms of depression. A paired t-test was conducted to compare pre-and post-intervention scores on the CRIES-13 and PHQ-A (see Table 2). A statistically significant reduction in PTSD scores was found. There was no significant change in depression scores. To ensure robustness, Wilcoxon signed-ranks tests were also conducted, yielding a significant difference for the CRIES-13, but not for the PHQ-A (see Table 2).

Table 2. *Results of Paired t-test and Wilcoxon Signed-Rank Test Examining the Change in Symptoms*

Questionnaire	*n*	M	SD	df	*t*	*p*	Cohen's *d*	Z	*p*
PHQ-A pre	12	10.35	7.17	10	0.68	0.51	0.20	-0.59	0.56
PHQ-A post	12	8.82	8.49						
CRIES-13 pre	17	42.59	12.13	16	5.43	<0.001*	1.32	-3.62	<0.001*
CRIES-13 post	17	19.93	19.13						

Note. CRIES-13 = Children's Revised Impact of Events Scale; PHQ-A = Patient Health Questionnaire for Adolescents; RCI = Reliable Change Index
*$p < 0.01$.

Table 3 shows the CRIES-13 and PHQ-A scores at t_1 and t_3, and the RCI scores for participants who completed pre- and post-treatment measurements. As indicated by the RCI, 10 of the 17 participants who completed the CRIES-13 improved (59%), seven remained unchanged (41%), and none worsened. Nine of the participants who improved scored below the cut-off point after treatment. Concerning the PHQ-A, three of the 12 participants improved (25%), eight remained unchanged (67%), and one worsened (8%). Two participants who improved scored below the cut-off score after treatment, whereas two participants who scored below the cut-off point before treatment, scored above the cut-off point after treatment.

Table 3. *Changes and RCI of Symptoms of PTSD and Depression*

Participant no	CRIES-13 t_1	CRIES-13 t_3	RCI CRIES-13 t_1-t_3	PHQ-A t_1	PHQ-A t_3	RCI PHQ-A t_1-t_3
1	49	36	-1.82	6	18	3.19*
2	30.3	23	-1.03	27	18	-2.39*
3	50	32	-2.52*	14	12.4	-0.43
4	51	6	-6.31*	—	—	—
5	13	6	-0.98	1	3	0.53
6	52	4	-6.73*	15	1	-3.72*
7	34	28	-0.84	5	3	-0.53
8	53	50	-0.42	—	—	—
9	49	28.2	-2.92*	8	12	1.06
10	49	13	-5.05*	—	—	—
11	27	6	-2.95*	—	—	—
12	43	0	-6.03*	—	—	—
13	40.1	0	-5.62*	12.4	0	-3.29*
14	46	41	-0.70	11.3	16	1.26
15	29	5	-3.37*	3	0	-0.80
16	61	60.7	-0.05	16	22.5	1.73
17	47.7	0	-6.69*	5.63	0	-1.50

Note: CRIES-13 = Children's Revised Impact of Events Scale; PHQ-A = Patient Health Questionnaire for Adolescents; RCI = Reliable Change Index
* Reliable change as indicated by the RCI

DISCUSSION

The aim of the current study was to provide an evaluation of a multimodal trauma-focused treatment approach offered to URMs in the Netherlands. Forty-one URMs, mostly from Eritrea and Syria, started with the intervention. These minors arrived in the Netherlands after a harrowing journey, often being exposed to atrocities, hunger, thirst, and losing loved ones including companions and friends. Minors reported they would like to receive help to alleviate psychological issues, such as difficulties sleeping. Moreover, most minors reported psychosocial problems, including worries about their family members and their asylum status. A few minors stated they wanted help with somatic issues. Somatization in refugees is connected with psychopathology and can be perceived as an idiom of distress (Rohlof et al., 2014). Moreover, some minors experienced physical abuse and neglect and might have experienced somatic issues as a result. In addition, most minors had developed heightened symptoms of PTSD, and approximately half reported moderate to severe symptoms of depression.

Minors attended approximately eight sessions of the trauma-focused treatment approach. Concerning programme integrity, therapists often deviated from the approach. ICMs and therapists elaborated that they often needed more time to offer psychoeducation. Moreover, therapists and ICMs emphasized the need to adapt the focus of the session to meet the current need of the minors. In addition to a focus on trauma, continuous stressors often played a prominent role in the treatment approach. The treatment approach often

consisted of a combination of modules, including the lifeline (as derived from KIDNET), sessions focused on trauma, and sessions focusing on continuous stressors.

The feasibility of the pre- and post-measurements of PTSD and depression was low. The majority of the minors did not complete the questionnaires, and as a result, these findings are not representative of the entire sample. Most minors who did complete the measurements reported a decrease in symptoms of PTSD. No significant change in symptoms of depression was found. An important reason for non-completion was that therapists were afraid to burden the minors by asking questions about their mental health. It is possible the minors who were experiencing mental health issues were spared by not conducting the questionnaires. This finding emphasizes the need of an (independent) assessor other than the therapist to conduct the questionnaires.

The results suggest that the trauma-focused treatment approach is partly feasible and indicates that certain barriers to mental health care can be overcome by offering this short-term, outreach approach. For example, several minors who experienced barriers to regular mental health care, where motivated for referral to another mental health facility after getting offered the treatment approach. The professionals involved in the execution of the treatment approach evaluated it positively, and all of them said they wanted to continue to offer it. Moreover, the drop-out (15% dropped out after 1–3 sessions) was similar to drop-out in other studies researching trauma-focused treatments (Imel et al., 2013). Drop-out was often due to circumstances linked to the minors' asylum status, and needing more help than this short-term treatment approach can offer.

There were several limitations to the feasibility of the treatment approach, including low treatment adherence and challenges faced during implementation of the protocol. Notably, factors limiting programme integrity and feasibility were frequently related to structural barriers. For example, deviations, reasons for drop-out, and missing data, were often due to factors such as news concerning asylum status, moving house, and restrictions due to COVID-19. When evaluating a treatment approach in the context of trauma and resettlement, structural barriers often arise. Although these barriers are out of reach for the minors and therapists, it is important to take these barriers into account while planning the evaluation and organizing funding. For example, it could be helpful to adopt a flexible approach to deal with the ever-changing context of these young refugees, and to support URMs in developing coping strategies to deal with these continuous, structural stressors.

Strengths and Limitations

The current study is one of the first to evaluate a trauma-focused treatment approach specifically for URMs (Demazure et al., 2018; Unterhitzenberger et al., 2015). Although there are several limitations due to the design of the study, this study offers an overview of a treatment approach that can be offered to this understudied population in a naturalistic setting. Conducting this culturally-sensitive outreach approach, we were able to reach a group subject to barriers to mental health care who often do not receive adequate care.

Another strength of the current study is that different perspectives are presented, including the perspectives of the therapists, ICMs and URMs.

A factor that might have contributed to the feasibility of the trauma-focused intervention was the flexibility of the treatment approach. During a previous evaluation (Van Es et al., 2019), professionals noted the importance of offering a flexible approach. This study offered insight into the wide range of requests for help reported by the participating URMs. Treatment sessions were often tailored to meet the needs of the minors, which is reflected in the main themes of the sessions as well as in the deviations reported by the therapists. A multimodal approach was conducted, offering modules of KIDNET, EMDR, and CBT, all of which are promising or recommended treatments for PTSD and depression. Multimodal treatments have been offered successfully to children suffering from psychological problems, including depression, anxiety, and trauma (Chiu et al., 2013; Hagen et al., 2019). Although the flexible approach was valued as a strength by both therapists and ICMs, it complicates drawing conclusions on what aspects of the approach contributed to its impact.

Several limitations deserve attention. First, the data collection of the questionnaires in this study relied solely on therapists, as there was insufficient funding for researchers to conduct the measurements. Because many sessions did not contain the planned treatment, it is not possible to draw any inferences about the impact of the presented treatment approach. Second, therapists were recruited based on their training level and experience with minors with different cultural backgrounds. It is plausible that this resulted in the selection of highly motivated therapists, and therapists with less experience and affinity with this population might have evaluated the approach less positively. Third, the CRIES-13 was used in the current study to measure symptoms of PTSD, however, this questionnaire is based on the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV). Future studies should include a more up-to-date questionnaire in line with the current DSM-5 or the International Classification of Diseases 11th Revision (ICD-11), such as the Child and Adolescent Trauma Screen (CATS) (Sachser et al., 2017). Fourth, URMs form a heterogeneous group with a wide range of cultural backgrounds, experiences, and requests for help. The generalizability of the findings is limited, as the current study only focused on a small sample size with participants from three different countries. As a prior evaluation of this approach focused solely on Eritrean minors, guardians often referred Eritrean minors. The current design did not allow for comparison of the treatment's impact for different cultural groups.

Research Implications

The current study aimed to explore the feasibility of the multimodal trauma-focused treatment approach. Future efforts should focus on examining the effectiveness of this treatment approach. Demazure et al. (2018) state that there are many challenges to conducting double-blinded RCTs of the impact of interventions for URMs. However, the authors suggest that small-N designs could be a viable alternative to evaluate intervention effectiveness. In addition to a quantitative evaluation, future research can adopt a mixed-

methods approach by including qualitative data, such as interviews with URMs who have received treatment, in order to hear the voices and experiences of the URMs themselves.

Clinical Implications

The collaboration between psychologists and ICMs emerged as one of the strengths of the treatment approach. The involvement of ICMs went beyond the translation of language. ICMs can aid in providing a culturally sensitive explanation of the treatment rationale, in bridging the cultural gap, in building a trusting relationship, and in motivating minors. Nierkens et al. (2002) emphasize that the quality and accessibility of health care can benefit from collaborating with ICMs. In line with the evaluation by ICMs, Qureshi et al. (2021) note that the role of ICMs can be improved by offering clarity regarding their role. To contribute to the professionalization of ICMs, it is essential to continue to offer supervision, guidance and training.

The current study offers several clinical implications for the multimodal trauma-focused treatment approach. Modifications include providing specific approaches to address continuous stressors, and offering more attention to psychoeducation, as an important deviation from the approach was that therapists often spent more time on continuous stressors and psychoeducation. Continuous stressors related to resettlement can play a crucial role in the development of mental health problems in refugees. A recent pilot study emphasized that current stressors, including the rejection of the asylum claim, can potentially increase symptoms of PTSD in URMs post-treatment. Bruhn et al. (2018) state that identifying and dealing with postmigration stressors might limit the impact of these stressors on treatment. Although addressing these problems can be very complex and at times impossible (e.g. when they are related to local legislation), interventions can focus on dealing with these problems, for example by strengthening the social network, and by improving coping strategies. The protocol could therefore benefit from providing specific (CBT) approaches to deal with continuous stressors. In addition, both therapists and ICMs noted they often needed more time for psychoeducation, which psychoeducation is suggested to have a positive impact on PTSD and psychosocial factors, such as social support (Im et al., 2018). The treatment approach protocol can be further improved by offering more attention to psychoeducation.

One of the major future challenges is implementing the presented treatment approach in a sustainable way. The current design requires many resources, including highly trained and experienced ICMs and therapists. Therapists conducting the treatment approach have to be trained to offer KIDNET, EMDR and CBT. However, it is not always feasible to secure these resources. One solution might be to put effort into training and motivating therapists who are less experienced. Motivation for participation in offering this treatment approach might be the collaboration with ICMs and working together with a network of experienced therapists to find out what works for URMs. To assure quality of the treatment, continued supervision and multidisciplinary consultation needs to be offered. Another option is to invest in alternative models. For example, the World Health Organization developed

Problem Management Plus (PM+), a brief intervention targeting common mental health problems, based on CBT and problem solving strategies (Dawson et al., 2015). A recent study found that PM+ is acceptable, feasible, safe, and may be effective in improving mental health and psychosocial functioning in refugees. In addition, PM+ can be delivered by non-specialist refugee helpers (de Graaff et al., 2020). Furthermore, two RCTs are currently assessing the effect of a stepped care approach addressing PTSD in URMs (Böge et al., 2020; Rosner et al., 2020). Using a stepped care model lay counsellors or ICMs could be trained to offer psychoeducation and the lifeline as derived from KIDNET.

The presented treatment approach seems to be indicated when URMs and their guardians experience barriers to regular mental health care. The outreach care and collaboration with ICMs aids in overcoming these barriers. However, it remains unclear whether the content of the treatment approach—including the lifeline as derived from KIDNET, EMDR, and CBT—is more suitable than other treatment approaches, such as TF-CBT. Future research efforts should focus on what treatment (module) is indicated for which minor. The aforementioned studies focusing on a stepped care model can further inform us on what works.

Conclusion

This study offers a first evaluation of the feasibility of a multimodal trauma-focused treatment approach specifically for URMs in the Netherlands, taking into account their specific needs; the context; pre- and postmigration stressors; and language and cultural differences. The results are promising and provide a first indication that this approach mostly overcomes barriers to mental health care, and that the treatment is partly feasible.

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REFERENCES

Al-Amer, R., Maneze, D., Ramjan, L., Villarosa, A. R., Darwish, R., & Salamonson, Y. (2020). Psychometric testing of the Arabic version of the Patient Health Questionnaire among adolescent refugees living in Jordan. *International Journal of Mental Health Nursing*, *29*(4), 685-692.

American Psychological Association. (2017). *Clinical practice guideline for the treatment of PTSD*.

Bean, T., Derluyn, I., Eurelings-Bontekoe, E., Broekaert, E., & Spinhoven, P. (2007). Comparing psychological distress, traumatic stress reactions, and experiences of unaccompanied refugee minors with experiences of adolescents accompanied by parents. *The Journal of Nervous and Mental Disease*, *195*(4), 288-297. https://doi.org/10.1097/01.nmd.0000243751.49499.93

Bean, T., Eurelings-Bontekoe, E., Mooijaart, A., & Spinhoven, P. (2006). Factors associated with mental health service need and utilization among unaccompanied refugee adolescents. *Administration and Policy in Mental Health*, *33*(3), 342-355. https://doi.org/10.1007/s10488-006-0046-2

Böge, K., Karnouk, C., Hahn, E., Schneider, F., Habel, U., Banaschewski, T., Meyer-Lindenberg, A., Salize, H. J., Kamp-Becker, I., & Padberg, F. (2020). Mental health in refugees and asylum seekers (MEHIRA): study design and methodology of a prospective multicentre randomized controlled trail investigating the effects of a stepped and collaborative care model. *Eur Arch Psychiatry and Clinical Neurosciences*, *270*(1), 95-106.

Bruhn, M., Rees, S., Mohsin, M., Silove, D., & Carlsson, J. (2018). The range and impact of postmigration stressors during treatment of trauma-affected refugees. *The Journal of Nervous and Mental Disease*, *206*(1), 61-68.

Carroll, C., Patterson, M., Wood, S., Booth, A., Rick, J., & Balain, S. (2007). A conceptual framework for implementation fidelity. *Implementation Science*, *2*, 40. https://doi.org/10.1186/1748-5908-2-40

Chiu, A. W., Langer, D. A., McLeod, B. D., Har, K., Drahota, A., Galla, B. M., Jacobs, J., Ifekwunigwe, M., & Wood, J. J. (2013). Effectiveness of modular CBT for child anxiety in elementary schools. *School Psychology Quarterly*, *28*(2), 141.

Cohen, J. A., Mannarino, A. P., Kliethermes, M., & Murray, L. A. (2012). Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect*, *36*(6), 528-541.

Dawson, K. S., Bryant, R. A., Harper, M., Tay, A. K., Rahman, A., Schafer, A., & Van Ommeren, M. (2015). Problem Management Plus (PM+): a WHO transdiagnostic psychological intervention for common mental health problems. *World Psychiatry*, *14*(3), 354.

de Graaff, A. M., Cuijpers, P., McDaid, D., Park, A., Woodward, A., Bryant, R. A., Fuhr, D. C., Kieft, B., Minkenberg, E., & Sijbrandij, M. (2020). Peer-provided Problem Management Plus (PM+) for adult Syrian refugees: a pilot randomised controlled trial on effectiveness and cost-effectiveness. *Epidemiology and Psychiatric Sciences*, *29*.

De Roos, C., Van der Oord, S., Zijlstra, B., Lucassen, S., Perrin, S., Emmelkamp, P., & de Jongh, A. (2017). Comparison of eye movement desensitization and reprocessing therapy, cognitive behavioral writing therapy, and wait-list in pediatric posttraumatic stress disorder following single-incident trauma: a multicenter randomized clinical trial. *Journal of Child Psychology and Psychiatry*, *58*(11), 1219-1228. https://doi.org/10.1111/jcpp.12768

Demazure, G., Gaultier, S., & Pinsault, N. (2018). Dealing with difference: a scoping review of psychotherapeutic interventions with unaccompanied refugee minors. *Euopean Child & Adolescent Psychiatry*, *27*(4), 447-466. https://doi.org/10.1007/s00787-017-1083-y

Derluyn, I., & Broekaert, E. (2008). Unaccompanied refugee children and adolescents: the glaring contrast between a legal and a psychological perspective. *International Journal of Law and Psychiatry*, *31*(4), 319-330. https://doi.org/10.1016/j.ijlp.2008.06.006

Diehle, J., Opmeer, B. C., Boer, F., Mannarino, A. P., & Lindauer, R. J. (2015). Trauma-focused cognitive behavioral therapy or eye movement desensitization and reprocessing: what works in children with posttraumatic stress symptoms? A randomized controlled trial. *European Child & Adolescent Psychiatry*, *24*(2), 227-236. https://doi.org/10.1007/s00787-014-0572-5

Drožđek, B., Kamperman, A. M., Tol, W. A., Knipscheer, J. W., & Kleber, R. J. (2014). Seven-year follow-up study of symptoms in asylum seekers and refugees with PTSD treated with trauma-focused groups. *Journal of Clinical Psychology*, *70*(4), 376-387.

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*(9812), 266-282. https://doi.org/10.1016/s0140-6736(11)60051-2

Hagen, K. A., Olseth, A. R., Laland, H., Rognstad, K., Apeland, A., Askeland, E., Taraldsen, K., Christensen, B., Kjøbli, J., & Ugueto, A. M. (2019). Evaluating Modular Approach to Therapy for Children with Anxiety, Depression, Trauma and Conduct Problems (MATCH-ADCT) in Norwegian child and adolescent outpatient clinics: study protocol for a randomized controlled trial. *Trials*, *20*(1), 1-14.

Im, H., Jettner, J. F., Warsame, A. H., Isse, M. M., Khoury, D., & Ross, A. I. (2018). Trauma-informed psychoeducation for Somali refugee youth in urban Kenya: effects on PTSD and psychosocial outcomes. *Journal of Child & Adolescent Trauma*, *11*(4), 431-441.

Imel, Z. E., Laska, K., Jakupcak, M., & Simpson, T. L. (2013). Meta-analysis of dropout in treatments for posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, *81*(3), 394.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, *1*(59), 12-19.

Jensen, T. K., Skar, A. S., Andersson, E. S., & Birkeland, M. S. (2019). Long-term mental health in unaccompanied refugee minors: pre- and post-flight predictors. *European Child & Adolescent Psychiatry*, *28*(12), 1671-1682. https://doi.org/10.1007/s00787-019-01340-6

Johnson, J. G., Harris, E. S., Spitzer, R. L., & Williams, J. B. W. (2002). The Patient Healh Questionnaire for Adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. *Journal of Adolescent Health*, *30*(3), 196-204.

Kocalevent, R.-D., Hinz, A., & Brähler, E. (2013). Standardization of the depression screener patient health questionnaire (PHQ-9) in the general population. *General Hospital Psychiatry*, *35*(5), 551-555.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*(9), 606-613.

Kroenke, K., Spitzer, R. L., Williams, J. B., & Löwe, B. (2010). The patient health questionnaire somatic, anxiety, and depressive symptom scales: a systematic review. *General Hospital Psychiatry*, *32*(4), 345-359.

Laban, C. J., Gernaat, H. B., Komproe, I. H., Van Der Tweel, I., & De Jong, J. T. (2005). Postmigration living problems and common psychiatric disorders in Iraqi asylum seekers in the Netherlands. *The Journal of Nervous and Mental Disease*, *193*(12), 825-832.

Majumder, P., O'Reilly, M., Karim, K., & Vostanis, P. (2015). 'This doctor, I not trust him, I'm not safe': the perceptions of mental health and services by unaccompanied refugee adolescents. *International Journal of Social Psychiatry*, *61*(2), 129-136. https://doi.org/10.1177/0020764014537236

Manea, L., Gilbody, S., & McMillan, D. (2012). Optimal cut-off score for diagnosing depression with the Patient Health Questionnaire (PHQ-9): a meta-analysis. *CMAJ*, *184*(3), E191-E196.

Neuner, F., Catani, C., Ruf, M., Schauer, E., Schauer, M., & Elbert, T. (2008). Narrative Exposure Therapy for the treatment of traumatized children and adolescents (KidNET): From neurocognitive theory to field intervention. *Child and Adolescent Psychiatric Clinics of North America*, *3*(17), 641-664.

Ni Raghallaigh, M. (2013). The Causes of Mistrust amongst Asylum Seekers and Refugees: Insights from Research with Unaccompanied Asylum-Seeking Minors Living in the Republic of Ireland. *Journal of Refugee Studies*, *27*(1), 82-100. https://doi.org/10.1093/jrs/fet006

NICE. (2005). *Post-traumatic stress disorder: The managment of PTSD in adults and children in primary and secondary care*. NICE.

NICE. (2019). *Depression in children and young people: identification and management*. NICE.

Nierkens, V., Krumeich, A., de Ridder, R., & Van Dongen, M. (2002). The future of intercultural mediation in Belgium. *Patient Education and Counseling*, *46*(4), 253-259.

Oras, R., Ezpeleta, S. C. d., & Ahmad, A. (2004). Treatment of traumatized refugee children with eye movement desensitization and reprocessing in a psychodynamic context. *Nordic Journal of Psychiatry*, *58*(3), 199-203.

Perrin, S., Meiser-Stedman, R., & Smith, P. (2005). The Children's Revised Impact of Event Scale (CRIES): validity as a screening instrument for PTSD. *Behavioural and Cognitive Psychotherapy*, *4*(33), 487-498.

Pfeiffer, E., Sachser, C., Rohlmann, F., & Goldbeck, L. (2018). Effectiveness of a trauma focused group intervention for young refugees: a randomized controlled trial. *Journal of Child Psychology and Psychiatry*, *59*(11), 1171-1179.

Qureshi, A., Ananyeva, O., & Collazos, F. (2021). Intercultural mediation in mental health care. *Oxford Textbook of Migrant Psychiatry*, 325.

Richardson, L. P., McCauley, E., Grossman, D. C., McCarty, C. A., Richards, J., Russo, J. E., Rockhill, C., & Katon, W. (2010). Evaluation of the Patient Health Questionnaire-9 Item for detecting major depression among adolescents. *Pediatrics*, *126*(6), 1117-1123. https://doi.org/10.1542/peds.2010-0852

Rohlof, H. G., Knipscheer, J. W., & Kleber, R. J. (2014).

Somatization in refugees: a review. *Social Psychiatry and Psychiatric Epidemiology*, *49*(11), 1793-1804.

Rosner, R., Sachser, C., Hornfeck, F., Kilian, R., Kindler, H., Muche, R., Müller, L. R. F., Thielemann, J., Waldmann, T., & Ziegenhain, U. (2020). Improving mental health care for unaccompanied young refugees through a stepped-care approach versus usual care+: study protocol of a cluster randomized controlled hybrid effectiveness implementation trial. *Trials*, *21*(1), 1-13.

Sachser, C., Berliner, L., Holt, T., Jensen, T. K., Jungbluth, N., Risch, E., Rosner, R., & Goldbeck, L. (2017). International development and psychometric properties of the Child and Adolescent Trauma Screen (CATS). *Journal of Affective Disorders*, *210*, 189-195.

Said, G., & King, D. (2020). Implementing Narrative Exposure Therapy for unaccompanied asylum-seeking minors with post-traumatic stress disorder: A pilot feasibility report. *Clinical Child Psychology and Psychiatry*, *25*(1), 213-226. https://doi.org/10.1177/1359104519864123

Shapiro, F., & Maxfield, L. (2002). Eye Movement Desensitization and Reprocessing (EMDR): information processing in the treatment of trauma. *Journal of Clinical Psychology*, *58*(8), 933-946. https://doi.org/10.1002/jclp.10068

Smith, P., Perrin, S., Dyregrov, A., & Yule, W. (2003). Principal components analysis of the impact of event scale with children in war. *Personality and Individual Differences*, *34*, 315-322.

Stein, D. J., Chiu, W. T., Hwang, I., Kessler, R. C., Sampson, N., Alonso, J., Borges, G., Bromet, E., Bruffaerts, R., & De Girolamo, G. (2010). Cross-national analysis of the associations between traumatic events and suicidal behavior: findings from the WHO World Mental Health Surveys. *PLoS One*, *5*(5), e10574.

Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, *27*(2), 237-246.

UNHCR. (1994). *Refugee children. Guidelines on protection and care*.

UNHCR. (2004). Assistance to unaccompanied refugee minors.

Unterhitzenberger, J., Eberle-Sejari, R., Rassenhofer, M., Sukale, T., Rosner, R., & Goldbeck, L. (2015). Trauma-focused cognitive behavioral therapy with unaccompanied refugee minors: a case series. *BMC Psychiatry*, *15*, 260. https://doi.org/10.1186/s12888-015-0645-0

Unterhitzenberger, J., Wintersohl, S., Lang, M., König, J., & Rosner, R. (2019). Providing manualized individual trauma-focused CBT to unaccompanied refugee minors with uncertain residence status: a pilot study. *Child and Adolescent Psychiatry and Mental Health*, *13*(1), 1-10.

Van Es, C. M., Sleijpen, M., Ghebreab, W., & Mooren, T. (2019). Cultuursensitief werken met alleenstaande jonge vluchtelingen. *Kind en Adolescent Praktijk*, *18*(4), 16.

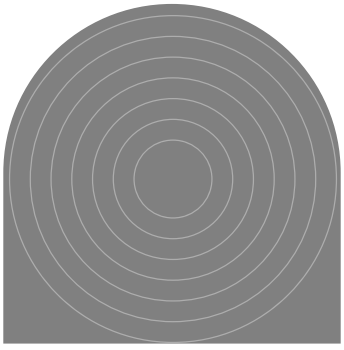
Van Es, C. M., Sleijpen, M., Mooren, T., te Brake, H., Ghebreab, W., & Boelen, P. A. (2019). Eritrean Unaccompanied Refugee Minors in Transition: A Focused Ethnography of Challenges and Needs. *Residential Treatment of Children and Youth*, *36*(2), 157-176. https://doi.org/10.1080/0886571x.2018.1548917

Van Es, C. M., Sleijpen, M., Velu, M. E., Boelen, P. A., Van Loon, R. E., Veldman, M., Kusmallah, N., Ekster, P. J., & Mooren, T. (2021). Overcoming barriers to mental health care: multimodal trauma-focused treatment approach for unaccompanied refugee minors. *Child and Adolescent Psychiatry and Mental Health*, *15*(1), 1-14.

Verlinden, E., Opmeer, B. C., Van Meijel, E. P., Beer, R., De Roos, C., Bicanic, I. A., Lamers-Winkelman, F., Olff, M., Boer, F., & Lindauer, R. J. (2015). Enhanced screening for posttraumatic stress disorder and comorbid diagnoses in children and adolescents. *European Journal of Psychotraumatology*, *6*(1), 26661.

Verlinden, E., Van Meijel, E. P., Opmeer, B. C., Beer, R., de Roos, C., Bicanic, I. A., Lamers-Winkelman, F., Olff, M., Boer, F., & Lindauer, R. J. (2014). Characteristics of the Children's Revised Impact of Event Scale in a clinically referred Dutch sample. *Journal of Traumatic Stress*, *27*(3), 338-344.

Vervliet, M., Lammertyn, J., Broekaert, E., & Derluyn, I. (2014). Longitudinal follow-up of the mental health of unaccompanied refugee minors. *European Child & Adolescent Psychiatry*, *23*(5), 337-346. https://doi.org/10.1007/s00787-013-0463-1



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Trauma-focused treatment for traumatic stress symptoms in unaccompanied refugee minors: A multiple baseline case series

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ABSTRACT

Background

Unaccompanied refugee minors (URMs) are at increased risk of developing mental health problems, such as symptoms of posttraumatic stress disorder (PTSD) and depression. In addition, URMs face several barriers to mental health care. Few studies have evaluated trauma-focused interventions for URMs that target these issues. The current study evaluated a multimodal trauma-focused treatment approach for URMs. It aimed to provide an initial indication of the effectiveness of this treatment approach and to provide a qualitative evaluation assessing treatment satisfaction of the participating URMs.

Methods

A mixed-methods study conducted among ten URMs, combining quantitative data with qualitative data through triangulation, was conducted. Quantitative data were collected using a non-concurrent multiple baseline design in which repeated, weekly assessments were carried out during a randomized baseline period, during treatment, and during a 4-week follow-up period. Questionnaires assessing PTSD (Children's Revised Impact of Event Scale) and symptoms of depression (The Patient Health Questionnaire-9, modified for adolescents) were used. In addition, treatment satisfaction was measured post-treatment using a semi-structured interview.

Results

During the qualitative evaluation, all but one URM noted they found the trauma-focused treatment approach useful and felt the treatment had positively impacted their wellbeing. However, the results of the quantitative evaluation did not show clinically reliable symptom reductions at posttest or follow-up. Implications for clinical practice and research are discussed.

Conclusions

The current study presents our search in developing a treatment approach for URMs. It adds to the current knowledge about methodological considerations in evaluating treatments for URMs, the potential effects of trauma-focused treatments on URMs, and the implementation of treatments for URMs.

Keywords

Unaccompanied Refugee Minors; Trauma-focused Treatment Approach; Multiple Baseline; Mixed-methods.

INTRODUCTION

In 2019, approximately 40% of all refugees in the world were minors (The UN Refugee Agency, 2020). About 7% of the minors applying for asylum in the European Union that year arrived without a primary caregiver (Eurostat, 2020). These unaccompanied refugee minors (URMs) are more vulnerable to develop psychological complaints than accompanied minors arriving in the country of resettlement with a parent or primary caregiver (Huemer et al., 2009; Vervliet, Lammertyn, et al., 2014; Vervliet, Meyer Demott, et al., 2014). For example, Derluyn, Broekaert and Schuyten (2008) found that URMs in Belgium were five times more likely to develop severe symptoms of anxiety, depression, and posttraumatic stress disorder (PTSD) than accompanied refugee minors. This increased vulnerability is assumed to be due to several risk factors, including the separation from their parents, a high exposure to potentially traumatic events, and the loss of their familiar environment and support system, whilst being faced with the continuous stressors associated with migration (Demazure, Gaultier, & Pinsault, 2017; Derluyn & Broekaert, 2008; McKelvey & Webb, 1995).

Although multiple studies indicate increased risk of developing mental health problems in URMs, little is known about optimal approaches to diminish distress in these minors (Demazure et al., 2017; Unterhitzenberger et al., 2015). Few studies on psychotherapeutic interventions addressing the specific problems and challenges URMs encounter have been performed. The majority of these studies is solely qualitative or based on case descriptions (Demazure et al., 2018; Unterhitzenberger et al., 2019a). This gap in knowledge on interventions might, in part, be due to the barriers faced when offering interventions to URMs (Murray, Davidson, & Schweitzer, 2010). For example, URMs are often preoccupied with continuous daily stressors, such as worries about the wellbeing of their family members and a complex family reunification procedure (Nickerson et al., 2011; Van Es, Sleijpen, Mooren, et al., 2019). Other barriers include difficulties in establishing a trusting relationship with adults, linguistic differences, and poor access to services (Bean et al., 2006; Demazure et al., 2018; Derluyn & Broekaert, 2008; Ni Raghallaigh, 2013). As a result, URMs may not receive the help they need. Diminishing these barriers and offering culturally sensitive and accessible interventions to this group of minors are key public health challenges (Ehntholt & Yule, 2006).

To overcome the aforementioned barriers, a culturally-sensitive, multimodal trauma-focused treatment approach specifically for URMs in The Netherlands was developed (Van Es et al., 2021). It consists of approximately eight, 80-minute sessions targeting ongoing stressors and symptoms of depression and (traumatic) stress. During the first session, a clinical intake interview takes place. In the following sessions, psychoeducation is offered and the treatment rationale is explained. Then, the URMs' lifeline (as derived from Narrative Exposure Therapy for children; KIDNET) is laid out. Next, it is decided during multidisciplinary consultation which treatment modules suited the request for help of the URMs best. The multimodal approach includes cognitive behavioral interventions, i.e. KIDNET, Eye Movement Desensitization and Reprocessing (EMDR), activation, and cognitive

restructuring and exposure. The approach is described in more detail in Van Es et al. (2021).

The multimodal trauma-focused treatment approach aims to diminish and overcome the aforementioned barriers and to address the specific, individual needs of traumatized URMs. Although the approach is trauma-focused, URMs do not have to talk extensively about their traumatic experiences which may help to overcome reluctance to disclose negative experiences. The therapist collaborates with an Intercultural Mediator (ICM) prior to and during each session to further reduce cultural and language difficulties. ICMs are close to the URMs in cultural background and experience. They aim to facilitate communication between the therapist and the URM, as they interpret language and offer knowledge on the cultural background of the URMs. Collaborative work with an ICM is assumed to help in building a trusting relationship and making interventions culturally sensitive. Finally, care is offered at or near the living environment of URMs to allow them to receive the intervention in a familiar environment, to save them the effort of traveling, and to prevent them from feeling different from others because they have to go to a mental health institution. Moreover, as the URMs do not have any travel time, they do not miss so many school hours.

Based on the findings of a feasibility trial (Van Es et al., 2021), it was suggested that the approach partly overcomes barriers to mental health care. To further evaluate the treatment approach, we designed the present study, using a mixed methods, non-concurrent multiple baseline design with ten participants with elevated symptoms of depression and/or PTSD. Although randomized controlled trials (RCTs) are considered the golden standard when evaluating the effectiveness of a program, Demazure et al. (2018) stated that the feasibility of conducting an RCT with URMs is limited. Therefore, Demazure et al. (2018) propose using alternative methods, including small-N designs. An advantage of multiple baseline designs is that they require smaller samples than an RCT, as statistical power is generated by within subject evaluation and participants serve as their own control. A multiple baseline design allows us to distinguish the effect of treatment from that of time and allows for more causal interpretations than an open trial (Arntz et al., 2013; Renner et al., 2016).The aims of the current study were: 1) to provide an initial indication of the effectiveness of this multimodal trauma-focused approach for traumatized URMs, and 2) to provide a qualitative evaluation assessing treatment satisfaction of the participating URMs. As this is one of the first studies to examine the effectiveness of this treatment, this study can also inform future research efforts on how to conduct research among URMs.

MATERIAL AND METHODS

Procedure

This study was a collaboration between ARQ Centrum'45, partner in ARQ National Psychotrauma Centre (a specialized mental health care institute for the treatment of complex psychotrauma complaints) and Nidos (a guardianship institution for unaccompanied and

separated children under the age of 18). ICMs were employed by Nidos and guardians were informed about the trauma-focused treatment approach by youth care professionals working at Nidos. Nidos guardians who observed symptoms of PTSD and/or depression among URMs and barriers to regular mental health care were informed of the possibility to refer URMs to ARQ Centrum'45, in consultation with the minors. All patients who were consecutively referred to ARQ Centrum'45 for the trauma-focused treatment approach between June 2019 and December 2020 and who received the trauma-focused treatment from one of the participating therapists were invited to take part in the study.

Guardians were informed about the study via telephone. Subsequently, the URMs were invited for an intake. A therapist, a researcher from ARQ Centrum'45, an ICM, and -in most instances- the guardian were present during the intake interview. In addition to the intake interview, the researcher and the ICM offered the URMs verbal information about the nature of the study, its purpose, procedures, expected duration, and the possible benefits and risks involved in participation. An information letter and informed consent form were handed out to the URM and, if necessary, translated by the ICM. For URMs under the age of 16, the legal guardian also signed the written informed consent. The first ten consecutive eligible participants who agreed to take part in the study were included in the present study.

In this non-concurrent multiple baseline study, we randomized participants over five different baseline (waitlist) periods of 4, 5, 6, 7, and 8 weeks, respectively. A random sequence of 10 different baseline periods was generated using the software package Random Allocation Software (Random Allocation Software, 2004) by an independent researcher. The sequence was generated such that each baseline period appeared twice in the sequence. The independent researcher was contacted in order to obtain the baseline period once a new participant was included in the study. During the baseline period, participants did not undergo any intervention.

During this study, the first and last assessments of the URMs were conducted by an independent researcher (MV) with the help from an ICM. Information on demographic variables and requests for help were collected during the intake interview. Questionnaires measuring symptoms of PTSD (Children's Revised Impact of Event Scale; CRIES-13) and symptoms of depression (The Patient Health Questionnaire-9, modified for adolescents; PHQ-A) were administered weekly during the baseline period, treatment period, and a 4-week follow-up period. These measurements were conducted via the telephone by the ICMs. In addition, during this phone call, the ICM asked the following questions: 1) How are you doing? and 2) Do you have any questions? Finally, after the 4-week follow-up period participants were invited for an individual interview conducted by a researcher and ICM to evaluate the trauma-focused treatment. The study was approved by the Medical Ethical Committee of Leiden University (number P18.248).

Therapists

The trauma-focused treatment was offered by therapists working at ARQ Centrum'45.

Therapists were licensed mental health care workers, with multiple years of experience working with refugee minors from different cultural backgrounds, trained to offer EMDR. Therapists took part in supervision and multidisciplinary consultation.

Participants

Ten consecutive patients referred to the trauma-focused treatment approach by their legal guardian or general practitioner were included in this study. Participants were URMs with elevated symptoms of PTSD and/or depression, living in the Netherlands, referred to ARQ Centrum'45, and who received treatment from one of the four participating therapists. In order to be eligible to participate in this study, participants had to meet all of the following criteria: (1) being a URM under the guardianship of Nidos; (2) aged up to 19 (as some URMs may receive extended youth care after turning 18, minors up to 19 years old could be referred for treatment); (3) presenting symptoms of PTSD and/or depression; (4) with consent to participate in the study from the URM and her/his guardian. Potential participants meeting any of the following criteria were excluded from participation in this study: (1) acute suicidality; (2) acute psychosis; (3) if there was a need to consult or involve a psychiatrist, for example, when medication or crisis intervention was required. Clinicians checked the criteria based on information from the referral and/or intake interview.

Ten participants took part in the study. The flowchart can be found in Figure 1. Three participants prematurely terminated treatment. One participant dropped out because outreach care could not be offered because of restrictions due to COVID-19. One participant received bad news concerning his asylum status and moved to another country. Lastly, one participant reported no complaints after a few sessions and stated she wanted to stop treatment to focus on her daily life.

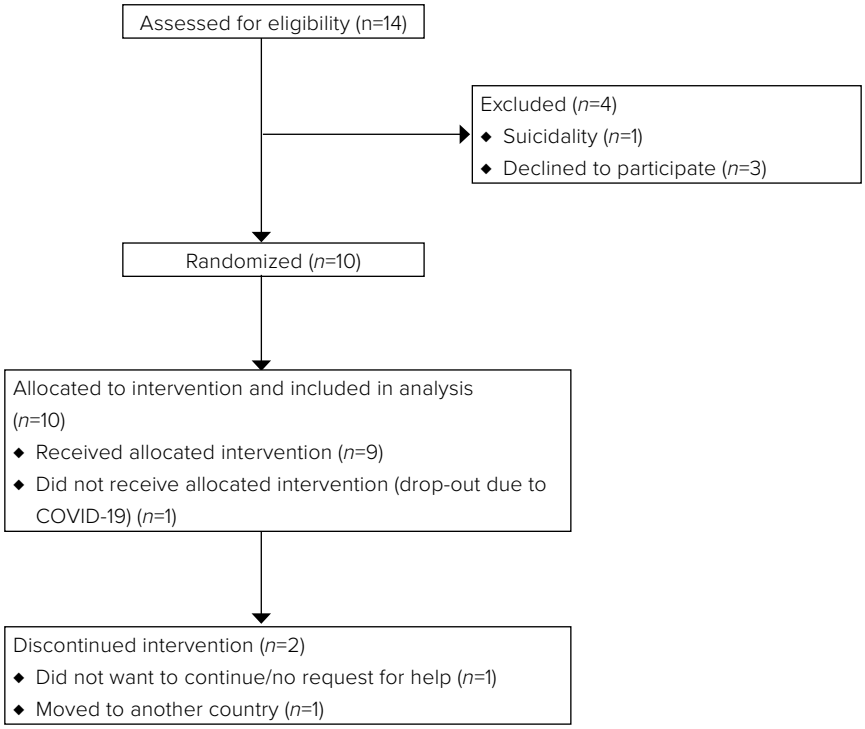
Instruments

Symptoms of Posttraumatic Stress

The CRIES-13 was administered to measure posttraumatic stress symptoms. The CRIES-13 is available in several languages (www.childrenandwar.org). The questionnaires were translated to Arabic and Tigrinya by ICMs prior to initiation of the study. The 13-item scale includes three subscales: intrusion, avoidance, and arousal. Items are rated on a 4-point scale with anchors 0 = *not at all,* 1 = *rarely,* 3 = *sometimes,* and 5 = *often* with a time period of the past seven days. A PTSD score is calculated by summing all item scores. In line with Verlinden et al. (2015), data from the CRIES-13 were counted as missing if more than one item on a subscale was missing. If less than one item per subscale was missing on the CRIES-13, missing values were replaced by the mean of the completed items on the same subscale, following the method presented by Kocalevent et al. (2013). Higher scores indicate more severe PTSD symptoms. A score ≥ 30 suggests an increased risk of PTSD (Perrin et al., 2005). Good psychometric properties have been reported for the CRIES-13 and it has been used extensively among children exposed to war and with different cultural

backgrounds (Perrin et al., 2005; Smith et al., 2003; Verlinden et al., 2014).

Figure 1. *Flowchart of Participants*



Symptoms of Depression

To measure symptoms of depression, the PHQ-A (the Patient Health Questionnaire-9, modified for adolescents) was used. This measure is adapted from the Patient Health Questionnaire-9 (Johnson et al., 2002). The PHQ-A is available in English and was translated to Arabic and Tigrinya by an ICM prior to initiation of the study. It includes nine items rated on a 4-point scale ranging from 0 (*not at all*) to 3 (*nearly every day*) with a time period of the past seven days. A total score was computed by summing all individual item scores with higher scores reflecting more severe depressive symptoms. In line with prior studies on the PHQ-9 (Kroenke et al., 2010), data were counted as missing if more than two items were missing. If two or less items were missing on the PHQ-A, missing values were replaced by the mean of the completed items (Kocalevent et al., 2013). Following research on the PHQ-9, a total score ≥ 10 was considered as the cut-off score for detecting depression (Manea et al., 2012). Despite a few differences, the PHQ-9 is mostly consistent with DSM-5 criteria for a major depressive disorder (Kroenke et al., 2001). The PHQ-9 is widely used in studies

among adolescents and good psychometric properties have been reported (Kroenke et al., 2001; Richardson et al., 2010). Although psychometric properties of the PHQ-A for refugee minors from different backgrounds have, to our knowledge, not yet been studied, the PHQ-A has been shown to have acceptable psychometric properties when completed by Arabic adolescent refugees (Al-Amer et al., 2020).

Evaluation of Treatment

Finally, a semi-structured qualitative interview was conducted by an independent researcher at the follow-up to qualitatively evaluate the treatment and assess treatment satisfaction according to the URMs. The qualitative interview consisted of questions about usefulness ("Was the treatment helpful, and if so, in what way?"; "Is there anything else you need?"), (emotional) change ("If you look back upon how you were feeling/functioning before you received this therapy and how you are doing now – what are the biggest changes?"), satisfaction ("What did you like/dislike about the treatment?"; "Would you recommend the treatment to someone with similar experiences?"), and questions concerning specific treatment components ("What did you think of the number of sessions?"; "Would you have minded traveling to receive treatment sessions?").

Statistical Analysis

Quantitative Analysis

First, visual inspection of the data was carried out in order to provide insight in the individual course of PTSD and depressive symptom severity during the baseline, intervention, and post-intervention period. Weekly obtained assessment data of the CRIES-13 and PHQ-A collected during the baseline, intervention, and post-intervention period were plotted in separate graphs for each participant. In order to establish whether observed intraindividual changes in PTSD and depressive symptom severity reflected statistically reliable changes, the Reliable Change Index (RCI) procedure as described by Jacobson and Truax (1992a), was used. The RCI is calculated as the ratio between the difference between two test scores obtained at two measurement occasions and the standard error of the difference score (SED). The SED was calculated based on baseline standard deviations derived from the study sample and test-retest reliability coefficients (.85 and .84 for the CRIES-13 and PHQ-9, respectively) reported by studies on the psychometric properties regarding the CRIES-13 and PHQ-9 (Kroenke et al., 2001; Verlinden et al., 2014). Baseline standard deviations in the current sample were comparable to those reported in studies on psychometric properties of the PHQ-A and CRIES-13 (Kroenke et al., 2001; Van der Kooij et al., 2013; Verlinden et al., 2014). RCI values larger than 1.96 (or smaller than -1.96) indicate that there is a statistical reliable intraindividual difference between two test scores, i.e. with 95% certainty, the difference between the test scores is due to actual change (improvement or deterioration) rather than measurement error. RCIs were calculated for the difference in PTSD and depressive symptom severity during baseline (t_1-t_2), treatment (t_2-t_3), and follow-up

(t_3-t_4). t_1 refers to the first baseline assessment, t_2 to the last baseline assessment, t_3 to the first follow-up assessment, and t_4 to the last follow-up assessment.

Missing datapoints were left out of the visual graphs. Missing datapoints for the RCI were handled using next observation carried backwards/forwards. If baseline or post-treatment datapoints were missing, the missing datapoints were imputed using the first available datapoint within the same period (i.e. baseline or post-treatment). Missing datapoints during the pre-treatment and follow-up period, were imputed using the last available datapoint within the same period (i.e. pre-treatment or follow-up).

Qualitative Analysis

Minutes taken during the qualitative evaluation interviews were analyzed using MAXQDA 10 (VERBI). The data were then analyzed using the General Inductive Approach (Thomas, 2003). In this approach, data analysis is guided by the evaluation objectives. First, the texts were read thoroughly. Second, specific text fragments that were linked to the research questions were identified. Third, fragments were labelled to create categories. These steps were conducted independently by two researchers (CvE and MV). During the fourth step, the overlap and redundancy of the categories were reduced. Finally, the most important categories were described. Both researchers discussed the categories until they reached a consensus. These five steps resulted in outcome categories that represented the most important themes.

Integrating Data

We conducted a concurrent mixed methods study, using a triangulation design (Creswell & Plano Clark, 2011). The aim of this design is to improve our understanding of a specific topic by obtaining complementary data. Using this design, quantitative and qualitative data are collected simultaneously. After data collection, one researcher (CvE) combined, compared, and contrasted the quantitative results and qualitative results. The integrated results are presented, describing whether the qualitative and quantitative data resulted in similar findings as well as highlighting different findings.

RESULTS

The average age of participants was 16.5 (SD = 1.08; range 15-18) years. Nine participants (90%) came from Eritrea and one from Syria (10%). Two participants were female (20%). Table 1 summarizes participant's main problems, the main focus of the sessions, no-show/drop-out, and additional comments. Missing datapoints of participants A, F, and G were due to drop-out. Other missing datapoints were mostly related to a participant (C) not being able to get out of bed; a participant (E) who experienced too much stress concerning family reunification to continue with the assessments; and a participant (H) did not want to continue with the questionnaires as she found it took too much time.

Table 1. *Treatment Overview per Participant*

Participant	Number of sessions	Main problem/request for help	Treatment module	No-show/drop-out	Comments	Qualitative/Quantitative Results
A	4	Forgetfulness, sleeping, nightmares	Intake, lifeline, and psychoeducation	Drop-out: did not want to continue, no request for help and too many daily stressors	Difficulties with foster mother.	*Quantitative.* Decrease in symptoms of depression during baseline. *Qualitative*. Did not take part in the interview.
B	11	Feeling down/insecure	Intake, lifeline, EMDR	Cancelled twice because of school activities and father passing away	Father passed away during treatment.	*Quantitative.* Decrease in symptoms of depression during baseline, increase in symptoms of depression during treatment, no change from start of treatment to follow-up. *Qualitative*. Increased focus, self-care, being proud of themselves talking to other about the past.
C	9	Feeling tired	Intake, lifeline	-	Received news that his father was not his biological father; is lying in bed for days; worries about asylum status; physical complaints; focus on establishing social network and activation.	*Quantitative.* A decrease in symptoms of depression during baseline and treatment, an increase in symptoms of depression during follow-up, no change from start of treatment to follow-up. *Qualitative*. Less physical aches, came out of bed more often, started remembering appointments.
D	7	Questions concerning identity, worries about physical health	Intake, lifeline, EMDR	-	Stress concerning relationship with family; worries about physical health and family reunification; questions concerning identity.	*Quantitative.* An increase in symptoms of depression from start treatment to follow-up, no other changes. *Qualitative*. Improved relationship with loved ones, still experiencing worries about family reunification

Table 1. *Continued*

Participant	Number of sessions	Main problem/request for help	Treatment module	No-show/drop-out	Comments	Qualitative/Quantitative Results
E	7	Sleeping, concentration, stress	Intake, lifeline, EMDR	-	Worries about family reunification; discussed sleeping hygiene.	*Quantitative.* An increase in symptoms of PTSD during baseline, a decrease in symptoms of PTSD during treatment, and an increase in symptoms of PTSD during follow-up, no change from start treatment to follow-up. An increase in symptoms of depression during baseline, follow-up and from start treatment to follow-up. *Qualitative*. An improvement in sleep and concentration, new problems in Eritrea and in school after treatment caused feelings of depression.
F	0	Feeling down, suicidal thoughts	Intake	No-show twice during intake, drop-out after moving country	Declared age of majority/ illegal; moved to another country.	*Quantitative.* No changes during baseline. *Qualitative*. Did not take part in the interview.
G	0	Sleeping, concentration, overthinking	-	Drop-out because of COVID-19	-	*Quantitative.* No changes during baseline. *Qualitative*. Did not take part in the interview.
H	8	Stress, sleeping, avoiding contacts because of memories	Intake, lifeline, EMDR	-	Worries about family and friends in Eritrea; positive news concerning family reunification.	*Quantitative.* A decrease in symptoms of depression and PTSD during baseline. No change from start treatment to follow-up. *Qualitative*. Thinking more about positive memories, feeling 'less bad' about the negative memories.
I	9	Sleeping, feeling more calm, concentration	Intake, lifeline, EMDR	Cancelled twice because of quarantine due to COVID-19	Bad news concerning family reunification; difficulties with peers.	*Quantitative.* A decrease in symptoms of depression during baseline, no other changes. *Qualitative*. Forgot negative memories, no other effects, prefers focusing on the future.
J	9	Stress and difficulties sleeping	Intake, lifeline	-	Worries about family members and family reunification.	*Quantitative.* A decrease in symptoms of depression and PTSD, no other changes. *Qualitative*. The treatment helped with practical issues, more keen to go to appointments

Note: EMDR = Eye Movement Desensitization and Reprocessing; PTSD = posttraumatic stress disorder

Symptoms of PTSD and Depression

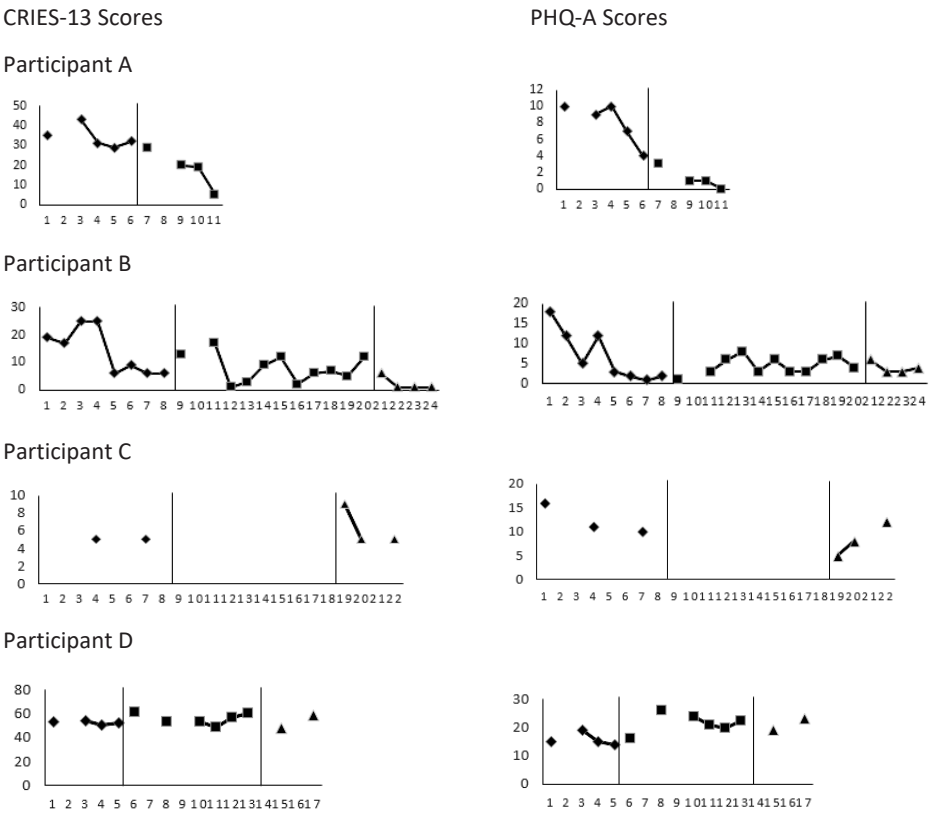
The baseline, pre-treatment, post-treatment, and follow-up measures are presented in Table 2. Weekly assessments of PTSD and depressive symptom severity are presented in Figure 2. Visual inspection suggests a decrease in symptoms of depression during the baseline period, but negligible change during treatment and follow-up. Moreover, fluctuations in symptoms can be seen in several participants during the baseline period (e.g., in participant B, I, and J).

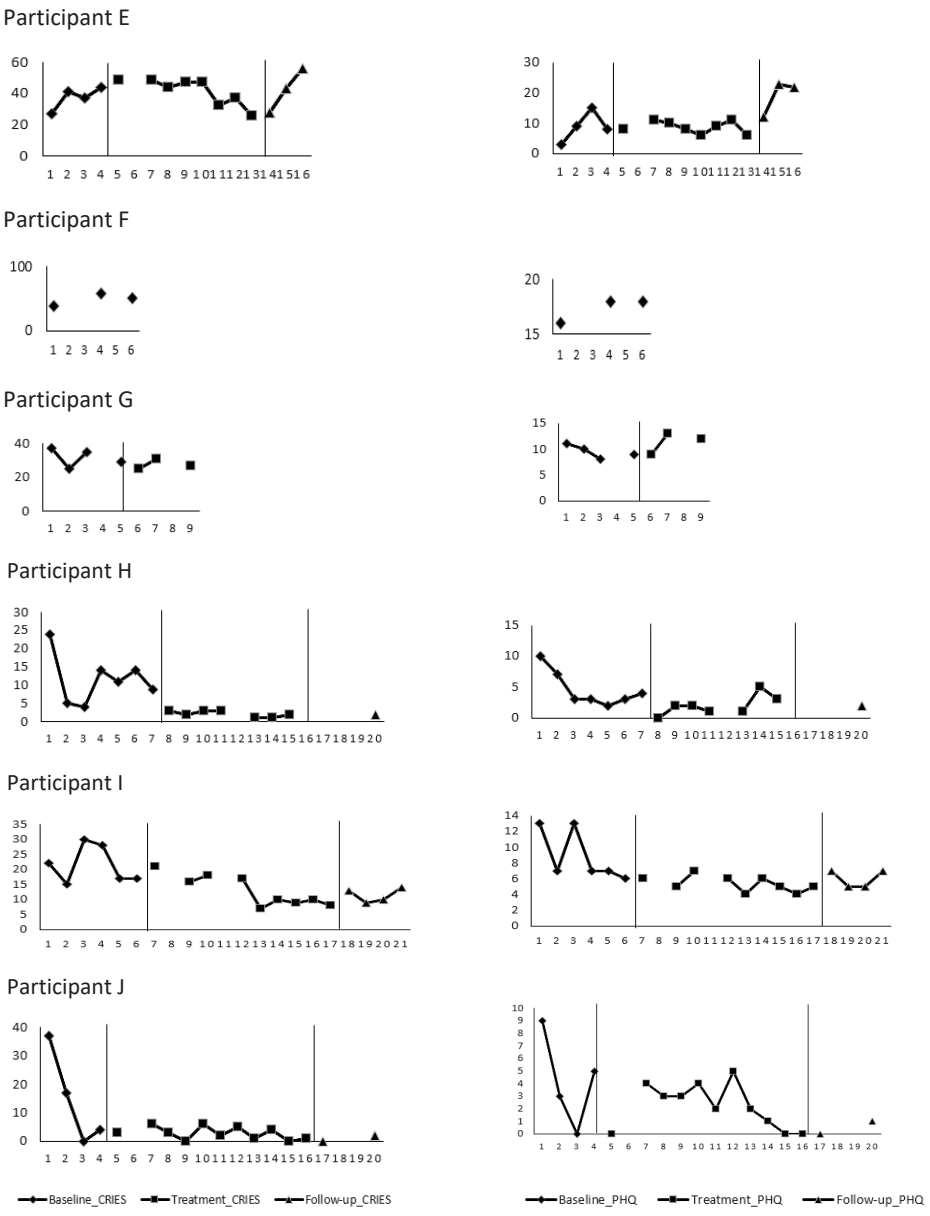
Table 2. *Baseline, Pre-treatment, Post-treatment, and Follow-up Measurements*

Measure	Baseline			Pre-treatment			Post-treatment			Follow-up		
	n	M	SD	*n*	M	SD	*n*	M	SD	*n*	M	SD
CRIES-13	10	29.8	13.3	9	23.2	20.6	6	17.3	17.6	7	19.9	26.2
PHQ-A	10	12.2	4.4	10	7.1	6.4	6	8.2	6.6	7	10.1	9.2

Note: CRIES-13 = Children's Revised Impact of Event Scale; PHQ-A = The Patient Health Questionnaire-9, modified for adolescents.

Figure 2. *Individual Scores on the PHQ-A and CRIES-13 Over Time*





Note. CRIES-13 = Children's Revised Impact of Events Scale; PHQ-A = Patient Health Questionnaire for Adolescents.

Table 3 presents the RCI scores during baseline (t_1-t_2), treatment (t_2-t_3), follow-up (t_3-t_4), and between the start of treatment and end of follow-up (t_2-t_4). During the baseline period, two participants improved with regard to PTSD symptom severity, one worsened, and six

remained unchanged. During treatment, only one participant improved with regard to PTSD symptom severity. However, this participant deteriorated during follow-up and overall, remained unchanged. The other participants (*n*=5) remained unchanged with regard to PTSD symptom severity during treatment. Overall, none of the participants evidenced statistically significant changes from the beginning of treatment to follow-up.

Table 3. *RCI of Symptoms of PTSD and Depression*

Participant	RCI t_1-t_2 CRIES-13	RCI t_2-t_3 CRIES-13	RCI t_3-t_4 CRIES-13	RCI t_2-t_4 CRIES-13	RCI t_1-t_2 PHQ-A	RCI t_2-t_3 PHQ-A	RCI t_3-t_4 PHQ-A	RCI t_2-t_4 PHQ-A
A	-.83^0	-	-	-	-2.79$^+$	-	-	-
B	-.83^0	-0.96^0	-0.69^0	-1.65^0	-6.77$^+$	1.99$^-$	-0.80^0	1.20^0
C	0.00^0	0.55^0	-0.55^0	0.00^0	-2.39$^+$	-1.99$^+$	2.79$^-$	0.80^0
D	1.10^0	-1.83^0	1.56^0	-0.28^0	0.40^0	1.25^0	1.54^0	2.79$^-$
E	3.03$^-$	-2.87$^+$	3.87$^-$	1.01^0	1.99$^-$	1.59^0	3.98$^-$	5.58$^-$
F	1.65^0	-	-	-	0.80^0	-	-	-
G	-1.65^0	-	-	-	-0.80^0	-	-	-
H	-2.89$^+$	-	-	-0.14^0	-3.98$^+$	-	-	0.80^0
I	-0.14^0	-1.10^0	0.14^0	-0.96^0	-2.79$^+$	0.40^0	0.00^0	0.40^0
J	-4.68$^+$	-0.41^0	0.28^0	-0.14^0	-3.59$^+$	0.00^0	0.40^0	0.40^0

^{0}no reliable change
$^+$reliable decrease in symptoms
$^-$reliable increase in symptoms
Note: CRIES-13 = Children's Revised Impact of Event Scale; PHQ-A = The Patient Health Questionnaire-9, modified for adolescents; PTSD = posttraumatic stress disorder; RCI = Reliable Change Index; t_1 = first baseline assessment; t_2 = last baseline assessment; t_3 = first follow-up assessment; t_4 = last follow-up assessment.

Six participants improved with regard to depressive symptom severity during baseline, one deteriorated, and three remained unchanged. During treatment, one improved, one worsened, and four remained unchanged. After treatment, two deteriorated, and four remained unchanged. From start of treatment to follow-up two worsened and five remained unchanged.

Evaluation by Participants

Participants who completed the study protocol from baseline to follow-up (*n*=7) took part in the qualitative evaluation of the multimodal trauma-focused treatment. Most participants (*n*=6) found the treatment helpful and would recommend it to others. They appreciated the outreach work, as five participants stated they would not have participated if they had to travel to a mental health institution. Moreover, three participants valued the occasional informal, personal nature of the contact. Some explained that they appreciated that the ICM sometimes stayed after a session to talk, walk, or cook together. For example, one URM said drinking coffee and walking with the ICM helped her after a difficult session, explaining: "[*After coffee*] *I walked home as a new person.*" Four participants reported that a useful aspect of the treatment was talking about their experiences. URMs explained they felt free

to share their experiences, were relieved after talking, and felt space to discuss subjects they would not address with others. One URM added:

> *They come back, and again, they don't give up. I'm starting to think: can I share my problems with these people? And then I started sharing. [...] Sometimes I was tired and wanted to sleep and did not want to talk, but they came back and helped me and little by little, I started talking.*

Finally, two participants stated they found the lifeline helpful. One added:

> *Now I have a chance to see all different parts of my life, the good and the bad. [...] This offers me balance.*

All but one participant noticed an impact of the treatment. For example, some (*n*=3) noted they could address difficult topics with loved ones and experienced an improved relationship with friends and family. Other benefits included an improved ability to concentrate, feeling proud of themselves, improved self-care, and experiencing improved sleep. The one URM who did not notice an impact explained that although negative experiences did not bother him so much anymore, the treatment did not impact his life. He would rather focus on his future, such as his education or social network. Another URM stated:

> *The biggest difference between before and after? Before I wasn't interested, I didn't feel like doing anything. I didn't want to go to school. Or didn't go to appointments. Sleeping was also difficult. After and during the treatment, I feel like I'm more keen, I go to school and to the appointments*

Notably, most URMs (*n*=5) spoke about the daily stressors they continued to experience, including worries about the future, anxiety concerning family reunification, troubles with peers, and worries about the lives and wellbeing of family members. For example, the father of a URM passed away, another URM received the news that his father was not his biological father, and yet another URM was declared illegal during the treatment. In addition, most URMs came from Eritrea, and during this study there was turmoil in their country of origin, leaving them worried about the lives of their families. Some explained that their complaints increased due to these issues.

> *Now there is a new problem concerning school and my family in Eritrea. [...] Right after the treatment I had less difficulties sleeping and concentrating. So now, after this situation I have nightmares and I am sleepwalking again. Because of these problems I'm depressed. Sometimes I contemplate suicide. I have a lot of problems now.*

Integrating Qualitative and Quantitative Data

In the qualitative evaluation, all but one URM noted they found the treatment useful and felt the treatment had positively impacted their wellbeing. However, this impact was not visible in the quantitative evaluation. The qualitative evaluation included results, such as improved sleep and improved ability to concentrate, that would be expected to manifest in the quantitative evaluation. However, other qualitative findings, including being able to address difficult topics with loved ones, are not expected to be reflected directly in the questionnaires measuring PTSD and depression. For example, participant B reported no change from start of treatment to follow-up on symptoms of depression and PTSD, but did report increased self-care and being proud of herself.

The impact of continuous stressors was sometimes reflected in both the quantitative as well as the qualitative data. For example, participant E reported an increase in symptoms of PTSD and depression during follow-up. The qualitative data indicated that this might have resulted from new problems that occurred at school and the tumultuous circumstances in Eritrea, where his family resided. Notably, most changes in symptoms of PTSD and depression were observed during the baseline period. No qualitative data on this time period were collected.

DISCUSSION

The current study explored the potential effectiveness and treatment satisfaction of a trauma-focused treatment approach in a small sample of URMs, suffering from symptoms of PTSD and/or depression. In addition, we aimed to provide implications for future research on how to conduct research among URMs. Although URMs are among the most vulnerable groups of refugees, studies evaluating the effectiveness of trauma-focused treatments for URMs remain scarce. We expected to find a decrease in symptoms of PTSD and depression considering that our modular treatment included promising treatment interventions, including EMDR and KIDNET. Notably, the baseline period was associated with a larger decrease of mental health issues than the treatment period. The results of our quantitative evaluation do not show clinically reliable symptom reductions at posttest or follow-up.

A question that arises is whether the offered treatment approach suited the current needs of the URMs. Potentially, another treatment, such as culturally adapted cognitive behavioral therapy (CBT) with attention for emotion-regulation and continuous stressors, might have been more suitable (Hinton et al., 2012). In addition, the limited number of sessions focused on EMDR or CBT might not have been enough to cause a significant change in symptoms of PTSD or depression. Another possibility is that the questionnaires do not reflect the actual impact of the treatment approach. For instance, the main problem reported by the URMs was not always related to PTSD and depression, but more often to psychosocial functioning. Consequently, the treatment approach might have focused more

on, and consequently affected, the psychosocial functioning and/or quality of life of the URMs. As suggested by the qualitative findings, the treatment might have had a positive impact on the URMs that is not directly related to symptoms of PTSD and depression, as some URMs, for example, indicated that they noticed an improvement in selfcare and in the will to discuss difficult topics with loved ones.

In line with previous studies, we found an indication that the treatment effect was impacted by continuous stressors (Unterhitzenberger et al., 2019a; Van Es et al., 2021). URMs were faced with a wide range of strenuous daily stressors during treatment, including the passing of a father and bad news concerning family reunification. Additionally, during the time of this study there was turmoil in the border region of Ethiopia and Eritrea, an area where many Eritrean refugees reside (British Broadcasting Corporation, 2021). This resulted in major worries concerning family reunion procedures as well as the lives and wellbeing of friends and family residing in Eritrea and Ethiopia. The impact of current stressors on mental health has been shown in several studies (Drožđek et al., 2014b; Laban et al., 2005a; Unterhitzenberger et al., 2019a). Although we did not systematically evaluate the impact of current stressors on PTSD and depression, or the impact of mental health problems on current stressors, some URMs indeed communicated that their mental health was impacted by continuous stressors. When offering trauma-focused treatment for URMs, it is of great importance to pay attention to reducing stressors resulting from the past as well as continuous stressors. This is not only of relevance because URMs report the impact of both stressors, but also because PTSD symptoms can maintain and provoke further daily stressors and vice versa. For example, school problems can be a result of the lack of concentration and conflicts with peers can be a result of hyperarousal (Neuner et al., 2010). Although a focus on daily stressors is important, focusing on mental health problems is critical as well.

All but one participant came from Eritrea. In Eritrea, talking about psychological problems is often seen as shameful and giving voice to dissatisfaction is often seen as being ungrateful. As a result, URMs taking part in the interviews may have been hesitant to answer questions about their current psychological wellbeing and satisfaction with the treatment, which may have resulted in socially desirable answers (Nidos, 2018). Furthermore, the questionnaires used in this study were not validated for an Eritrean population. In addition, the translations aimed to provide a direct translation of the questionnaires and did not account for cultural appropriateness of questions or translation of cultural concepts (Pernice, 1994; Robila & Akinsulure-Smith, 2012). However, a study amongst traumatized refugees in the Netherlands suggested that local idioms of distress may not play a major role when assessing PTSD, anxiety, and depression (Wind et al., 2017). Although we aimed to overcome the aforementioned challenges by collaborating with ICMs in the assessments and combining qualitative data with quantitative data, we should be aware that the background and culture of these URMs might have affected the results of the current study.

Most changes in symptoms were observed during the baseline period. This suggests

that the symptoms of PTSD and depression were not stable in this sample during this period of time. The changes during baseline might have been due to events in the lives of these URMs (e.g., news concerning family reunification). Another explanation might be that the weekly contact with the ICM, who conducted the questionnaires and assessed how the URM was doing, positively impacted the wellbeing of the URMs. However, as we did not systematically assess events or other factors that may have impacted the mental health of URMs during the baseline period this limits our ability to make any statements on the cause of the changes during this period. Arntz et al. (2013) suggested the multiple baseline design might be more suited for stable problems without a large time effect during the baseline period. As the baseline periods were unstable, it was more difficult to distinguish the effect of treatment from that of time. Using a longer baseline period in future studies might result in a more stable baseline.

The feasibility of the current study was influenced by factors related to the setting and population, including news concerning asylum status and family reunification. In our earlier study, we found that the feasibility of the assessments was low, possibly as a result of therapists conducting the assessments (Van Es et al., 2021). Although the involvement of ICMs in the assessments increased response rates, some URMs did not complete all questionnaires. Most participants who refused to fill in questionnaires did so because they were experiencing (too much) stress. Missing questionnaires and drop-out did not seem to be related to the nature of the treatment.

Strengths and Limitations

Strengths concerning the study include that it is one of the first to evaluate the effectiveness of a trauma-focused treatment approach specifically for URMs. Moreover, the study is conducted in a clinical, naturalistic setting. Another strength is that, in contrast to our feasibility study (Van Es et al., 2021), the assessments were not conducted by the therapist. However, the ICM conducting the questionnaires was also involved in the treatment and both the ICM and researcher were aware of the treatment status and -condition.

Limitations include the restricted generalizability of the current findings. Firstly, all but one URM came from Eritrea. Secondly, the substantial number of drop-outs and missing data might have affected study outcomes. Another limitation is the use of the CRIES-13 to measure symptoms of PTSD, as the questionnaire is not in line with the contemporary DSM-5 or ICD-11. Moreover, the questionnaire could possibly be filled in with a continuous stressor in mind instead of a prior traumatic event, as it was not combined with a questionnaire assessing stressors (Criterion A).

Scientific Implications

It must be stressed that the challenges we faced during this study should not discourage future research, as these URMs deserve specialized treatment, adapted to their specific needs. The findings of this study have several possible scientific implications. First, future research is

needed to broaden our understanding of the acceptability and effectiveness of the presented trauma-focused treatment approach. It was difficult to establish the effectiveness of the current treatment approach as the treatment approach was offered in a flexible manner and therapists were free to choose modules that best suited the needs of the URMs. This resulted in a wide variety of subjects addressed during the treatment sessions, again resulting in difficulties in drawing conclusions about the effectiveness of the treatment approach. We found that the treatment approach partly overcomes barriers to treatment in a highly specialized population that is not motivated for treatment. In addition, most URMs evaluated the approach positively and stated it had positively impacted their wellbeing. More research is needed to further understand which treatment components were helpful, and which components did not contribute to the acceptability and effectiveness of the treatment approach. Until further examination of this treatments is conducted, preliminary implementation is cautioned.

Second, future research efforts might focus on other promising treatments for URMs. For example, Unterhitzenberger et al. (2019a) painted a promising picture, indicating that TF-CBT is feasible and possibly effective in diminishing symptoms of PTSD in URMs. In addition, a research protocol was recently published, describing a RCTs comparing stepped-care models to care as usual for URMs (Rosner et al., 2020).

Conclusion

The current study represents our ongoing search in developing a suitable treatment approach for an understudied population deserving the treatment they need. This study adds to the knowledge about methodological considerations in evaluating treatments for URMs, the potential effects of trauma-focused treatments, and the implementation of treatments for URMs.

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REFERENCES

Al-Amer, R., Maneze, D., Ramjan, L., Villarosa, A. R., Darwish, R., & Salamonson, Y. (2020). Psychometric testing of the Arabic version of the Patient Health Questionnaire among adolescent refugees living in Jordan. *International Journal of Mental Health Nursing*, *29*(4), 685-692.

Arntz, A., Sofi, D., & Van Breukelen, G. (2013). Imagery rescripting as treatment for complicated PTSD in refugees: a multiple baseline case series study. *Behaviour Research and Therapy*, *51*(6), 274-283.

Bean, T., Eurelings-Bontekoe, E., Mooijaart, A., & Spinhoven, P. (2006). Factors associated with mental health service need and utilization among unaccompanied refugee adolescents. *Administration Policy Mental Health*, *33*(3), 342-355. https://doi.org/10.1007/s10488-006-0046-2

British Broadcasting Corporation. (2021). *Ethiopia's Tigray war: The short, medium and long story*. Retrieved 14-09-2021 from https://www.bbc.com/news/world-africa-54964378

Creswell, J. W., & Plano Clark, V. (2011). Choosing a mixed methods design. *Designing and Conducting Mixed Methods Research*, *2*, 53-106.

Demazure, G., Gaultier, S., & Pinsault, N. (2018). Dealing with difference: a scoping review of psychotherapeutic interventions with unaccompanied refugee minors. *European Child & Adolescent Psychiatry*, *27*(4), 447-466. https://doi.org/10.1007/s00787-017-1083-y

Derluyn, I., & Broekaert, E. (2008). Unaccompanied refugee children and adolescents: the glaring contrast between a legal and a psychological perspective. *International Journal of Law Psychiatry*, *31*(4), 319-330. https://doi.org/10.1016/j.ijlp.2008.06.006

Drožđek, B., Kamperman, A. M., Tol, W. A., Knipscheer, J. W., & Kleber, R. J. (2014). Seven-year follow-up study of symptoms in asylum seekers and refugees with PTSD treated with trauma-focused groups. *Journal of Clinical Psychology*, *70*(4), 376-387.

Eurostat. (2020). *Asylum applicants considered to be unaccompanied minors* [newsrelease]. Eurostat.

Hinton, D. E., Rivera, E. I., Hofmann, S. G., Barlow, D. H., & Otto, M. W. (2012). Adapting CBT for traumatized refugees and ethnic minority patients: Examples from culturally adapted CBT (CA-CBT). *Transcultural Psychiatry*, *49*(2), 340-365.

Huemer, J., Karnik, N. S., Voelkl-Kernstock, S., Granditsch, E., Dervic, K., Friedrich, M. H., & Steiner, H. (2009). Mental health issues in unaccompanied refugee minors. *Child and Adolescent Psychiatry and Mental Health*, *3*(1), 13. https://doi.org/10.1186/1753-2000-3-13

Jacobson, N. S., & Truax, P. (1992). Clinical significance : A statistical approach to defining meaningful change in psychotherapy research. In A. E. Kazdin (Ed.), *Methodological Issues & Strategies in Clinical Research* (pp. 631–648). American Psychological Association. https://doi.org/10.1037/10109-042

Johnson, J. G., Harris, E. S., Spitzer, R. L., & Williams, J. B. W. (2002). The Patient Healh Questionnaire for Adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. *Journal of Adolescent Health*, *30*(3), 196-204.

Kocalevent, R.-D., Hinz, A., & Brähler, E. (2013). Standardization of the depression screener patient health questionnaire (PHQ-9) in the general population. *General Hospital Psychiatry*, *35*(5), 551-555.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*(9), 606-613.

Kroenke, K., Spitzer, R. L., Williams, J. B., & Löwe, B. (2010). The patient health questionnaire somatic, anxiety, and depressive symptom scales: a systematic review. *General Hospital Psychiatry*, *32*(4), 345-359.

Laban, C. J., Gernaat, H. B., Komproe, I. H., Van Der Tweel, I., & De Jong, J. T. (2005). Postmigration living problems and common psychiatric disorders in Iraqi asylum seekers in the Netherlands. *The Journal of Nervous and Mental Disease*, *193*(12), 825-832.

Manea, L., Gilbody, S., & McMillan, D. (2012). Optimal cut-off score for diagnosing depression with the Patient Health Questionnaire (PHQ-9): a meta-analysis. *CMAJ*, *184*(3), E191-E196.

Neuner, F., Kurreck, S., Ruf, M., Odenwald, M., Elbert, T., & Schauer, M. (2010). Can asylum-seekers with posttraumatic stress disorder be successfully treated? A randomized controlled pilot study. *Cognitive Behaviour Therapy*, *39*(2), 81-91.

Ni Raghallaigh, M. (2013). The Causes of Mistrust amongst Asylum Seekers and Refugees: Insights from Research with Unaccompanied Asylum-Seeking Minors Living in the Republic of Ireland. *Journal of Refugee Studies*, *27*(1), 82-100. https://doi.org/10.1093/jrs/fet006

Nickerson, A., Bryant, R. A., Silove, D., & Steel, Z. (2011). A critical review of psychological treatments of posttraumatic stress disorder in refugees. *Clinical*

Psychology Review, *31*(3), 399-417.

Nidos. (2018). *Normen en waarden in de Eritrese samenleving*. Utrecht: Nidos.

Pernice, R. (1994). Methodological issues in research with refugees and immigrants. *Professional Psychology: Research and Practice*, *25*(3), 207.

Perrin, S., Meiser-Stedman, R., & Smith, P. (2005). The Children's Revised Impact of Event Scale (CRIES): validity as a screening instrument for PTSD. *Behavioural and Cognitive Psychotherapy*, *4*(33), 487-498.

Random Allocation Software. (2004). *Random Allocation Software*. Retrieved 26-10-2021 from https://mahmoodsaghaei.tripod.com/Softwares/randalloc.html

Renner, F., Arntz, A., Peeters, F. P., Lobbestael, J., & Huibers, M. J. (2016). Schema therapy for chronic depression: results of a multiple single case series. *Journal of Behavior Therapy and Experimental Psychiatry*, *51*, 66-73.

Richardson, L. P., McCauley, E., Grossman, D. C., McCarty, C. A., Richards, J., Russo, J. E., Rockhill, C., & Katon, W. (2010). Evaluation of the Patient Health Questionnaire-9 Item for detecting major depression among adolescents. *Pediatrics*, *126*(6), 1117-1123. https://doi.org/10.1542/peds.2010-0852

Robila, M., & Akinsulure-Smith, A. M. (2012). Psychological ethics and immigration. *The Oxford Handbook of International Psychological Ethics*, 191.

Rosner, R., Sachser, C., Hornfeck, F., Kilian, R., Kindler, H., Muche, R., Müller, L. R. F., Thielemann, J., Waldmann, T., & Ziegenhain, U. (2020). Improving mental health care for unaccompanied young refugees through a stepped-care approach versus usual care+: study protocol of a cluster randomized controlled hybrid effectiveness implementation trial. *Trials*, *21*(1), 1-13.

Smith, P., Perrin, S., Dyregrov, A., & Yule, W. (2003). Principal components analysis of the impact of event scale with children in war. *Personality and Individual Differences*, *34*, 315-322.

The UN Refugee Agency. (2020). *Global Trends - Forced Displacement in 2019*.

Thomas, D. R. (2003). *A general inductive approach for qualitative data analysis*. Paper presented at School of Population Health, University of Auckland, New Zealand, August.

Unterhitzenberger, J., Wintersohl, S., Lang, M., König, J., & Rosner, R. (2019). Providing manualized individual trauma-focused CBT to unaccompanied refugee minors with uncertain residence status: a pilot study. *Child and Adolescent Psychiatry and Mental Health*, *13*(1), 1-10.

Van der Kooij, I. W., Verlinden, E., de Jonge, C. D., de Kruijf, S., Bipat, S., Boer, F., Lindauer, R. J., & Graafsma, T. L. (2013). Use of a screening tool for post traumatic stress disorder in children in suriname. *Academic Journal of Suriname*, *4*, 347-352.

Van Es, C. M., Sleijpen, M., Mooren, T., te Brake, H., Ghebreab, W., & Boelen, P. A. (2019). Eritrean Unaccompanied Refugee Minors in Transition: A Focused Ethnography of Challenges and Needs. *Residential Treatment of Children and Youth*, *36*(2), 157-176. https://doi.org/10.1080/0886571x.2018.1548917

Van Es, C. M., Sleijpen, M., Velu, M. E., Boelen, P. A., Van Loon, R. E., Veldman, M., Kusmallah, N., Ekster, P. J., & Mooren, T. (2021). Overcoming barriers to mental health care: multimodal trauma-focused treatment approach for unaccompanied refugee minors. *Child and Adolescent Psychiatry and Mental Health*, *15*(1), 1-14.

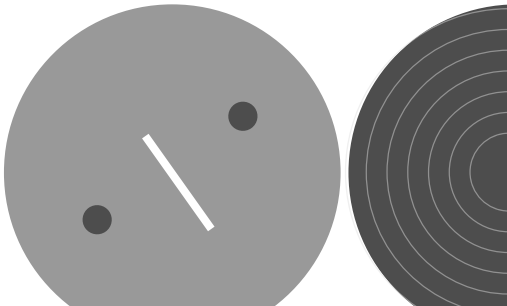
Verlinden, E., Opmeer, B. C., Van Meijel, E. P., Beer, R., De Roos, C., Bicanic, I. A., Lamers-Winkelman, F., Olff, M., Boer, F., & Lindauer, R. J. (2015). Enhanced screening for posttraumatic stress disorder and comorbid diagnoses in children and adolescents. *European Journal of Psychotraumatology*, *6*(1), 26661.

Verlinden, E., Van Meijel, E. P., Opmeer, B. C., Beer, R., de Roos, C., Bicanic, I. A., Lamers-Winkelman, F., Olff, M., Boer, F., & Lindauer, R. J. (2014). Characteristics of the Children's Revised Impact of Event Scale in a clinically referred Dutch sample. *Journal of Traumatic Stress*, *27*(3), 338-344.

Vervliet, M., Lammertyn, J., Broekaert, E., & Derluyn, I. (2014). Longitudinal follow-up of the mental health of unaccompanied refugee minors. *European Child & Adolescent Psychiatry*, *23*(5), 337-346. https://doi.org/10.1007/s00787-013-0463-1

Vervliet, M., Meyer Demott, M. A., Jakobsen, M., Broekaert, E., Heir, T., & Derluyn, I. (2014). The mental health of unaccompanied refugee minors on arrival in the host country. *Scandinavian Journal of Psychology*, *55*(1), 33-37. https://doi.org/10.1111/sjop.12094

Wind, T. R., Van der Aa, N., de la Rie, S., & Knipscheer, J. (2017). The assessment of psychopathology among traumatized refugees: measurement invariance of the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist-25 across five linguistic groups. *European Journal of Psychotraumatology*, *8*(sup2), 1321357.



8

Summary of main findings and general discussion

This dissertation aims to increase our understanding of the needs of refugee families and unaccompanied refugee minors (URMs) and to evaluate mental health intervention programs developed specifically for URMs and refugee families resettling in the Netherlands. The development of children and adolescents can be seen as a process resulting from interactions between individuals and different ecological levels of their context, including their family, community, and society (Bronfenbrenner, 1979; Reed et al., 2012; Scharpf et al., 2021). Moreover, refugee children and adolescents are impacted by pre-migration, peri-migration, and post-migration experiences. This ecological and chronological framework, proposed by Reed et al. (2012) can help in conceptualizing risk factors as well as protective factors impacting the mental health of refugee children and adolescents (Betancourt & Khan, 2008; Reed et al., 2012). Accordingly, we took into account the impact of earlier and current stressors, and protective and risk factors on different levels.

Different perspectives and methods were explored to inform the development and refinement of care systems and programs for this population. The first part on this dissertation focused on multiple family therapy (MFT) and a preventive, cultural adaptation of this program (Family Empowerment; FAME). The second part comprised of three studies on unaccompanied refugee minors (URMs), exploring their needs and challenges, and evaluating the feasibility and effectiveness of a trauma-focused treatment approach developed specifically for URMs in the Netherlands. In this final chapter, the main findings of this dissertation are discussed. In addition, implications of these findings for future research, clinical work, and the improvement of programs aiming to improve mental health and family functioning are addressed.

SUMMARY OF MAIN FINDINGS

Part 1. Refugee Families

MFT is increasingly implemented for various populations, including families dealing with the consequences of trauma (Kiser et al., 2010; Weine et al., 2008). However, due to factors including the heterogeneity of studies and the lack of conceptual clarity, there had been no systematic reviews or meta-analyses assessing the impact of MFT on mental health issues and family functioning. In **Chapter 2**, we therefore presented an overview of existing literature on the impact of MFT on mental health problems and/or family functioning, and a meta-analysis examining the efficacy of MFT. We found that MFT is associated with improvements in family functioning, with a small effect size. In addition, MFT is suggested to result in improvements in positive and negative symptoms of schizophrenia with a large effect size, although this effect was not statistically significant. Finally, MFT was not associated with changes in mood and conduct problems.

Furthermore, we explored the feasibility of FAME, a preventive MFT program, adapted specifically for asylum seekers families in the Netherlands. As research protocol

publications contribute to the transparency of research and prevent selective publication and reporting, **Chapter 3** presented the study protocol for a FAME feasibility trial. The development and evaluation of FAME as described in this study protocol is in line with the cycle of intervention development proposed by Weine (2011). The aim was to realize the third step of this cycle: to perform a pilot intervention trial in order to demonstrate program characteristics such as feasibility, acceptability, and potential effectiveness. We described several anticipated challenges to the implementation of the study, such as the impact of post-migration stressors, including relocations.

The study protocol is followed by **Chapter 4**, describing the mixed-methods pilot trial assessing the feasibility of FAME. The study identified several challenges to program integrity, including constraints in time, attendance, and difficulties in organizing adequate rooms. A small group of participants completed all pre-and-post-FAME assessments measuring symptoms of depression and posttraumatic stress disorder (PTSD). Most participants noted they had appreciated gathering with multiple families. Some developed new coping strategies and more awareness of the impact of stress on their family. Although the quantitative results indicated that FAME might coincide with a decrease in anxiety and depression in parents, no change in family functioning was observed.

Part 2. Unaccompanied Refugee Minors

To map how URMs can be supported to improve their quality of life in the Netherlands, the perspectives of Eritrean minors and their guardians and mentors were explored using a focused ethnography study (**Chapter 5**). The study found the following themes to be crucial in the lives of Eritrean URMs in the Netherlands: relationships, psychological stress, preparation for independent living, spirituality, and leisure activities. Challenges encountered by URMs included finding their way without their parents as well as dealing with worries about family reunification and family members. Strengths according to URMs and their guardians and mentors included that URMs were focused on their education and learning the Dutch language, that URMs were independent concerning activities of daily living, and that the URMs formed important sources of support for each other. The ethnography also indicated that the wellbeing of Eritrean URMs is linked to their socio-ecological system, both in the Netherlands and in Eritrea. Finally, the findings highlighted the need for more focused attention to their highly specialized mental health issues, such as culturally sensitive interventions focusing on previous experiences as well as on continuous stressors.

As few studies have evaluated trauma-focused treatments for URMs and as URMs are faced with several barriers to mental health care, a short-term, multimodal trauma-focused treatment approach was developed. **Chapter 6** presented a pilot study of this approach, evaluating the main request for help, treatment integrity, and the course of symptoms of PTSD and depression during the treatment. The majority of the participants did not complete the pre- and post-treatment assessments of PTSD and depression. The results suggested that

the trauma-focused treatment approach is partly feasible. Challenges to the feasibility of the approach, including low treatment adherence, were often related to structural barriers, such as news concerning asylum status and relocations. In addition, therapists deviated from the treatment protocol to adapt the focus of the session to meet the specific needs of the URMs. The results offered an indication that several barriers to mental health care were overcome. The added value of offering outreach care and collaboration with intercultural mediators (ICMs) was emphasized by the results.

Finally, we aimed to evaluate the effectiveness of the multimodal treatment approach. Because the feasibility of randomized controlled trials -the 'golden standard' in evaluating program effectiveness- is limited when conducting research with URMs (Demazure et al., 2018), an alternative method to evaluate effectiveness was applied. In **Chapter 7** we presented a mixed-methods study, combining a multiple baseline design and interviews assessing treatment satisfaction through triangulation. The quantitative results did not demonstrate that participants experienced a reduction in symptoms of PTSD and/or depression. Based on the qualitative evaluation, all but one minor found the treatment useful and thought the treatment had positively impacted their wellbeing. Both the quantitative and qualitative results reflect the impact of continuous stressors on the wellbeing of the participating URMs.

The current dissertation has a specific focus on family functioning and the caregiver-child relationship. The relationship between family members can be helpful when facing adversity and insecurity. The impact of separation from loved ones and the importance of family in getting through strenuous times is illustrated by a letter written by my grandfather to my grandmother in 1944. He wrote this letter from prison, after a failed attempt to escape after years of being a prisoner of war.

> *If I look besides me, I see your pictures, of you and our children. When I think of you, I know that is where my goal in life lies, that my hope for returning is with you. That's why it's not bad at all, it's wonderful peace. [...] This time without you is like a chunk of my life has been cut off. I often fantasize about it, how it could have been. I wander through the woods with you, I tell the children: Today is your day, what do you want to do? We build a tent in our living room and I tell a story. Sometimes you have to be able to turn off your feelings, to push away what you long for. But isn't my final destination with our family? We are so very happily married, we received our children in love, what connection can be stronger?*

DISCUSSION

How can Refugee Families be Supported in Strengthening Family Functioning and Experienced Social Support?

Amira, her parents, and her sister join FAME, a preventive MFT program organized at the asylum seeker centre where they live. Her mother explains to the FAME-facilitators that she has developed psychological problems as

a result of experiences before and during the flight. She has noticed that this has affected her relationship with her daughters. She feels tense and gets angry quicker than she used to. She has also noticed that the constant forced relocations have an impact on her daughters. They get sad every time they have to say goodbye to their friends and have learning difficulties as a result of the many different schools they have had to attend. Her most important sources of support are her husband and their religion.

Family Functioning. The meta-analysis (Chapter 2) indicated that MFT is associated with small improvements in family functioning. Concerning families in the context of trauma, Rosenblum et al. (2017) stated that MFT is associated with improvements in parenting stress. However, the first evaluation of FAME did not indicate that participation in the program was related to improvements in family functioning. This might be because FAME did not suit the needs of the participating families or, additionally, that the program duration, frequency, and intensity were not enough to effectuate changes in family functioning. Some participating parents did report that they were more aware of the impact of stress on their families and children, and noted an impact on parental wellbeing, including improved coping, less worrying, and less anger. Potentially, in the long term, these improvements could positively impact family functioning and the parent-child relationship. For example, anger and personal coping are suggested to be related to family functioning (Evans et al., 2003; Shakespeare-Finch et al., 2002; Shehan, 1987).

Social Support. The systematic review (Chapter 2) suggested that MFT might have a positive impact on social functioning, social skills, and experienced social support (Chacko et al., 2015; Ma et al., 2018; McDonald et al., 2006; Morris et al., 2014; Valencia et al., 2010). It was hypothesized that FAME would strengthen social support, as social support is one of the main themes of the sessions and FAME brings multiple families residing in the same living location together in one room. Parents who participated in FAME specifically valued coming together with different families as it offered them opportunities to learn from each other. Although several parents felt supported by the other families during FAME, they did not experience changes in social support outside FAME.

In short, there is limited evidence of the impact of MFT and FAME on family functioning and social support. That we did not find evidence supporting the potential impact of FAME might be due to stressors related to the current situation of the families. That is, families indicated that their actual problems could not be solved by attending FAME and that they experienced a lot of stress due to stressors linked to their current living situation and procedure, including relocations and news concerning the asylum procedure. One mother explained that as a result of these current stressors, it was not possible to benefit from the potential impact of FAME. Moreover, the great limitations to the feasibility of the study as well as the feasibility of FAME resulted in large rates of drop-out and missing data. The

absence of statistical significant indices supporting the effects of FAME might be due to these issues. Recommendations for future research, clinical practice, and implementation are listed below.

How Can URMs be Supported in Strengthening the Caregiver-Child Relationship and Mental Health?

> *The legal guardian of Merhawi, an unaccompanied refugee minor from Eritrea, is worried about him. He has noticed that Merhawi has been acting irritable. During the night, Merhawi wanders through the hallways of his living group. When he discusses this with him, Merhawi says he is very stressed. He worries about his family and the family reunification procedure. He has difficulties falling asleep and when he does sleep, he has terrible nightmares. In consultation with Merhawi, his guardian refers him to the multimodal trauma-focused treatment approach.*

Caregiver-Child Relationship. During the focus groups examining needs and challenges faced by Eritrean URMs in the Netherlands, URMs and their professional caregivers (guardians and mentors) emphasized the importance of the caregiver-child relationship. URMs reported several factors that negatively impacted their relationship with their professional caregivers, including language differences, too little contact, uncertainty about who they could turn to for help, and not always feeling heard or helped. They suggested that continuity in contact, information concerning decision-making, and the possibility to call in an ICM could help to improve the caregiver-child relationship. These findings resulted in several implications for the practice of legal guardians and mentors working with URMs, presented in a toolkit for professionals (Sleijpen et al., 2018). Implications included collaborating with ICMs and sharing information about yourself as a professional caregiver, as self-disclosure is linked to higher levels of trust (Nazione et al., 2019; Sleijpen et al., 2018).

Mental Health. Concerning mental health, URMs reported several coping strategies in dealing with stress, including staying in bed and talking to friends they trust. The main coping strategy reported by Eritrean URMs was spirituality and religion, a common approach to dealing with stress among (Eritrean) refugee minors (Araya, 2001; Ní Raghallaigh & Gilligan, 2010; Sleijpen et al., 2017a). Some URMs explained they have devoted more time to religious activities since arriving in the Netherlands as they experience higher level of stress than in Eritrea. Their professional caregivers recognized that religion was an important resource, but also shared their concerns that religion interfered with other activities, such as learning the Dutch language. This resulted in friction between URMs and their professional guardians. The findings indicate the importance of URMs and their professional caregivers sharing their perspectives. Understanding each other's point of view can aid in finding a

balance between spending time on religious activities and spending time on other activities focused on their (educational) development. In addition, URMs could benefit from guidance and support to strengthen their resources and coping strategies.

Research has indicated that social support can positively affect the mental health of URMs (Oppedal & Idsoe, 2015; Sierau et al., 2019). Although the Eritrean URMs formed an important source of social support for each other, they indicated a need for a stronger social network. They reported challenges in developing and strengthening a social network, often due to difficulties in trusting others and language- and culture differences. To support URMs in strengthening their sources of social support, it is suggested that professional caregivers put effort into locating family members abroad. Moreover, URMs could benefit from participation in culturally diverse peer networks (Oppedal & Idsoe, 2015). Professional caregivers could help URMs to participate in networks by discussing the opportunity to join a sport club or community centre (Sleijpen et al., 2018).

Notably, URMs and their caregivers reported a need for specific mental health support, mentioning mental health problems, such as sleeping issues and emotion-regulation. Mental health problems can affect the day-to-day lives of URMs, while daily stressors can also play an important role in the development and the maintenance of mental health problems (Neuner et al., 2010). For example, a URM participating in the focus groups explained that he did not experience stressors related to school, but other stressors complicated focusing on school, remembering what he learned, and paying attention.

Although there is a need of specific mental health support, many URMs experience barriers to mental healthcare, such as distrust towards mental health services and difficulties in understanding the value of sharing past distressing experiences (Demazure et al., 2021). The results of our feasibility evaluation of the multimodal, trauma-focused, culturally-sensitive treatment approach suggests that the approach partly overcomes barriers to mental health care. Most URMs indicated that the treatment was useful and that it has positively impacted their wellbeing. However, the quantitative results did not reflect a change in symptoms of PTSD and/or depression.

Again, the influence of stressors concerning their current situation and procedure was very clear in our studies focusing on URMs. For example, worries about the wellbeing of family members, news about family reunification, and concerns about family reunification all seemed to have a direct impact on the wellbeing of the URMs.

Program Integrity Versus Attending Specific Needs

The studies presented in this dissertation were closely related to the clinical practice of professionals, facilitators, and therapists working with refugee families and URMs, offering us a detailed, realistic view of the implementation of these programs. How a program is implemented may have a positive or negative effect on the program effectiveness (Dane & Schneider, 1998; Durlak & DuPre, 2008; Kösters et al., 2017). Although the evaluation studies in this dissertation were based on protocols describing how the programs should

be implemented, facilitators and therapists often deviated from these protocols.

On the one hand it is important to offer programs as intended. If program integrity is high, this could offer us invaluable information on which program components are related to the effectiveness of a program. The results of the study evaluating the effectiveness of the trauma-focused treatment approach (Chapter 7) did not present conclusive findings on the effectiveness of the treatment approach. As therapists were free to choose modules that suited the needs of the minors based on their own experience and expertise, it was difficult to understand how the (lack of) effectiveness of the treatment approach was related to specific treatment components. On the other hand, therapists and facilitators explained that they deviated from the protocols to address the specific needs of the minors and families and thereby increase the acceptability of the treatment.

A question that arises is: What are core components of the programs presented in this dissertation, and what components can be adapted to offer an acceptable, culturally-sensitive version of the program? The difficulty in this question can be illustrated by the evaluation of FAME. The systematic review and meta-analysis (Chapter 2) presented our search for conceptual clarity surrounding MFT. It was suggested that the following elements are key to MFT: 1) involvement of multiple families, 2) involvement of multiple generations, 3) an explicit focus or problem shared by all families, and 4) sessions focusing on interfamilial interaction and alliance between different families. However, several parents participating in FAME stated they preferred that their children did not take part in all sessions of FAME. If we were to choose to offer FAME to only parents, we would attend to their needs. However, we then would abandon one of the suggested core components of MFT.

Further evaluations are needed to determine how therapists and facilitators can adapt programs to attend to the participants' needs, while still offering the core components of the program. A review on cultural adaptations of psychological treatments for refugees stated that most adaptations were made to the method of delivery rather than to the content of the treatment. They emphasized the importance of program integrity while adapting methods to improve contextual acceptability (Chowdhary et al., 2014). Moreover, an often used MFT format –Families and Schools Together– as described in McDonald et al. (2012) uses a manual with presumed core components as well as flexible components. The flexible components were reviewed by a culturally representative team, who then made cultural adaptations. Rigorous evaluations of such cultural adaptations could shed more light on the applicability of core components as well as cultural adaptations.

Implications for Research, Clinical Practice, and Implementation

The challenges we faced during our studies substantiate the complex situations refugees and asylum seekers in the Netherlands deal with. When researching newly developed programs for understudied populations, these challenges can inform us on how to conduct research in these populations, how to improve the clinical practice, and how to increase the feasibility of programs for resettling asylum seekers and refugees.

Recommendations for the development or adaptation, evaluation, and implementation of mental health intervention programs for resettling refugees:

- When developing a program or adapting an existing one, pay attention to the specific needs and context of the target population. For example, conduct a mixed methods (ethnographic) study to elucidate risk factors, protective factors, and contextual factors that influence the psychological wellbeing of the participants.
- Tailor the intervention program to accommodate the participants' cultural and linguistic background. It is suggested to adapt the method of delivery rather than changing the content or core components of a program. Possible cultural adaptations to the method of delivery include using colloquial terms and metaphors corresponding with the linguistic and cultural background of the target population, offering appropriate psychoeducation, and collaborating with facilitators with a similar background, such as an ICM.
- Look beyond the traditional focus on PTSD and keep in mind the broader context and needs of the population. For example, a focus on dealing with psychosocial problems as well strengthening healthy coping and social support might address current (mental health) needs.
- Offer trauma-focused treatment if indicated. To appropriately address the diverse and complex needs of the population, consider stepped care or multimodal approaches.
- Assessments and evaluations should look beyond clinical measures of psychopathology to examine a broader sense of the participants' experience. Mixed methods can help in doing so. If quantitative measures are used, focused attention on their cultural appropriateness and translation of concepts is needed.
- When developing, evaluating, and implementing programs for resettling refugees, several resources, such as offering outreach care and collaborating with ICMs, can help to overcome barriers.

Supporting Refugee Families and URMs – Conducting Research.

Merhawi finds the questionnaires confusing. He does not understand the questions and why they are being asked. He asks the intercultural mediator to clarify the questions and to give examples for each question. After this explanation, he understands the questionnaires and the aim of the assessments better. Although the intercultural mediator and researcher try to explain this, he still does not fully understand why he has to answer the same questions every week.

Amira's mother is very busy. When the researchers try to plan a date for the assessments, she is afraid to tell them she is unable to come this week because of other obligations. When she does not show up, the researchers plan another date that suits her better. One family that takes part in the same FAME group is forced to relocate to another asylum centre and is unable to join the final assessments.

Challenges to the Feasibility of Research. We anticipated several challenges to the feasibility of conducting research with refugee families and URMs. In order to limit the impact of these challenges, ICMs and local professionals supported us in the assessments, and assessments were conducted at a location and date that suited the participants. Notwithstanding these efforts, some challenges could not be overcome and impacted the feasibility of the studies.

Firstly, there was a considerable amount of missing data. This was related to several issues, such as difficulties understanding the questionnaires, low motivation to take part

in the assessments, drop-out, and forced relocations. Moreover, in the study evaluating FAME, the open-group format limited the possibility to complete pre- and post-FAME assessments. Finally, therapists and local professionals sometimes thought the participants were too overburdened to take part in the assessments. Perceiving refugees as too vulnerable to participate in research has been a common underlying concern amongst researchers (Carlsson et al., 2014). However, as refugee families and URMs are in need for appropriate mental health intervention programs that suit their specific needs, it is the ethical responsibility of researchers to conduct valid and reliable research evaluating these programs in order to inform further development of such programs.

Secondly, due to insufficient resources there were no independent assessors involved in most of our studies. The assessors were possibly prone to bias as they were aware of the treatment status and were often involved in the implementation of the program themselves. Moreover, participants might have been more likely to respond in a socially desirable manner if therapists or co-facilitators were involved in the assessments.

Thirdly, the generalizability of the studies was limited due to a focus on an Eritrean sample of URMs and a small sample of refugee families taking part in all assessments. Although URMs form a culturally heterogeneous group, this is not reflected in the sample included in our studies. When we initiated our research, the majority of URMs in the Netherlands came from Eritrea and there were specific concerns regarding these minors voiced by healthcare professionals (Sleijpen et al., 2018). Therefore, during the initial stages of our research, we focused on Eritrean minors. Although we aimed to broaden our focus while conducting the studies evaluating the multimodal trauma-treatment, professionals referring URMs were familiar with our earlier work, resulting in an over-representation of Eritrean minors.

Strengths of the Studies. The research presented in this dissertation has several strengths. Firstly, the research was closely related to a naturalistic setting. We focused on URMs who perceived many barriers to mental health care and families who had only recently arrived in the Netherlands. We did not apply strict exclusion criteria, resulting in a group of participants that would likely be encountered in settings were psychosocial care is provided. Secondly, an important strength of this dissertation is our use of quantitative data, qualitative data, and combinations thereof (i.e. mixed methods). Focusing solely on quantitative questionnaires might ignore aspects of effectiveness, feasibility, and acceptability that were important to the participating refugee families and URMs themselves. In addition, the population included in our studies represent a diversity in background and experience. By combining a range of methodologies, we can identify and understand factors that played a role in this specific contextual and cultural setting (Betancourt & Williams, 2008; Robila & Akinsulure-Smith, 2012; Ungar, 2012).

Recommendations for Future Research. This dissertation resulted in several recommendations for future research on MFT and specifically, FAME. Because of the open-

group format, meaning families can join the group at any time, it is challenging to conduct pre-and-post-FAME measurements. A possible next step in evaluating and improving FAME might be to conduct elaborate qualitative evaluations through interviews. These interviews can focus on potential benefits of the program, that may differ from person to person, as well as potential mechanisms of change, such as awareness of the impact of stress on the parent-child relationship, coping strategies, social support, and the ability to mentalize. Qualitative measures can to give room to participants' voices and increase our understanding on whether and how FAME addresses their needs. If quantitative instruments were to be used in future research on FAME, it is important to reconsider the instruments used in the current study. For example, the Patient Health Questionnaire-4 (PHQ-4) was used to determine whether parents noticed improvements in symptoms of anxiety and depression. However, parents might have felt caught off guard by these questions as FAME does not directly target these symptoms. In addition, as FAME is a preventive program focused mainly on reinforcing the parent-child relationship, family functioning, and social support, it might not be appropriate to expect significant changes on symptoms of anxiety and depression.

We aimed to assess improvements in family functioning by using the systematic clinical outcome and routine evaluation (SCORE-15) questionnaire. This questionnaire aims to capture several components of family functioning, including strengths and adaptability, the extent to which a family becomes overwhelmed by difficulties, and disruptive communication (Stratton et al., 2014). However, the concept of family functioning includes an even wider range of facets, including family cohesion and supportive family relations (Haar et al., 2020; Uruk et al., 2007). Future evaluations should keep into account these multiple facets comprised by the concept of family functioning.

The quantitative assessments might not have captured the potential effect of the multimodal treatment approach for URMs. The approach was short-term and several sessions were focused on motivating URMs and offering psychoeducation on mental health care. Few sessions focused on targeting symptoms of PTSD and depression through Eye Movement Desensitization and Reprocessing (EMDR) and cognitive behaviour therapy (CBT). Potentially, the strength of the treatment approach does not lie in diminishing symptoms of PTSD and/or depression, but in lowering barriers to mental health care, building a trusting relationship, gaining insight in the needs of the participating URMs, and improvements in social and global functioning. Accordingly, the treatment approach might be used as a pre-therapy module before embarking on treatments focused on PTSD and/or depression. Using qualitative evaluations could give us a broader view on the potential benefits of the multimodal treatment approach.

Finally, future research should focus on evaluating and improving the validity and reliability of assessments for refugee families and URMs. There is a lack of assessments tailored for these specific populations (Robila & Akinsulure-Smith, 2012). While developing and translating suitable assessments, there should be a focus on the translation of cultural concepts and the cultural appropriateness of the assessments. Until such assessments are

available, future studies should take into account that there is sufficient time to explain the assessments to participants who are likely unfamiliar with these research designs and assessments. In addition, the limitations of the results and their interpretation should be acknowledged and described (Robila & Akinsulure-Smith, 2012).

Supporting Refugee Families and URMs – Clinical Implications.

After attending eight sessions of FAME, the mother of Amira expresses that she has learned a lot from the other families concerning coping and the parent-child relationship. However, she explains that FAME could not help her with her current stressors. The stressors the family is faced with, including insecurity about their asylum status and illness of her daughter, are too distressing for FAME to have a real impact on her family.

Merhawi received seven sessions of the multimodal trauma-focused treatment approach. Most sessions focused on his trauma-related complaints. During the treatment he received the news that his family might be in danger. He was unable to reach them. Some session focused on these worries. After the treatment he noticed improvements in sleeping and concentrating. He especially valued the practical advice, such as engagement in mindfulness and sports. He told the researcher that his depressive symptoms had increased after the treatment due to the worries about his family.

Implications for Clinical Practice. An intervention or program can only be impactful when it is relevant and feasible. The studies described in this dissertation were the first to systematically evaluate the presented mental health intervention programs and focused mainly on feasibility and acceptability. Understanding the experiences of the participating URMs and families can help us to develop acceptable, effective, and inclusive treatments (Said et al., 2021; Webb & McMurran, 2008). The results provide several implications for clinical practice. Firstly, most studies emphasized the importance of considering psychosocial factors. The basic needs of participants were not always met, making it difficult to prioritize other themes, such as mental health or the parent-child relationship. Some parents explained that their current stressors were too impactful to focus on improving the parent-child relationship (Chapter 4). Moreover, some URMs do not consider mental health a priority and prefer to focus on daily problems. This might be because the concept of mental health is unfamiliar and they have not yet formed a clear understanding of this concept (Majumder et al., 2015). Therefore, it is key for facilitators and therapists to be clear about the goal of the program or intervention. The importance of clarity and spending enough time on psychoeducation was confirmed by therapists and ICMs involved in the implementation of the multimodal treatment approach (Chapter 6). Similarly, when offering

programs to (recently arrived) refugees, mental health practitioners should show an interest in daily problems, rather than only focusing on past experiences (Demazure et al., 2021).

Secondly, the results underline the importance of appropriate timing of interventions. Prior to offering a program, it should preferably be clear whether the key elements and aims of the program match the current needs of the participants. Sometimes, other priorities, such as housing, asylum status, and family reunification, require attention. Therefore, it is important to take sufficient time to discuss the rationale of the program and mutual expectations. The therapist or facilitator and the family or URM should agree on common goals as this can improve the working relationship between the therapist or facilitator and the participant, which can positively impact program outcome (Bordin, 1979; Demazure et al., 2021). This may mean that practical support or building trust requires more attention before having room to focus on other concepts, such as mental health, the parent-child relationship, or social support (Fazel & Betancourt, 2018). In addition, local professionals, such as legal guardians, mentors, social workers, or professionals working at the Dutch Council for Refugees could offer refugees support in dealing with daily stressors. Facilitators and therapists themselves can also pay attention to daily stressors by allowing room to discuss the stressors, discussing potential solutions, and by strengthening coping and resources.

Recommendations for Clinical Practice. FAME and the multimodal trauma-focused treatment approach have been developed based on explorations with refugee families (Mooren & Bala, 2016; Mooren et al., 2020) and URMs (Sleijpen et al., 2017b; Sleijpen et al., 2018) and years of knowledge and experience working with these populations. This offers a starting point from which we can further explore - what works and what does not? Until (more) evidence establishes whether refugee families and URMs can benefit from FAME and the treatment approach, caution is needed when implementing these programs.

There were several indications that FAME could be improved to better meet the needs of participating families. Therefore, a next step would be to critically evaluate and adapt the program protocol. Many resources were used to motivate families to participate in FAME, with a limited effect. Facilitators involved in the development and evaluation of FAME have made several suggestions to motivate participants in the future. They explained that families should be recruited universally, meaning any family residing at the asylum centre can join the first information session. During this session, facilitators can explain the aim of the program as well as the program format. Moreover, families who have participated in FAME before can inform the new families on the FAME and their experiences with the program. Potential participants can then ask questions and decide whether FAME suits their current needs and whether the timing is right for them.

When facilitators reflected on FAME, they suggested that the core elements of FAME are: awareness of the impact of stress on parenting, coping and resources, emotion-regulation, and social support. Activities that are in line with these components should be

selected and described in a manual. In addition, facilitators stated that FAME might be improved by offering longer sessions over a longer period of time. This will allow for several changes to be made to improve the program. Firstly, it will allow facilitators to offer more psychoeducation and explain the rationale of FAME and its activities further. Secondly, it will allow families to discuss important subjects more in-depth, as they have stated a need for more in-depth conversations. Thirdly, it will offer the facilitators time to work in a group with all family members present, as well as time to work in parallel groups. When all family members are present, facilitators can have insight in family interactions and use these interactions to work on the abovementioned core elements. In parallel groups, children will have time to play and parents will have time to discuss difficult topics, such as stressors and harsh parenting.

Similarly, to address symptoms of PTSD and depression, the multimodal treatment approach might benefit from offering more sessions over a longer period of time, allowing therapists to focus on psychoeducation and daily stressors as well as on targeting symptoms of PTSD and depression through EMDR or CBT.

Mental health intervention programs for URMs and refugee families should create a context for their problems, meaning programs should be adapted to meet the specific needs of the participating refugees. Two approaches, namely multimodal approaches and stepped care approaches might offer solutions to appropriately address their needs (Berliner et al., 2004; Ellis et al., 2013; Rosner et al., 2020). Multimodal approaches have been used frequently in refugee mental health treatment. It has been argued that a multimodal approach can suit the diverse and complex needs of refugees rather than focusing only on trauma or PTSD (Nickerson et al., 2011). The multimodal approach for URMs could be improved by developing more specific modules to address daily stressors, social support, and coping strategies and resources, for example based on CBT. A next step would be to define core components through evaluations with URMs, therapists, and ICMs, and to develop cultural adaptations for the flexible components. Facilitators involved in the evaluation of FAME have also stated that a multimodal approach might help them address to address a wide range of needs, while being able to adapt the program to suit the families' request for help and current needs as well as the composition of the group (i.e. number of families, the age of the participating children, and whether or not children take part).

Alternatively, it is suggested that stepped care approaches might offer solutions to target the specific needs of refugees. Rosner et al. (2020) propose a stepped care model consisting of three components: screening, preventive group treatment, and individual treatment. After screening and indication, URMs can take part in a manualized preventive group offered by non-specialist social workers. During participation in this group, the social workers will gain an understanding of the URMs histories and cultural background. Psychoeducation, relaxation techniques, trauma narratives, and cognitive restructuring are offered to improve social support, regain a sense of safety, and foster self-efficacy. In addition, after screening and indication, URMs can get offered trauma focused cognitive

behavioural therapy (TF-CBT) with three additional sessions focusing specifically on relapse prevention and dealing with problems related to asylum stressors.

Tools for Clinical Practice. The studies presented in this dissertation have led to various concrete tools for the clinical practice, including the development and refinement of the protocol for FAME and the multimodal treatment approach. Furthermore, a report and toolkit for professionals working with (Eritrean) URMs have been developed based on the result of the focused ethnography (Chapter 5), workshops with guardians, mentors, ICMs, URMs and (scientific) literature (Sleijpen et al., 2017b; Sleijpen et al., 2018). The toolkit describes important themes, case examples, and recommendations for professionals working with URMs in the Netherlands (Sleijpen et al., 2018).

> **Supporting Refugee Families and URMs – Implementation of Programs.**
>
> *Because of the many obligations the family of Amira has, they often forget that they are invited to attend FAME. One of the facilitators visits them every week to remind them about the sessions, this helps them to remember the appointments. It is helpful that FAME is offered at their living location so that the family doesn't have to travel far.*
>
> *Merhawi notes it was helpful that he could choose a location that suited him best. He didn't want to discuss distressing experiences in his own room, so they found a suitable place nearby. He appreciated the informal moments, such as walking and talking with the ICM after a session.*

In addition to research and clinical implications, it is also of importance to pay attention to the implementation of programs, as a successful implementation can add to the improvement of replicability and the actual (public health) impact of programs (Rudd et al., 2020). Most studies reflected the limitations to the feasibility of the mental health intervention programs. Our experiences have resulted in several recommendations to improve the implementation of the programs.

Investing Time and Resources. Firstly, the execution of the programs requires many resources. Therapists, facilitators, and researchers travelled around the Netherlands to reach and involve the participants. They were flexible in doing so, spending time to remind the participants of their appointments, to offer sufficient explanation and psychoeducation, and to offer several opportunities to take part in assessments. Possibly as a result of these investments, participants evaluated the programs positively and barriers to mental health care were partly overcome. Being flexible and investing time and resources might be a prerequisite to offering programs and conducting research within a refugee population.

However, several challenges, such as high rates of drop-out and missing data, were not overcome by these investments.

Cultural Adaptations. Secondly, the implementation of the programs emphasized the importance of cultural adaptations. Many (mental health) programs are based on white, Eurocentric, Western cultural norms, and many refugees are unfamiliar with such interventions. Programs should be adapted while keeping in mind specific idioms of distress. For example, URMs often ask for medical care when confronted with (psycho)somatic complaints (Björkenstam et al., 2020), which calls for an understanding of their perspective as well as clear explanation of the Western perspective on these symptoms. Delivering culturally sensitive adaptation of programs involves knowledge of cultures, openness, and cultural sensitivity (Robila & Akinsulure-Smith, 2012). Identifying and understanding the perspectives of refugees themselves, as well as applying culturally specific metaphors and expressions can improve the cultural appropriateness of a program (Hinton & Patel, 2017). A systematic review on psychological treatments for refugees suggested that treatments with cultural adaptations, such as using colloquial expressions and improving cultural competence of therapists, have a larger treatment effect than non-adapted treatments in the same population (Chowdhary et al., 2014).

It was aimed to provide a culturally sensitive adaptation of MFT by collaborating with interpreters and by focusing on universal aspects of parenting (Mooren & Bala, 2016; Van IJzendoorn & Sagi-Schwartz, 2008). There was sufficient time and space to discuss different perspectives. Another example of cultural adaptation was our collaborative work with ICMs when offering the multimodal, trauma-focused treatment approach. Before each session, the ICM and therapist discussed how to provide a culturally sensitive explanation of the treatment (session) and its rationale. In addition, the ICM helped to identify suitable metaphors and examples. After each session, the ICM discussed with the therapist what they had noticed based on their experience and background. It is suggested that the involvement of an interpreter can support the effective delivery of (trauma-focused) interventions and the interpretation of cultural meaning (d'Ardenne et al., 2007; Tribe, 2009). Qureshi et al. (2010) suggested that involvement of an ICM can support linguistic, contextual, and cultural interpretation as well as improving the relationship between the clinician and the client, as long as the ICM is well-trained and the clinician is trained in cultural competence and (collaborating with) ICMs.

Involving the Context. Thirdly, the implementation of the programs has taught us the importance of involving the (direct) context of the participants. During trauma-focused treatment for children and adolescents, it is advised to involve a parent or caregiver. They can be an important source of safety, support, and guidance (Cohen & Mannarino, 2015). Moreover, they form an important source of information as they know the child or adolescent well. Finally, involving them in treatment can inform them on how they can best

support their child. As the parents of URMs were not able to join during the treatment approach, therapists focused on involving the guardian or mentor of the URMs. Engaging these professional caregivers can emphasize that they are important stakeholders in the process of the minor (Franco, 2018). In addition, in non-refugee children residing in foster care, involvement of foster parents is associated with enhanced engagement and treatment completion (Cohen & Mannarino, 2015). During FAME, the involvement of the direct context was inextricably linked to the format of the program, which focuses on the involvement of family members as well as other families to increase opportunities to share experiences and perspectives and to learn from each other.

Conclusion

In conclusion, developing, evaluating, and implementing mental health intervention programs that align with the needs and context of resettling refugees is a challenging task. At the same time, it is the ethical responsibility of (mental health) professionals and researchers to continue to perform this important task for, and in collaboration with, resettling refugee children, adolescents, and families.

REFERENCES

Araya, B. (2001). *Counseling in an Eritrean context*. Trenton: The Red Sea Press.

Berliner, P., Mikkelsen, E. N., Bovbjerg, A., & Wiking, M. (2004). Psychotherapy treatment of torture survivors. *International Journal of Psychosocial Rehabilitation*, *8*, 85-96.

Betancourt, T. S., & Khan, K. T. (2008). The mental health of children affected by armed conflict: Protective processes and pathways to resilience. *International Review of Psychiatry*, *20*(3), 317-328.

Betancourt, T. S., & Williams, T. (2008). Building an evidence base on mental health interventions for children affected by armed conflict. *Intervention*, *6*(1), 39.

Björkenstam, E., Helgesson, M., Norredam, M., Sijbrandij, M., de Montgomery, C. J., & Mittendorfer-Rutz, E. (2020). Differences in psychiatric care utilization between refugees, non-refugee migrants and Swedish-born youth. *Psychological Medicine*, 1-11. https://doi.org/10.1017/S0033291720003190

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*(3), 252.

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

Carlsson, J., Sonne, C., & Silove, D. (2014). From pioneers to scientists: challenges in establishing evidence-gathering models in torture and trauma mental health services for refugees. *The Journal of Nervous and Mental Disease*, *202*(9), 630-637.

Chacko, A., Gopalan, G., Franco, L., Dean-Assael, K., Jackson, J., Marcus, S., Hoagwood, K., & McKay, M. (2015). Multiple family group service model for children with disruptive behavior disorders: Child outcomes at post-treatment. *Journal of Emotional and Behavioral Disorders*, *23*(2), 67-77.

Chowdhary, N., Jotheeswaran, A., Nadkarni, A., Hollon, S., King, M., Jordans, M., Rahman, A., Verdeli, H., Araya, R., & Patel, V. (2014). The methods and outcomes of cultural adaptations of psychological treatments for depressive disorders: a systematic review. *Psychological Medicine*, *44*(6), 1131-1146.

Cohen, J. A., & Mannarino, A. P. (2015). Trauma-focused cognitive behavioral therapy for traumatized children and families. *Child and Adolescent Psychiatric Clinics of North America*, *24*(3), 557.

d'Ardenne, P., Farmer, E., Ruaro, L., & Priebe, S. (2007). Not lost in translation: Protocols for interpreting trauma-focused CBT. *Behavioural and Cognitive Psychotherapy*, *35*(3), 303-316.

Dane, A. V., & Schneider, B. H. (1998). Program integrity in primary and early secondary prevention: are implementation effects out of control? *Clinical Psychology Review*, *18*(1), 23-45.

Demazure, G., Baeyens, C., & Pinsault, N. (2021). Unaccompanied refugee minors' perception of mental health services and professionals: a systematic review of qualitative studies. *Child and Adolescent Mental Health*. https://doi.org/10.1111/camh.12486

Demazure, G., Gaultier, S., & Pinsault, N. (2018). Dealing with difference: a scoping review of psychotherapeutic interventions with unaccompanied refugee minors. *European Child & Adolescent Psychiatry*, *27*(4), 447-466.

Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology*, *41*(3), 327-350.

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.

Evans, L., McHugh, T., Hopwood, M., & Watt, C. (2003). Chronic posttraumatic stress disorder and family functioning of Vietnam veterans and their partners. *Australian & New Zealand Journal of Psychiatry*, *37*(6), 765-772.

Fazel, M., & Betancourt, T. S. (2018). Preventive mental health interventions for refugee children and adolescents in high-income settings. *The Lancet Child & Adolescent Health*, *2*(2), 121-132.

Franco, D. (2018). Trauma without borders: The necessity for school-based interventions in treating unaccompanied refugee minors. *Child and Adolescent Social Work Journal*, *35*(6), 551-565.

Haar, K., El-Khani, A., Molgaard, V., & Maalouf, W. (2020). Strong families: a new family skills training programme for challenged and humanitarian settings: a single-arm intervention tested in Afghanistan. *BMC Public Health*, *20*(1), 1-16.

Hinton, D. E., & Patel, A. (2017). Cultural adaptations of cognitive behavioral therapy. *Psychiatric Clinics*, *40*(4), 701-714.

Kiser, L. J., Donohue, A., Hodgkinson, S., Medoff, D., & Black, M. M. (2010). Strengthening family coping resources: The feasibility of a multifamily group intervention for families exposed to trauma. *Journal of Traumatic Stress*, *23*(6), 802-806.

Kösters, M. P., Chinapaw, M. J., Zwaanswijk, M., Van der Wal, M. F., Utens, E. M., & Koot, H. M. (2017).

Friends for life: implementation of an indicated prevention program targeting childhood anxiety and depression in a naturalistic setting. *Mental Health & Prevention*, *6*, 44-50. https://doi.org/10.1016/j.mhp.2017.03.003

Ma, J. L., Lai, K. Y., & Xia, L. L. L. (2018). Treatment efficacy of multiple family therapy for Chinese families of children with attention deficit hyperactivity disorder. *Family Process*, *57*(2), 399-414.

Majumder, P., O'Reilly, M., Karim, K., & Vostanis, P. (2015). 'This doctor, I not trust him, I'm not safe': The perceptions of mental health and services by unaccompanied refugee adolescents. *International Journal of Social Psychiatry*, *61*(2), 129-136.

McDonald, L., Coover, G., Sandler, J., Thao, T., & Shalhoub, H. (2012). Cultural adaptation of an evidence based parenting programme with elders from South East Asia in the US: co producing Families and Schools Together–FAST. *Journal of Children's Services, 7*(2), 113-127.

McDonald, L., Moberg, D. P., Brown, R., Rodriguez-Espiricueta, I., Flores, N. I., Burke, M. P., & Coover, G. (2006). After-school multifamily groups: A randomized controlled trial involving low-income, urban, Latino children. *Children & Schools*, *28*(1), 25-34.

Mooren, T., & Bala, J. (2016). Goed ouderschap in moeilijke tijden. *Utrecht: Pharos*.

Mooren T., Bala J., Rabaia Y. (2020) A Family-Centered Approach to Working with Refugee Children and Adolescents. In: Song S., Ventevogel P. (eds) *Child, Adolescent and Family Refugee Mental Health*. Springer, Cham. https://doi.org/10.1007/978-3-030-45278-0_15

Morris, E., Le Huray, C., Skagerberg, E., Gomes, R., & Ninteman, A. (2014). Families changing families: The protective function of multi-family therapy for children in education. *Clinical Child Psychology and Psychiatry*, *19*(4), 617-632.

Murray, K. E., Davidson, G. R., & Schweitzer, R. D. (2010). Review of refugee mental health interventions following resettlement: best practices and recommendations. *American Journal of Orthopsychiatry*, *80*(4), 576.

Nazione, S., Perrault, E. K., & Keating, D. M. (2019). Finding common ground: Can provider-patient race concordance and self-disclosure bolster patient trust, perceptions, and intentions? *Journal of Racial and Ethnic Health Disparities*, *6*(5), 962-972.

Neuner, F., Kurreck, S., Ruf, M., Odenwald, M., Elbert, T., & Schauer, M. (2010). Can asylum-seekers with posttraumatic stress disorder be successfully treated? A randomized controlled pilot study. *Cognitive Behaviour Therapy*, *39*(2), 81-91.

Ní Raghallaigh, M., & Gilligan, R. (2010). Active survival in the lives of unaccompanied minors: coping strategies, resilience, and the relevance of religion. *Child & Family Social Work*, *15*(2), 226-237.

Nickerson, A., Bryant, R. A., Silove, D., & Steel, Z. (2011). A critical review of psychological treatments of posttraumatic stress disorder in refugees. *Clinical Psychology Review*, *31*(3), 399-417.

Oppedal, B., & Idsoe, T. (2015). The role of social support in the acculturation and mental health of unaccompanied minor asylum seekers. *Scandinavian Journal of Psychology*, *56*(2), 203-211.

Qureshi, A., Revollo, H. W., Collazos, F., Harrak, J. E., Visiers, C., Ramos, M. D. M., & Casas, M. (2010). Intercultural mediation: Reconstructing hermes – the messenger gets a voice. In *Migration and Mental Health* (pp. 245-260) https://doi.org/10.1017/CBO9780511760990.021

Reed, R. V., Fazel, M., Jones, L., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in low-income and middle-income countries: risk and protective factors. *The Lancet*, *379*(9812), 250-265.

Robila, M., & Akinsulure-Smith, A. M. (2012). Psychological ethics and immigration. In M.M. Leach, M.J. Stevens, G. Lindsay, Y. Korkut, A. Ferrero (eds). *The Oxford Handbook of International Psychological Ethics*, 191-200.

Rosenblum, K. L., Muzik, M., Morelen, D. M., Alfafara, E. A., Miller, N. M., Waddell, R. M., Schuster, M. M., & Ribaudo, J. (2017). A community-based randomized controlled trial of Mom Power parenting intervention for mothers with interpersonal trauma histories and their young children. *Archives of Women's Mental Health*, *20*(5), 673-686.

Rosner, R., Sachser, C., Hornfeck, F., Kilian, R., Kindler, H., Muche, R., Müller, L. R. F., Thielemann, J., Waldmann, T., & Ziegenhain, U. (2020). Improving mental health care for unaccompanied young refugees through a stepped-care approach versus usual care+: study protocol of a cluster randomized controlled hybrid effectiveness implementation trial. *Trials*, *21*(1), 1-13.

Rudd, B. N., Davis, M., & Beidas, R. S. (2020). Integrating implementation science in clinical research to maximize public health impact: a call for the reporting and alignment of implementation strategy use with implementation outcomes in clinical research. *Implementation Science*, *15*(1), 1-11.

Said, G., Alqadri, Y., & King, D. (2021). Unaccompanied minors' experiences of narrative exposure therapy. *The Cognitive Behaviour Therapist*,

14(e11), 1-20.

Scharpf, F., Kaltenbach, E., Nickerson, A., & Hecker, T. (2021). A systematic review of socio-ecological factors contributing to risk and protection of the mental health of refugee children and adolescents. *Clinical Psychology Review*, *83*, 101930.

Shakespeare-Finch, J., Smith, S., & Obst, P. (2002). Trauma, coping resources, and family functioning in emergency services personnel: A comparative study. *Work & Stress*, *16*(3), 275-282.

Shehan, C. L. (1987). Spouse support and Vietnam veterans' adjustment to post-traumatic stress disorder. *Family Relations*, *36*, 55-60.

Sierau, S., Schneider, E., Nesterko, Y., & Glaesmer, H. (2019). Alone, but protected? Effects of social support on mental health of unaccompanied refugee minors. *European Child & Adolescent Psychiatry*, *28*(6), 769-780.

Sleijpen, M., Mooren, T., Kleber, R. J., & Boeije, H. R. (2017a). Lives on hold: A qualitative study of young refugees' resilience strategies. *Childhood*, *24*(3), 348-365.

Sleijpen, M., Van Es, C., Te Brake, H., & Mooren, T. (2017b). *Alleenstaande minderjarigen uit Eritrea in Nederland.* Utrecht: Nidos.

Sleijpen, M., Van Es, C., te Brake, H., & Mooren, T. (2018). Toolkit voor de begeleiding van Eritrese alleenstaande minderjarigen in Nederland. *Diemen: Arq Psychotrauma Expert Groep*.

Stratton, P., Lask, J., Bland, J., Nowotny, E., Evans, C., Singh, R., Janes, E., & Peppiatt, A. (2014). Detecting therapeutic improvement early in therapy: validation of the SCORE-15 index of family functioning and change. *Journal of Family Therapy*, *36*(1), 3-19.

Tribe, R. (2009). Working with interpreters in mental health. *International Journal of Culture and Mental Health*, *2*(2), 92-101.

Ungar, M. (2012). Researching and theorizing resilience across cultures and contexts. *Preventive Medicine: An International Journal Devoted to Practice and Theory, 55(*5), 387–389.

Uruk, A. C., Sayger, T. V., & Cogdal, P. A. (2007). Examining the influence of family cohesion and adaptability on trauma symptoms and psychological well-being. *Journal of College Student Psychotherapy*, *22*(2), 51-63.

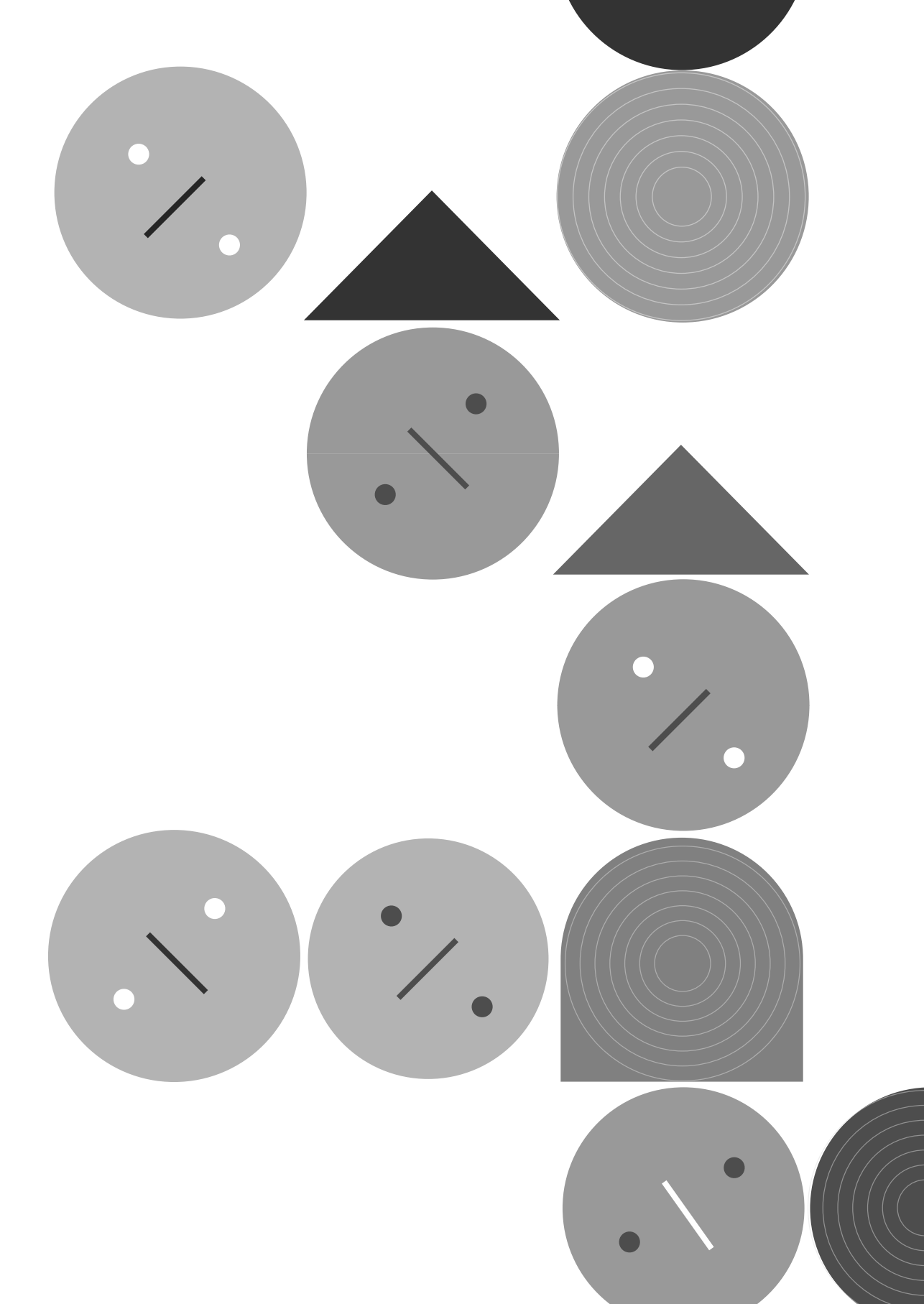
Valencia, M., Rascon, M. L., Juarez, F., Escamilla, R., Saracco, R., & Liberman, R. P. (2010). Application in Mexico of psychosocial rehabilitation with schizophrenia patients. *Psychiatry: Interpersonal and Biological Processes*, *73*(3), 248-263.

Van IJzendoorn, M. H., & Sagi-Schwartz, A. (2008). Cross-cultural patterns of attachment: Universal and contextual dimensions. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 880–905). New York: The Guilford Press.

Webb, D., & McMurran, M. (2008). A Delphi survey of patients' views of services for borderline personality disorder: A preliminary report. *Personality and Mental Health*, *2*(1), 17-24.

Weine, S., Kulauzovic, Y., Klebic, A., Besic, S., Mujagic, A., Muzurovic, J., Spahovic, D., Sclove, S., Pavkovic, I., & Feetham, S. (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. (2011). Developing preventive mental health interventions for refugee families in resettlement. *Family Process*, *50*(3), 410-430.



A

Samenvatting (Dutch summary)
Dankwoord (Acknowledgements)
Curriculum Vitae & List of Publications

SAMENVATTING

Summary in Dutch

Wereldwijd zijn er meer dan 80 miljoen mensen gedwongen om hun woonplek achter te laten vanwege oorlog en vervolging. Meer dan een derde van hen zijn kinderen en adolescenten onder de 18 jaar. De meesten zijn samen met familie gevlucht, maar een deel vluchtte zonder ouder of verzorger. Deze kinderen en jongeren worden alleenstaande minderjarige vreemdelingen (AMV's) genoemd. Dit proefschrift onderzocht hoe vluchtelingengezinnen en AMV's in Nederland zo goed mogelijk kunnen worden ondersteund. Door de behoeften van deze gezinnen en jongeren in kaart te brengen, kan de ondersteuning die hen wordt geboden verder ontwikkeld en verbeterd worden. Daarnaast hebben we onze eerste ervaringen met interventieprogramma's binnen de geestelijke gezondheidszorg voor deze populaties beschreven. Om een uitgebreide verkenning van deze onderwerpen uit te voeren met aandacht voor de ervaringen van de deelnemende gezinnen en jongeren, zijn kwantitatieve en kwalitatieve methoden gecombineerd. We hebben ons gericht op de volgende vragen: 1) Hoe kunnen het functioneren als gezin en de sociale steun van vluchtelingen bevorderd worden? en 2) Hoe kan de relatie van de verzorger met de jongere en de geestelijke gezondheid van AMV's worden ondersteund?

Deel 1: Hoe kunnen het functioneren als gezin en de sociale steun van vluchtelingen bevorderd worden?

Om de eerste vraag te beantwoorden, begint dit proefschrift met een systematische review en meta-analyse over therapie waarbij meerdere gezinnen worden betrokken (multiple family therapy; MFT). Deze systematische review en meta-analyse (beschreven in **hoofdstuk 2**) biedt een overzicht van bestaande gecontroleerde studies gericht op de impact van MFT op geestelijke gezondheid en gezinsfunctioneren. Daarnaast werd een meta-analyse uitgevoerd om de werkzaamheid van MFT in het verminderen van psychische problemen en het verbeteren van gezinsfunctioneren te onderzoeken. De meeste onderzoeken richtten zich op schizofrenie, stemmingsproblemen en gedragsproblemen. De uitkomst suggereert dat MFT een positieve invloed heeft op sociaal functioneren, sociale vaardigheden en ervaren sociale steun. Tevens bleek dat MFT samengaat met verbeteringen op het gebied van gezinsfunctioneren, zij het met een kleine effectgrootte. Ook werden aanwijzingen gevonden dat MFT kan leiden tot verbeteringen in positieve en negatieve symptomen van schizofrenie met een grote effectgrootte, alhoewel dit effect niet statistisch significant is. Deelname aan MFT leek niet samen te gaan met veranderingen op het gebied van stemmingswisselingen en gedragsproblemen. Tenslotte concludeerden we dat er meer gedegen onderzoek nodig is om de potentiële effectiviteit, de kerncomponenten en mogelijke werkmechanismen van MFT beter te begrijpen.

Omdat traumatische gebeurtenissen en migratie-gerelateerde stress grote invloed hebben op ouderschap en het gezinsfunctioneren, werd een secundair preventief MFT-programma ontwikkeld, genaamd Family Empowerment (FAME). FAME heeft als doel de ouder-kind relatie, het gezinsfunctioneren en ervaren sociale steun van asielzoekersgezinnen in Nederland te versterken en de verergering van emotionele problemen te voorkomen.

In **hoofdstuk 3** presenteren we een onderzoeksprotocol voor FAME. Het onderzoek dat is beschreven had als doel de haalbaarheid, aanvaardbaarheid en potentiële effectiviteit van FAME te evalueren. Vervolgens beschrijven we de daadwerkelijke pilot-evaluatie van FAME in **hoofdstuk 4**. Kwalitatieve en kwantitatieve methoden werden gecombineerd om de haalbaarheid van FAME te evalueren. Zo is gebruik gemaakt van interviews met ouders die hebben deelgenomen aan FAME en ontwikkelden we een instrument om de programma-integriteit – de mate waarin een interventie wordt uitgevoerd zoals bedoeld - te meten. Ook werden voorafgaand en na afloop van deelname aan FAME vragenlijsten afgenomen om verandering op het gebied van gezinsfunctioneren en symptomen van depressie en angst van de deelnemende ouders te meten. Slechts een klein deel van de deelnemers hebben deze vragenlijsten ingevuld. Ouders die aan FAME deel hebben genomen hechtten er vooral waarde aan om met verschillende gezinnen samen te komen, omdat het hen kansen bied om van elkaar te leren. Hoewel verschillende ouders zich tijdens FAME gesteund voelden door de andere gezinnen, ondervonden zij geen veranderingen in de sociale steun buiten FAME. Er zijn aanwijzingen gevonden dat FAME kan samengaan met een afname van angst en depressie, maar het programma bleek een beperkte impact op het gezinsfunctioneren te hebben. Mogelijk sluit FAME, in de huidige vorm, niet voldoende aan bij de behoeften van de deelnemende gezinnen. Een andere mogelijkheid is dat de duur en frequentie van het programma niet voldoende waren om veranderingen in het gezinsfunctioneren te bewerkstelligen.

Deel 2: Hoe kan de relatie van de verzorger met de jongere en de geestelijke gezondheid van AMV's worden ondersteund?

Een groot deel van de AMV's in Nederland komt uit Eritrea. Deze minderjarigen zijn blootgesteld aan verschillende schrijnende gebeurtenissen en worden bij aankomst in Nederland geconfronteerd met psychosociale uitdagingen en ingrijpende veranderingen in hun sociaalecologische omgeving. Om de uitdagingen en behoeften van Eritrese AMV's in Nederland in kaart te brengen, beschrijven we in **hoofdstuk 5** een gerichte etnografie. Een gerichte etnografie heeft als doel om een groep in een specifieke context te bestuderen waarbij gebruik wordt gemaakt van intensieve dataverzameling door middel van focusgroepen en observaties. Uit focusgroepen met Eritrese AMV's en interviews met hun professionele verzorgers bleken de volgende thema's centraal te staan in het dagelijks leven van Eritrese AMV's: (a) relaties, (b) psychologische stress, (c) voorbereiding op zelfstandig wonen, (d) spiritualiteit en (e) vrije tijd. Elk thema gaat samen met belangrijke uitdagingen, waaronder gezinshereniging, zorgen om het welzijn van familieleden en het vinden van de weg in een 'nieuwe' samenleving zonder ouders. AMV's rapporteerden verschillende factoren die een negatieve invloed hebben op hun relatie met hun professionele verzorgers, waaronder taalverschillen, te weinig contact, onzekerheid over tot wie ze zich kunnen wenden voor hulp en het zich niet altijd gehoord of geholpen voelen. Zij suggereerden dat continuïteit in contact, informatie over besluitvorming en de

mogelijkheid om een interculturele mediator in te schakelen zouden kunnen helpen om de relatie met de verzorger te verbeteren.

AMV's en hun professionele verzorgers gaven blijk behoefte te hebben aan geestelijke gezondheidsondersteuning die aansluit bij de specifieke behoeften van AMV's. Zo benoemden zij dat er bij Eritrese AMV's sprake is van verschillende psychische problemen, onder andere met betrekking tot slapen en emotieregulatie. Ondanks deze behoefte ervoeren veel AMV's drempels naar de geestelijke gezondheidszorg, waaronder wantrouwen jegens zorgverleners en moeite met het delen van nare ervaringen uit het verleden. Er is nog weinig bekend over traumagerichte interventies voor AMV's. Om deze reden werd een kortdurende, multimodale, traumagerichte behandelaanpak aangepast voor AMV's in Nederland. Het doel van deze aanpak was om drempels tot de geestelijke gezondheidszorg te verlagen en om symptomen van depressie en posttraumatische stressstoornis (PTSS) te verminderen. Drempels werden verlaagd door de aanpak aan te bieden op de woonlocatie van de jongere, of een andere locatie naar keuze, door een flexibele, multimodale behandelaanpak aan te bieden waarbij de sessies zich richtten op de hulpvraag van de jongere en ten slotte door de aanpak aan te bieden in samenwerking met een interculturele mediator, iemand die niet alleen de taal, maar ook de cultuur 'vertaalt'. **Hoofdstuk 6 en 7** presenteren evaluaties van deze behandelaanpak.

Hoofdstuk 6 biedt een beschrijving van een studie waarin de hulpvraag, de programma-integriteit, de haalbaarheid van de behandelaanpak en het beloop van symptomen van depressie en PTSS werden onderzocht. Hiervoor werd gebruik gemaakt van verschillende vormen van dataverzameling, waaronder een lijst waarmee de programma-integriteit werd bestudeerd en gestandaardiseerde vragenlijsten voor het meten van symptomen van PTSS en depressie. De deelnemende AMV's rapporteerden vooral psychische problemen, zoals slaapproblemen, en psychosociale problemen, waaronder zorgen over gezinshereniging. Wat betreft de programma-integriteit viel op dat regelmatig werd afgeweken van de voorgeschreven behandelaanpak om tegemoet te komen aan de behoeften van de AMV's. Factoren die de haalbaarheid van de aanpak beperkten, waren vaak gerelateerd aan dagelijkse stressoren, zoals nieuws over de asielstatus. De resultaten geven een eerste indicatie dat deze aanpak drempels naar de geestelijke gezondheidszorg deels verlagen en benadrukken de meerwaarde van samenwerking met interculturele mediators.

Hoofdstuk 7 biedt een eerste evaluatie van de potentiële effectiviteit van de behandelaanpak en de tevredenheid van de AMV's die de behandelaanpak ondergingen. De effectiviteit van de behandelaanpak werd gemeten met een multiple baseline design. Dit houdt in dat er herhaalde, wekelijkse metingen werden uitgevoerd tijdens een gerandomiseerde baselineperiode (van wisselende duur) en tijdens de behandeling en een follow-upperiode van vier weken. Deze metingen bestonden uit dezelfde vragenlijsten die werden gebruikt in hoofdstuk 6, gericht op het meten van symptomen van PTSS en depressie. De kwalitatieve dataverzameling bestond uit een semigestructureerd interview gericht op de tevredenheid van de deelnemende AMV's. Tijdens de evaluatie gaven bijna

alle AMV's aan dat ze de traumagerichte behandelaanpak nuttig vonden. Zij rapporteerden ook dat de behandeling een positieve invloed had op hun welzijn. De resultaten van de kwantitatieve evaluatie toonden geen klinisch betrouwbare symptoomverminderingen na de behandeling of bij follow-up.

Ten slotte vatten we de bevindingen samen en bespreken deze bevindingen verder in **hoofdstuk 8**. In dit hoofdstuk bespreken we de uitdagingen die we zijn tegengekomen bij het ontwikkelen, evalueren en implementeren van interventieprogramma's voor asielzoekersgezinnen en AMV's in Nederland. Tegelijkertijd benadrukken we dat het de ethische verantwoordelijkheid van professionals en onderzoekers is om deze belangrijke taak te blijven vervullen. Bij dergelijk onderzoek moet de samenwerking met vluchtelingenkinderen, -jongeren en -gezinnen worden opgezocht. De uitdagingen die wij zijn tegengekomen bieden ons aanknopingspunten voor het opzetten van vervolgonderzoek, het verbeteren van de klinische praktijk en het vergroten van de haalbaarheid voor programma's voor asielzoekers en vluchtelingen.

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CURRICULUM VITAE & LIST OF PUBLICATIONS

About the Author

Carlijn van Es was born on August 15, 1990, in Hilversum. She obtained her Master's degree (with merit) in Clinical Developmental Psychology from the University of Amsterdam (2013). During her Master's degree she completed her internship at ARQ Centrum'45, working with refugee children, adolescents, and families. Afterwards, Carlijn became interested in how individuals cope with the psychological consequences of trauma. She moved to London to further develop her knowledge and skills on this subject. She obtained her Master's degree (with distinction) in War & Psychiatry from King's College London in 2015.

After returning to the Netherlands, Carlijn worked as a child psychologist at UvA minds. During this year she specialized in mindfulness, completing several mindfulness courses focusing on mothers and their babies, and families dealing with a range of psychological problems. In 2016 she returned to ARQ National Psychotrauma Centre to work as a junior policy advisor at ARQ Centre of Expertise for the Impact of Disasters and Crises. Her research focused on the resilience and psychosocial support of individuals and families who have been exposed to potentially traumatic events, with special attention for refugees and asylum seekers. Soon afterwards, in August 2016, she started her PhD project under the supervision of Paul Boelen, Trudy Mooren, and Hans te Brake.

Carlijn has been involved in a variety of projects during her PhD, including the research project Geweld in de Jeudgzorg (Violence in Youth Care) led by Micha de Winter and the 'Trauma Experts' project - a collaboration of experts in the field of trauma, focused on pooling their knowledge on trauma on their website www.traumaexperts.nl. During the final stages of her PhD, Carlijn worked as a project leader for the 'Samen Sterk' project, a project focused on strengthening the resilience of unaccompanied refugee minors and their families during major life changes.

During most of the time Carlijn also worked in clinical practice. As a psychologist, she completed training in Mindfulness, Narrative Exposure Therapy, and Cognitive Behavioral Therapy. In the beginning of 2022, Carlijn started her 'GZ-opleiding' at ARQ, with internships at Levvel and UvA minds.

Publications

Djelantik, A.A.A.M.J, **van Es, C.M.**, Lahuis, A.M., Mooren, N. (2022). The challenges of conducting mental health research among resettled refugee populations: An ecological framework from a researchers' perspective. *International Journal of Mental Health*. https://doi.org/10.1080/00207411.2022.2069962

Sleijpen, M., **van Es, C.**, te Brake, H., & Mooren, T. (2018). *Toolkit voor de begeleiding van Eritrese alleenstaande minderjarigen in Nederland*. Utrecht: Stichting Nidos.

Van Es, C.M., Boelen, P.A., Zwaanswijk, M., Te Brake, H., & Mooren, T. (2021). Family Empowerment (FAME): A feasibility trial of preventive multifamily groups for asylum seeker families in the Netherlands. *Journal of Marital and Family Therapy, 47*(4), 864-881.

Van Es, C., & Mooren, T. (2018). Verbetering van hulp aan kinderen, jongeren en gezinnen. *Impact Magazine, 4*, 32-35.

Van Es, C.M., Mooren, T., Zwaanswijk, M., te Brake, H., & Boelen, P.A. (2019). Family Empowerment (FAME): Study protocol for a pilot implementation and evaluation of a preventive multifamily program for asylum seeker families. *Pilot and Feasibility Studies, 5*.

Van Es, C.M., Sleijpen, M., Mooren, T., te Brake, H., Ghebreab, W., & Boelen, P.A. (2018). Eritrean Unaccompanied Refugee Minors in Transition: A Focused Ethnography of Challenges and Needs. *Residential Treatment for Children & Youth, 2*, 157-176.

Van Es, C., Sleijpen, M., Ghebreab, W., & Mooren, T. (2019). Cultuursensitief werken met alleenstaande jonge vluchtelingen. *Kind & Adolescent Praktijk, 4*, 16-22.

Van Es, C.M., Sleijpen, M., Velu, M.E., Boelen, P.A., van Loon, R.E., Veldman, M., Kusmallah, N., Ekster, P.J.C., & Mooren, T. (2021). Overcoming barriers to mental health care: multimodal trauma-focused treatment approach for unaccompanied refugee minors. *Child and Adolescent Psychiatry and Mental Health, 15*(1), 1-14.

Versluis, C., **van Es, C.**, Jacobs, J., Mooren, T., Drogendijk, A., de la Rie, S., & Kunz, C. (2017). *Health[e]Refugees / Mental health [E-health module].* https://www.healthefoundation.eu

Manuscripts submitted for publication

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Carlijn van Es

Circles of care

Supporting refugee families, children, and adolescents

Over a third of all forcibly displaced persons worldwide are children and adolescents under the age of 18. Most children and adolescents flee together with their families, but a substantial minority without their parents or caregivers. These minors are referred to as unaccompanied refugee minors (URMs).

This dissertation has focused on two central themes: refugee families and URMs. We aimed to answer the following questions: 'How can refugee families be supported in strengthening family functioning and social support?', and 'How can URMs be supported in strengthening the caregiver-child relationship and mental health?' Multi-informant and mixed-methods approaches were used to give voice to the participating refugees themselves and others closely involved in their lives, including legal guardians, mentors, mental health care professionals, and intercultural mediators.

Several chapters provide an evaluation of the feasibility and (potential) effectiveness of two programs developed specifically for refugee families and URMs resettling in the Netherlands: a preventive multifamily program for families living at asylum seekers (Family Empowerment; FAME) and a multimodal trauma-focused treatment approach for URMs.

The complex context of refugees and asylum seekers in the Netherlands is substantiated by the challenges we faced during our studies. This dissertation offers an overview of the specific situation refugee families and URMs function in. It emphasizes the importance of the socio-ecological system of this population. We offer several implications for the improvement of research, clinical care, and implementation of programs for resettling asylum seekers and refugees.

Carlijn van Es works as a researcher and clinician at ARQ Centrum'45 and Utrecht University.

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