



Building Happy Families

Impact evaluation of a parenting and family skills intervention for migrant and displaced Burmese families in Thailand

International Rescue Committee | NOVEMBER 2014





Authored by: Amanda Sim, Jeannie Annan, Eve Puffer, Carmel Salhi and Theresa Betancourt.

Acknowledgements

This project was implemented by the International Rescue Committee (IRC) in Thailand. Special thanks to the project team—Angeline Khin May Lwin, Sidmone Thwe, Piyawan Trakansupakorn, Jarungsak Srisamood, Luc Ferran, and Chakkrid Chansang—for their dedication and tireless efforts. Su Su Mon provided excellent research assistance, which made this study possible. We also thank the IRC operations staff in Mae Sot for their support and flexibility throughout this project. Finally, we would like to thank the 479 families who participated in the study for their patience, time, and willingness to share their stories.

The project was made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of the IRC and do not necessarily reflect the views of USAID or the United States Government. The project was also funded by an anonymous donor.

Photography by Peter Biro

Building Happy Families

Impact evaluation of a parenting and family skills
intervention for migrant and displaced
Burmese families in Thailand

International Rescue Committee | NOVEMBER 2014

Table of Contents

2	Executive Summary
7	Introduction
8	The Happy Families Program
	Theory of Change
10	Impact Evaluation
	Research Questions
	Study Design and Methodology
	Hypotheses
13	Target Population
15	Results
21	Study Strengths and Limitations
22	Conclusions and Recommendations for Research, Policy and Practice
25	Annexes
29	Bibliography



USAID
FROM THE AMERICAN PEOPLE



FRONT AND BACK COVERS: A mother with her daughter in a community of Burmese migrants near Mae Sot.
OPPOSITE PAGE: Portrait of a woman holding a child in a community of Burmese migrants near Mae Sot.

©2014 International Rescue Committee | 122 East 42ND Street, New York, NY 10168 | Rescue.org

Executive Summary

Children who are forcibly displaced due to economic pressures, persecution, and armed conflict face significant threats to their wellbeing. Research points to the crucial role of parents and families in protecting children from the negative effects of adversity and in promoting resilience, which is broadly defined as the achievement of positive outcomes in spite of exposure to risk. However, stressors associated with forced migration, including economic hardship, discrimination, abuse, and the breakdown of social support structures, can have debilitating effects on the protective capacity of parents and families, and may even increase the risk of child abuse and maltreatment. There is substantial evidence from high-income countries that interventions targeted at improving parenting practices and family functioning can effectively reduce the risk of child maltreatment as well as promote positive developmental outcomes. Although there is a small but growing evidence base on the impact of such interventions in low- and middle-income countries (LMICs), there remains a lack of knowledge about the feasibility and effectiveness of parenting and family skills interventions for children and families coping with specific risks related to forced migration.

In order to address this evidence gap, the **International Rescue Committee (IRC)**, in collaboration with researchers from the **Harvard School of Public Health** and **Duke University**, conducted a randomized controlled trial of a parenting and family skills intervention for Burmese migrant and displaced families living on the Thai–Burmese border. A total of 479 households from 20 communities participated in the study from 2011 to 2013.

The study aimed to address the following research questions:

1. Can an evidence-based parenting and family skills intervention be implemented in a low-resource, displacement setting?
2. Does the intervention have an impact on parenting practices, family functioning, and child behavior, psychosocial wellbeing, and resilience?
3. What are participants' perceptions of changes in their lives (both positive and negative) and the processes by which those changes occurred?

Results

1. High attendance and satisfaction indicate feasibility and acceptability of the intervention.

Participant attendance was high over the course of the

program in spite of the transient nature of this population, with an average attendance rate of 87% or 10 out of 12 sessions. Over 60% of families attended all 12 sessions and only 10% of participants dropped out of the program. The majority of caregiver and child participants reported high satisfaction with the program.

2. **The intervention improved positive parenting practices and caregiver–child interaction.** On average, children who participated in the intervention reported a 12% increase in positive interactions with their caregiver compared to the waitlist control group. Caregivers in the treatment group also reported a small but non-significant improvement in interactions with their children. Both children and caregivers reported a significant increase in parenting consistency such as setting rules and giving clear instructions. Children in the treatment group reported a small but non-significant increase in their caregivers' use of positive discipline overall and a 20% increase specifically in receiving rewards for good behavior, which was statistically significant. There was no effect on caregiver-reported use of positive discipline strategies. In qualitative interviews, caregivers described spending more time with their children on activities such as playing or drawing together. Some caregivers described replacing harsh punishment with positive, non-violent discipline strategies, such as giving rewards and praise. A few caregivers also reported having more developmentally appropriate expectations and feeling more love and concern for their children.

3. **The intervention reduced negative parenting practices, including some forms of harsh punishment.** Compared to those in the waitlist control group, caregivers in the treatment group reported an average decrease of 13% on a range of negative parenting behaviors, and children reported an average decrease of 10%. Two measures were used to assess the frequency of harsh punishment: the Discipline Interview and the Discipline Module of the Multiple Indicator Cluster Survey (MICS). Caregivers reported an average decrease of 13% in the use of harsh punishment overall, as measured by the Discipline Interview. In particular, caregivers reported a 90% decrease in scaring their child into behaving well, an 18% decrease in beating their child, and a 17% decrease in swearing at their child. Children reported a small but non-significant decrease in their caregivers' use of harsh punishment overall and a 15% reduction specifically in spanking and slapping,

which was statistically significant. Results for the MICS show a small, non-significant decrease in harsh discipline practices overall as reported by caregivers only. When analyzing individual items on harsh discipline, the only significant result was a 16% decrease in caregivers' use of a hard object to beat their children. In qualitative interviews, caregivers described stopping or decreasing the use of harsh punishment such as beating, shouting, or swearing at their child. A few respondents explained that they stopped using harsh punishment as a result of feeling more empathy for the child and learning about how harsh punishment can negatively affect the child's development.

- 4. The intervention had a positive impact on family functioning.** Caregivers and children who participated in the intervention reported a significant increase in family cohesion compared to those who were in the waitlist control group. While both caregivers and children reported an increase in positive family communication, the result was significant only for the child report. Results also show significant reductions in negative family interactions among treatment group participants compared to those who were in the waitlist control group, with caregivers reporting an average decrease of 13% and children reporting an average decrease of 8%. In qualitative interviews, caregivers described spending more time having "family meetings," which was discussed during the program. Respondents described making more decisions and plans with their partner and children, and some described their family as more "peaceful" and "united."
- 5. The intervention decreased children's behavioral problems and improved children's attention and resilience according to either caregiver or child report, but did not have an impact on children's emotional problems.** Caregivers and children who participated in the intervention reported a significant decrease in children's externalizing behavior problems compared to those in the waitlist control group. Caregivers also reported a significant decrease in children's attention-related problems such as lack of concentration, but child-reported results showed no impact on this outcome. There was no significant impact on children's internalizing or emotional problems such as depression or anxiety. Children, but not caregivers, reported a significant, positive impact on indicators of child resilience. In qualitative interviews, caregivers described their child as more polite, obedient, and helpful after participating in the intervention. Some caregivers also observed that their child's social

interactions with peers had improved, and that delinquent behaviors such as swearing and stealing had decreased. Some also described a feedback loop in which more positive caregiver-child interactions resulted in children feeling closer to and less afraid of their caregivers, which in turn resulted in improved child behavior.

- 6. Qualitative findings suggest potential unanticipated improvements in caregiver mental health and relationships with other family and community members.** Interviews with caregivers revealed potential unanticipated improvements in their own psychosocial wellbeing, particularly an improved ability to regulate negative emotions or "control the mind" by using relaxation techniques taught during the intervention. Several respondents reported that they (or their male partners) had stopped or reduced alcohol consumption since the intervention. Caregivers described improvements in their relationships with their partners and others in the community, including less conflict and improved communication. Some respondents also observed positive changes in their partners or children who did not attend the program, which they attributed to the knowledge and skills that they shared with their family members. Qualitative findings suggest two potential pathways of change. First, all respondents attributed the changes in themselves, their children, and their family to the knowledge that they had gained from the intervention. Second, some respondents identified their increased ability to "control the mind" as the foundation to subsequent improvements in their interactions with children, partners, and community members. In particular, they attributed the decrease in their use of harsh punishment and conflict with their partner and neighbors to better emotion regulation since the intervention.

Conclusions and Recommendations

- 1. Parenting and family interventions can be feasible and acceptable to a low resource, displaced population given adequate contextual and cultural adaptations.** High uptake, attendance, and completion of the program, combined with qualitative feedback from participants, suggest that the intervention was feasible and acceptable to the target population. Positive feedback on program facilitators also point to the feasibility of delivering an evidence-based, manualized intervention through lay workers recruited from the local community, which is particularly relevant in low-resource, displacement

Executive Summary (continued)

settings where service delivery systems are weak or non-existent and trained clinicians are scarce. Successful implementation of the intervention and its acceptability to program participants were likely due to careful contextual and cultural adaptations based on qualitative research. These adaptations were essential to enhancing the feasibility and acceptability of the intervention, but were also performed judiciously in order to maintain the integrity of the evidence-based intervention.

- 2. Brief parenting and family interventions can improve parenting practices, caregiver–child interactions, and family functioning in contexts of displacement and chronic adversity.** Results from this study show that the intervention increased positive parenting and caregiver–child interaction, decreased negative parenting behaviors including some forms of harsh punishment, increased family cohesion and communication, and reduced negative family interactions. Effect sizes were all in the small to moderate range consistent with those found in similar studies in high income countries, indicating the need for further implementation research to understand how to boost the impact of the intervention. In particular, more intensive training and supervision of intervention facilitators in order to improve the quality and fidelity of intervention delivery may be key to increasing effect sizes. In low-resource environments with few trained clinicians, there is a need to ensure that implementation strategies harness the local knowledge and networks of community-based lay facilitators while providing adequate training and supervision to maintain quality and fidelity. Furthermore, while six-month follow up results with the treatment group point to general maintenance of many intervention effects, qualitative findings suggest that participants would benefit from concrete strategies such as booster sessions or parent support groups to reinforce learning and maintain positive effects after completion of the program.
- 3. Brief parenting and family interventions can reduce child behavioral problems, and may have the potential to promote child resilience in conditions of adversity.** Results from this study show that the intervention had a significant impact on children’s externalizing behavior problems and that the effect size – while small – was consistent with those found in similar studies in high income countries. Results show weaker effects on other

child psychosocial outcomes such as emotional problems, but child-reported improvements on locally-developed indicators of resilience point to the potential of the intervention to increase children’s resilience to adversity in displacement settings. As the intervention was designed and delivered as a prevention program, longitudinal research is necessary to understand the potential longer-term effects on the prevention of behavioral and mental health problems and the promotion of positive developmental outcomes throughout children’s adolescence and early adulthood.

- 4. Brief parenting and family interventions may have the potential to promote caregiver mental health and reduce family violence.** Qualitative findings suggest that the intervention may have improved caregivers’ ability to cope with stress and anger, as well as reduced conflict between partners. Research has shown that caregiver mental health has a significant influence on children’s wellbeing and development, with caregivers who are depressed or anxious less able to form secure attachments with their children, which in turn increases the risk of children developing conduct and emotional disorders. Further research is required to explore the potential of parenting and family interventions to improve caregiver mental health, which in turn would likely contribute to improvements in the primary outcomes of parenting practices, caregiver–child interactions, and child wellbeing. Qualitative findings from this study and a similar study in Liberia also suggest that parenting and family interventions may have the potential to improve marital relationships and reduce marital conflict. While there is currently no evidence on the impact of parenting and family interventions on intimate partner or family violence, there is a significant body of research demonstrating the links between exposure to domestic violence and child wellbeing. Given these links, further research on parenting and family interventions should seek to measure impacts on marital functioning and conflict, which in turn may contribute to the prevention or reduction of behavioral and mental health problems in children.
- 5. Further research is necessary to uncover potential moderators and mediators of program effectiveness in order to maximize impact for the most at-risk children and families.** Qualitative findings from this study suggest that one important pathway of change for this population of caregivers may center around caregiver mental health, specifically emotion regulation. Mediation analyses would

help ensure that theories of change are based on an understanding of the intervention ingredients that predict key outcomes around parenting behavior and child wellbeing, thereby facilitating the design of interventions that are tailored to the observed mechanisms of change in specific populations. In addition, moderator analyses to understand whether a program is more or less effective for different subgroups are crucial to targeting those children and families that may need specialized or additional intervention. Such analyses have important implications for decisions around targeting and dosage, which in turn influences questions of cost effectiveness and implementation at scale. Given the level of risk and scarcity of resources in conflict-affected and displacement settings, further implementation and research should focus on how to achieve the most impact for the most at-risk children and families.

Recommendations for Research

1. Conduct implementation research on how to boost and maintain intervention effects, particularly through testing the impact of various training, supervision, and delivery models.
2. Ensure that studies include longitudinal data collection to assess the maintenance of intervention effects and impacts on child outcomes through adolescence and early adulthood.
3. Investigate the impact of parenting and family interventions on other outcomes, including caregiver mental health, marital functioning, and intimate partner violence.
4. Conduct mediator analyses to determine mechanisms of change that can inform the design of more effective interventions for specific populations, particularly those affected by conflict, displacement and other adversity. Conduct moderator analyses to identify and refine targeting of subpopulations that are harder to reach or require more intensive intervention.
5. Ensure that all studies include dosage, costing, and cost effectiveness analyses in order to inform the most impactful allocation of scarce resources.

Recommendations for Policy

1. Advocate for, support, and fund the inclusion of parenting and family interventions in child protection and development policy and practice, drawing on the well-established evidence base on parenting interventions in high-income countries and the growing body of research from low- and middle-income countries.

2. Build the capacity of the local social workforce in the theory, principles, and approaches underpinning parenting and family interventions. Investigate the feasibility and effectiveness of various delivery models using the social workforce to determine how parenting and family interventions can be delivered sustainably and at scale.
3. Fund multi-year programs that combine high quality, evidence-based intervention delivery with rigorous evaluation to address outstanding research questions. Ensure that funding and program cycles allow for sufficient resources and time to undertake rigorous efficacy or effectiveness trials and longitudinal follow-up for intervention research.

Recommendations for Practice

1. Ensure intervention design and delivery are culturally and contextually grounded through the application of rigorous mixed-methods research, which purposefully sequences qualitative and quantitative data collection for both formative research and to improve understanding of intervention mechanisms.
2. Strengthen models for facilitator training, mentoring, and supervision, particularly for lay workers or paraprofessionals with minimal training and experience in low-resource settings.
3. Incorporate concrete strategies into the intervention such as home visits, booster sessions, and parent support groups to reinforce learning and maintain positive effects after the completion of the program. ■



Introduction

Children who are forcibly displaced due to economic pressures, persecution, and armed conflict face significant threats to their wellbeing. Compelled to navigate the transition to a new and unfamiliar setting during a formative stage of their development, children affected by forced migration are at a heightened risk of psychological distress and poor developmental outcomes (Reed et al. 2012). This risk is amplified when transition to the post-migration environment is fraught with new or continuing social and economic challenges.

Research points to the crucial role of parents and families in protecting children from the negative effects of adversity and in promoting resilience—broadly defined as the achievement of positive outcomes in spite of exposure to risk (Luthar 1993; Rutter 1985; Masten 2001). However, stressors associated with forced migration, including economic hardship, discrimination, abuse, and the breakdown of social support structures, can have debilitating effects on the protective capacity of parents and families, and may even increase the risk of child abuse and maltreatment (Gewirtz, Forgatch & Wieling 2008). Research has shown that family-level risk factors such as poor parenting skills, family conflict, and parental stress, as well as environmental risk factors such as poverty, discrimination, poor social support, and lack of access to services, are linked to heightened risk of child abuse and neglect (WHO 2002; Coulton, Korbin & Su 1999). Family violence, including intimate partner violence and child abuse, has also been reported to increase in conflict-affected and post-conflict settings (Fazel et al. 2012).

While child maltreatment can occur in many different settings, the United Nations Secretary-General's Study on Violence against Children highlights that the majority of violence is perpetrated by those closest to the child, including parents and other caregivers, and often in the context of discipline. Analysis of data from 33 low- and middle-income countries (LMICs) confirms the pervasive use of violent disciplinary practices: on average, three out of four children between the ages of 2 and 14 are subjected to some form of violent discipline, half of whom experience physical punishment (UNICEF 2010). In another study of 28 LMICs, children from poorer families were at higher risk of psychological and physical abuse (Akmatov 2011).

There is substantial evidence from high-income countries that interventions targeted at improving parenting practices and family functioning can effectively reduce the risk of child maltreatment as well as promote positive developmental

outcomes (WHO 2009). Although there is a small but growing evidence base on the impact of such interventions in LMICs (Knerr, Gardner & Cluver 2013), there remains a lack of knowledge about the feasibility and effectiveness of parenting and family skills interventions for children and families coping with specific risks related to forced migration. The majority of intervention studies with conflict-affected and displaced populations have focused on individual or group-based mental health treatment, rather than on family processes that may result in reducing psychological distress and promoting positive outcomes for children and families (Tol et al. 2011).

In order to address this evidence gap, the **International Rescue Committee (IRC)**, in collaboration with researchers from the **Harvard School of Public Health** and **Duke University**, conducted a randomized impact evaluation of a parenting and family skills intervention for Burmese migrant and displaced families living on the Thai–Burmese border. The IRC is an international humanitarian and development organization that has been delivering services to refugees and other displaced persons in Thailand since 1976. The majority of the estimated 1.5 to 2 million displaced persons in Thailand originate from Burma, also known as Myanmar. Compelled to leave their homes by a combination of political persecution, repression, armed conflict and economic pressures, many Burmese live and work in Thailand without refugee status or other forms of legal documentation. Threats to their safety and wellbeing include poverty, lack of access to basic services, harassment and abuse by Thai authorities and employers, and risk of arrest and deportation (IRC 2012). Children face particular risks, as they are often denied their rights to citizenship, education, and healthcare, and are vulnerable to violence and exploitation in the family, school, and community.

This report presents findings from the impact evaluation of a parenting and family skills intervention called the **Happy Families Program** which was implemented by the IRC from 2011 to 2013. It is the first of its kind to be implemented with the Burmese displaced population in Thailand and rigorously evaluated through a randomized controlled trial. The goal of the study is to generate evidence around what works to protect vulnerable children from the negative effects of forced migration and support them to achieve positive social and emotional outcomes in the face of adversity. The IRC is investing globally in programming and research on parenting and family skills interventions in low-resource and conflict-affected settings. In addition to this study, the IRC has evaluated similar interventions in Burundi (Annan et al. 2013) and Liberia (Puffer et al. 2014). ■

OPPOSITE PAGE: A father with his daughter in a community of Burmese migrants near Mae Sot.

The Happy Families Program

The Happy Families Program is a 12-week, group-based parenting and family skills intervention for children aged 8 to 12 and their caregivers. It was adapted from the Strengthening Families Program, an evidence-based intervention developed in the United States in 1982 and since disseminated to 17 countries, including Thailand (Kumpfer et al. 2008).

In order to maximize cultural and contextual relevance, the IRC and its research partners conducted qualitative research with children and caregivers in four of the 20 study sites to inform the selection and adaptation of the intervention. Qualitative research revealed risk factors for child maltreatment and poor psychosocial outcomes, including harsh punishment, parental stress, alcohol use, and family conflict, as well as the protective capacity of positive parenting and family functioning. In response to findings about high levels of parental stress in particular, intervention content on anger and stress management was expanded to include culturally appropriate coping and relaxation techniques such as breathing exercises. Cultural and religious concepts such as *metta* or “loving-kindness,” also discovered through the course of qualitative research, were incorporated in the intervention to facilitate discussion around the negative effects of harsh punishment

in a way that resonated with participants' existing beliefs. In addition, qualitative findings were used to make adaptations to the delivery of the intervention in order to address safety concerns and to promote attendance in spite of restrictions on participants' time and freedom of movement. These adaptations included holding all sessions in the evenings and on weekends, and in the immediate vicinity of participants' homes. Renamed the Happy Families Program, the intervention was piloted with 11 families to further refine the intervention model and content prior to rollout to 20 study sites.

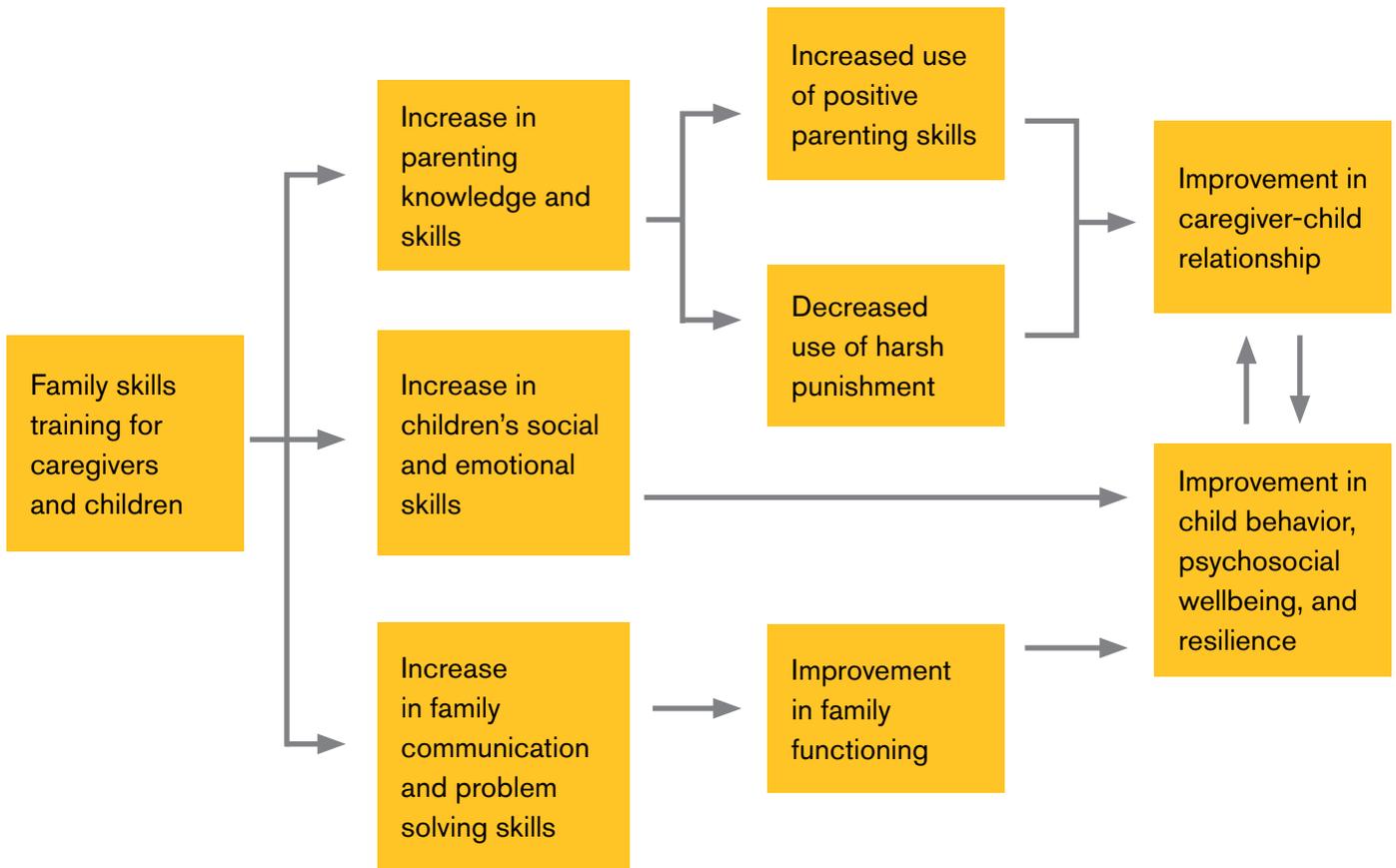
Caregivers and their children participated in parallel group sessions each week, followed by joint activities in which each family practiced the skills that they had learned under the guidance of program facilitators. The program also included structured opportunities for positive interactions between caregivers and children, beginning each week's session with a family meal and ending with games to promote bonding and relationship building. In order to motivate regular attendance, the program provided a small gift, usually a household item such as soap or cooking oil, to families each week as well as childcare for children under five years of age.

Table One. Happy Families Program Topics

Caregiver Sessions	Child Sessions
Child development and appropriate expectations	Speaking and listening to others
Managing stress	Rewarding good behavior
Rewarding good behavior	Saying “no” to stay out of trouble
Setting goals and objectives with children	Communication for happy families
Communication for better relationships	Communication to seek help
Effects of alcohol and drugs on families	Effects of alcohol, tobacco, and drugs
Problem solving	Problem solving
Behavior management	Recognizing feelings
Maintaining change	Dealing with criticism and anger

The intervention was delivered by teams of IRC program staff and community-based lay facilitators who received several weeks of training in intervention delivery, as well as ongoing feedback throughout the implementation. IRC program and technical staff conducted regular monitoring of program implementation to ensure intervention fidelity (i.e., adherence to the program manual) and to identify facilitators in need of extra supervision and coaching. Participant attendance and satisfaction were monitored through weekly attendance logs and brief satisfaction surveys conducted midway and at the end of the program.

Theory of Change



Impact Evaluation

Research Questions

The IRC and research partners from the Harvard School of Public Health and Duke University conducted a randomized evaluation of the Happy Families Program to answer the following research questions:

1. Can an evidence-based parenting and family skills intervention be implemented in a low-resource, displacement setting?
2. Does the intervention have an impact on parenting practices, family functioning, and child behavior, psychosocial wellbeing, and resilience?
3. What are participants' perceptions of changes in their lives (both positive and negative) and the processes by which those changes occurred?

Study Design and Methodology

The study used a randomized waitlist controlled trial design in order to attribute results to the intervention. Participants were randomly assigned to a treatment group that received the intervention immediately following the baseline survey,

and a waitlist control group that received the intervention upon completion of the end-line survey. Due to operational constraints, the study was implemented in two phases, with 10 communities in each phase, selected based on proximity and language. In total, 240 families were randomly assigned to the treatment group and 239 families to the control group, stratified by community and implementation phase.

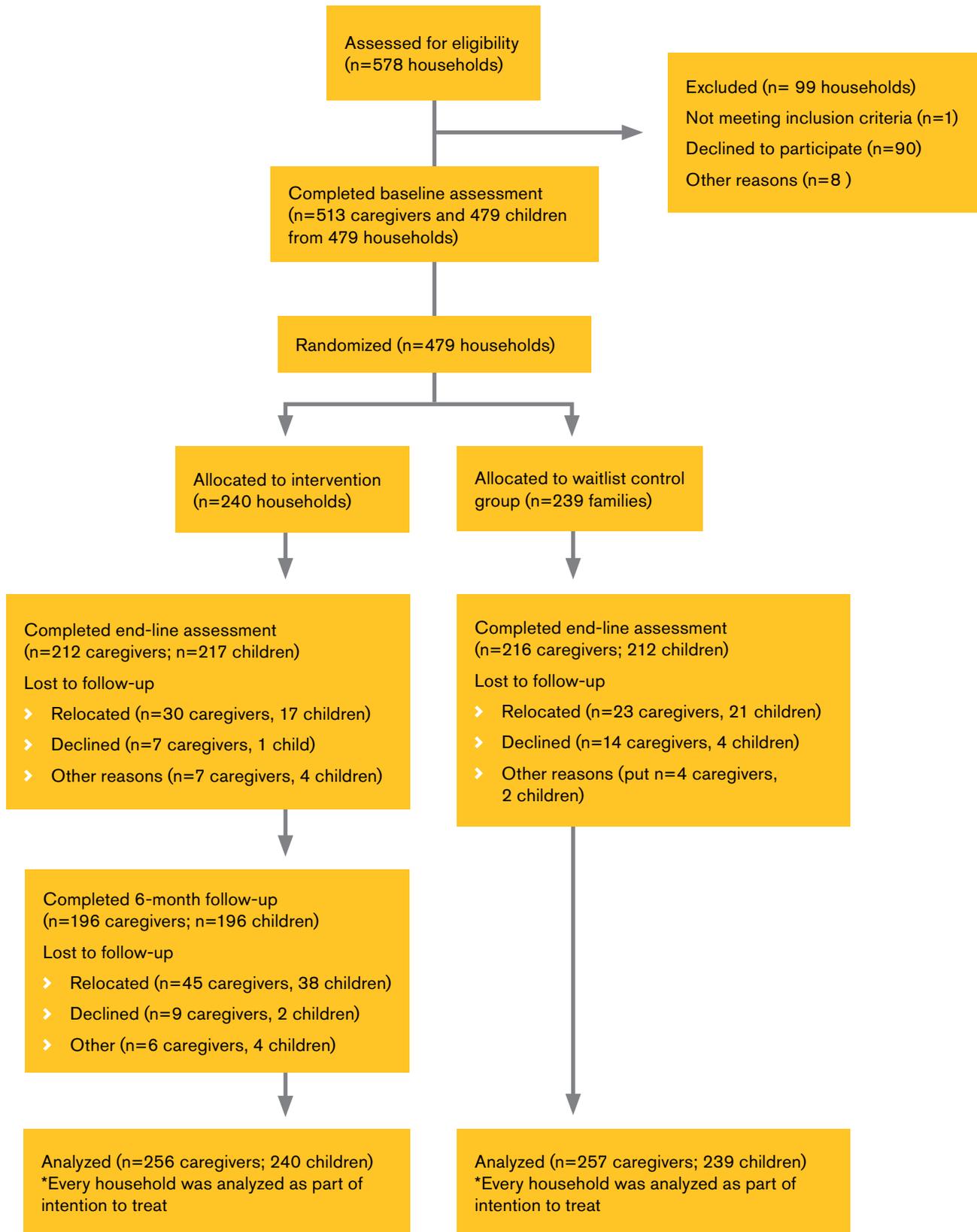
Informed consent was obtained from the caregiver and the child prior to data collection. In the event that cases of child abuse or other risk of harm emerged through the course of the study, the IRC followed protocols for response and referral. All study procedures were approved by the Harvard School of Public Health Institutional Review Board.

Baseline data were collected from all participants prior to randomization. In addition to the enrolled caregiver(s), one child aged 8 to 12 from each household was randomly selected to participate in the study. The surveys were conducted in the respondent's preferred language (either Burmese or Karen) by a trained local research assistant using Android phones, with the exception of Karen language assessments, which were conducted using paper and pencil. The survey

Table Two. Measures

Construct	Measure	Author, Year
Parenting practices	Parental Acceptance and Rejection Questionnaire	Rohner, R., 2005
	Parent Behavior	Developed for this study based on qualitative research, 2011
Discipline practices	Discipline Interview	Lansford, J.E., et al., 2005
	Discipline module of Multiple Indicator Cluster Survey (MICS)	UNICEF, 2005
Family functioning	Burmese Family Functioning Scale	Developed for this study based on qualitative research, 2011
Child mental health	Child Behavior Checklist/Youth Self Report	Achenbach, T. & Rescorla, L., 2001
Child resilience	Burmese Child Resilience Scale	Developed for this study based on qualitative research, 2011
Caregiver alcohol use	Alcohol Use Disorders Identification Test (AUDIT)	World Health Organization (WHO), 2001

Figure One. Participant Flow



Impact Evaluation (continued)

included questions related to family functioning, including communication, cohesion, and negative family interactions; positive and harsh forms of parenting; caregiver–child interactions; and child mental health and resilience.

The end-line survey was conducted with all participants one month after the treatment group completed the program. Participants in the treatment group completed an additional survey six months after the completion of the program in order to detect possible longitudinal and maintenance effects. All data were self-reported by the caregiver and child participants. Surveyors were not involved in delivering the intervention and were blinded to the treatment condition.

In addition, 25 families were purposively selected to participate in qualitative semi-structured interviews post-intervention. The interviews included questions about any perceived effects on relationships between caregivers, children, family members, and relations with the broader community—both positive and negative—due to the intervention. Interviews were audio recorded, transcribed, translated into English, and analyzed using thematic content analysis.¹

A “difference-in-differences” analysis was conducted to examine if there were statistically significant differences on outcomes of interest between the treatment and control groups from baseline to end-line. Longitudinal analysis was conducted on data collected from treatment group participants only at baseline, one month post-intervention and six months post-intervention. An “intention-to-treat” approach was used, meaning that all participants who were enrolled in the study were included in the analysis, even if they were assigned to the treatment group but did not participate in the program. Estimates of treatment effects are generally more conservative but also less biased using this approach.

Hypotheses

The study aimed to test the following hypotheses:

- » Participants in the treatment group will report an increase in positive parenting practices and caregiver–child interactions compared to participants in the control group;
- » Participants in the treatment group will report a decrease in negative parenting practices, including the use of harsh punishment, compared to participants in the control group;
- » Participants in the treatment group will report an increase in family functioning compared to participants in the control group;
- » Participants in the treatment group will report a reduction in children's social, emotional, and behavioral problems, and an increase in resilience compared to participants in the control group. ■

¹ Thematic content analysis refers to a common method of qualitative analysis in which the researcher looks for patterns or themes in the data.

BELOW: A mother in Mae Sot dresses her child in the morning.



Target Population

The IRC implemented the Happy Families Program in 20 urban and rural communities in Tak province, Thailand on the western border with Burma/Myanmar. Tak province is the fourth largest province in Thailand and is a popular gateway for Burmese refugees and migrants entering Thailand. Selected communities contain large Burmese populations, including three sites with predominantly Burmese-Karen populations.²

To recruit families for the study, the IRC conducted a series of community meetings with local leaders, teachers, parents and other caregivers to describe the program and screen interested families for eligibility. In some communities, community-based facilitators identified and recruited families who met the inclusion criteria. The only criteria for participating in the study were being of Burmese origin and being a parent or caregiver to a child between the ages of 8 and 12. A total of 479 families were enrolled into the study.



² The Karen are a culturally and linguistically distinct ethnic group that has traditionally resided in the hills straddling the border between Thailand and Burma/Myanmar. The Karen have engaged in armed resistance against the Burmese state since 1945.

Table Three. Demographic characteristics of caregiver participants

		Freq	%
Sex	Male	87	17
	Female	426	83
Ethnicity	Burman	349	68
	Karen	97	19
	Muslim	41	8
	Other	25	5
Religion	Buddhism	453	88
	Islam	44	9
	Christianity	16	3
Marital status	Married	453	88
	Unmarried	60	12
Education level	No formal schooling	120	23
	Kindergarten	44	9
	Primary school	260	50
	Middle school	65	12
	High school	20	4
	University	4	1
Employment	Unemployed	178	35
Legal status	No legal documentation	375	73

The majority of caregiver participants were women (83%) and biological mothers to the participating children (69%). Biological fathers made up 15% of the sample, followed by grandparents, uncles or aunts, and older siblings. The average age of participating caregivers was 41 years and the median age was 40 years, with a range of 16 to 80 years. Half of the participants had received some primary education and 23% did not have any formal education. The majority (73%) did not possess legal documentation for living and working in Thailand (e.g., had no documents, expired documents, or informal documents), 29% had documentation that required renewal or imposed restrictions on employment and travel (e.g.,

Target Population (continued)

registration with the Thai Ministry of Interior, ethnic minority card), and 1% had permanent residency.

Approximately one third (35%) of the participating caregivers were unemployed. Out of those who were working, 61% were doing agricultural work and worked 48 hours per week on average. The average household size was 5 members, and combined household income averaged 4,987 Thai Baht (\$157.92 US Dollars) in the previous month, with a median household income of 4,450 Thai Baht (\$140.91 US Dollars). Housing characteristics, such as the type of material used for the floor, roof, and walls of a dwelling, were used as indicators of socioeconomic status. Bamboo was the predominant material used for the floor and walls of participants' dwellings (59% and 42% respectively) and thatch or palm leaf was mainly used for roofing (42%). In terms of asset ownership, 63% of households had electricity, 71% owned a mobile phone, 46% owned a television, and 46% owned a bicycle.

Child participants were almost evenly split between boys (49%) and girls (51%). On average, children were 10 years old, ranging from 7 to 15 years.

Most children (71%) lived with both biological parents. Almost a third of the children (27%) were not in school, with no significant difference between boys and girls. The majority of children (76%) reported doing some form of paid or unpaid work in the previous week; out of the children who reported working, 25% were employed by a non-household member. Children who performed work for a non-household member reported working more hours on average (20 hours per week) than children who were employed by a household member (17 hours per week). ■

BELOW: A group of children in a community of Burmese migrants near Mae Sot.



Results

1. High attendance and satisfaction indicating feasibility and acceptability

Participant attendance was high over the course of the program, in spite of the transient nature of this population, with an average attendance rate of 87% or 10 out of 12 sessions. Over 60% of families attended all 12 sessions and only 10% of participants dropped out of the program. Such high rates of attendance and retention suggest that the program was accepted and well-liked by participants. This is supported by monitoring data collected from 378 caregivers and 434 children who participated in the program: 85% of caregivers and 84% of children reported being “very satisfied.” According to participant feedback, caregivers most enjoyed learning about family meetings, teaching good behavior, setting goals and objectives, negative effects of drugs and alcohol, and using rewards. Children most enjoyed the sessions on communication skills and staying away from drugs and alcohol.

In qualitative interviews with a subsample of caregivers, the main motivators for program uptake and attendance were to gain “knowledge,” teach children how to be polite and obedient,

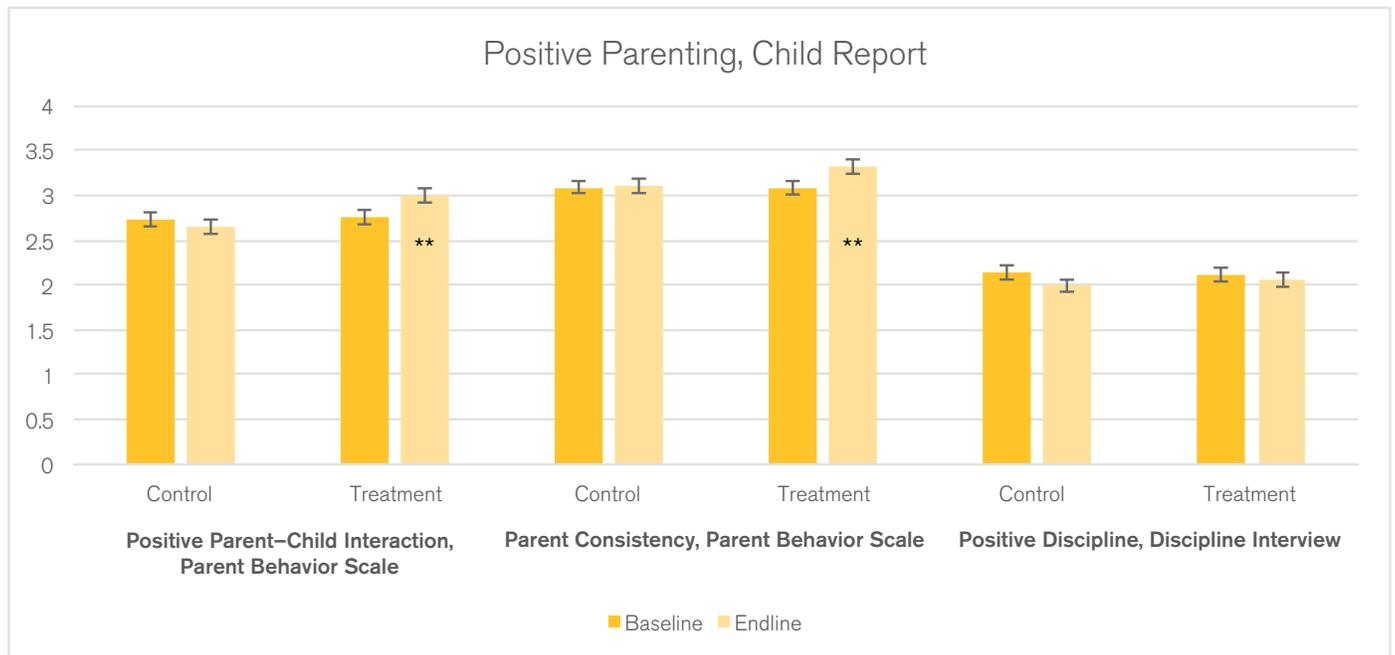
“ I think this program is suitable for the Burmese family. We came from Burma and we feel inferior among Thai people. We were not educated and we want our children and grandchildren to be educated. It was easy [to attend]. The teachers at the program are nice...If I go this week, I get knowledge and if I go again, I will get more knowledge. I think like that.”

—58-YEAR-OLD GRANDMOTHER

and have a “united family.” Caregivers described being motivated to attend every week in order to hear what new information would be shared, with a few respondents explicitly mentioning their desire to make up for a lack of education by attending the program. Some caregivers cited the timing and location of the program, as well as the availability of childcare and support from their spouse, as facilitators of attendance, while others described their commitment to the program as the

Figure Two. Caregiver report of frequency of positive parenting behaviors at baseline and end-line, by study arm.

Confidence intervals: 95%; * indicates statistical significance.



Results (continued)

main reason for their regular attendance, in spite of barriers related to work, illness, and poor weather.

2. Impact on positive parenting practices

We assessed three dimensions of positive parenting: caregiver–child interaction, parenting consistency, and positive discipline. On a scale of 1 to 4 (1—almost never, 2—rarely, 3—sometimes, 4—almost always), caregivers reported at baseline an average score of 3.0 or “sometimes” on a range of positive caregiver–child interactions such as giving praise and showing physical affection. The average baseline score for parenting consistency (e.g., giving clear instructions, monitoring children’s whereabouts and activities) was slightly higher at 3.56. Caregivers reported at baseline frequent use of some positive discipline strategies but not others: on average, caregivers reported rewarding good behavior 2–3 times a month, and teaching children to behave well about once a week, but rarely used strategies such as time out or repeated practice of good behaviors.

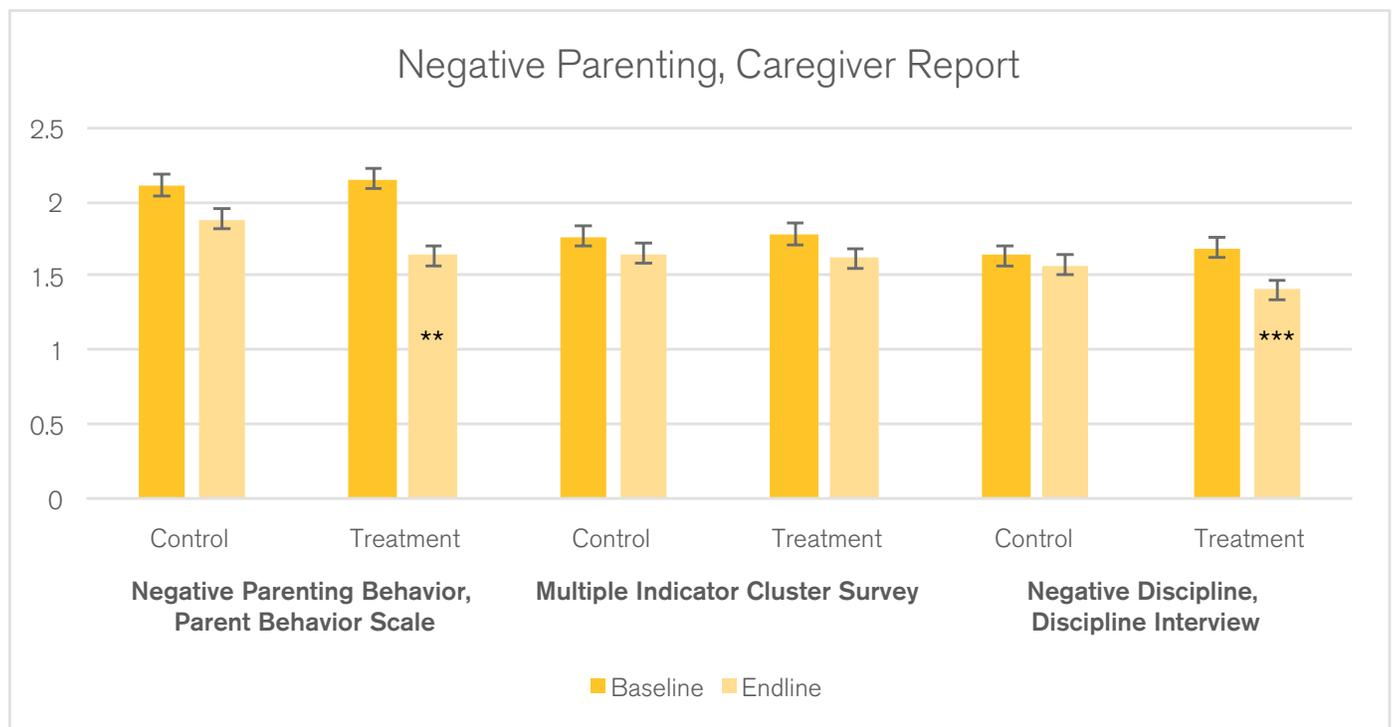
The intervention improved positive parenting practices and caregiver–child interaction. On average, children who

participated in the intervention reported a 12% increase in positive interactions with their caregiver (effect size 0.33; $p < 0.01$) compared to the waitlist control group. Caregivers in the treatment group also reported a small, non-significant improvement in interactions with their children (effect size 0.20). Both children (effect size 0.28; $p < 0.01$) and caregivers (effect size 0.24; $p < 0.05$) reported a significant increase in parenting consistency. Children in the treatment group reported a small but non-significant increase in their caregivers’ use of positive discipline overall (effect size 0.12), and a 20% increase specifically in receiving rewards for good behavior, which was statistically significant (effect size 0.50; $p < 0.01$). There was no effect on caregiver-reported use of positive discipline strategies.

Improvement in positive caregiver–child interaction was maintained at six months post intervention among the treatment group participants. However, caregiver-reported parenting consistency returned to baseline levels, and both caregivers and children reported a possible decline in the use of positive discipline strategies six months post intervention.

Figure Three. Caregiver report of frequency of negative parenting behaviors in the last 4 weeks at baseline and end-line, by study arm.

Confidence intervals: 95%; * indicates statistical significance



Qualitative findings were consistent with the results presented above. Caregivers described spending more time engaging in activities with their children such as playing or drawing together, and some observed that their children had become more affectionate, communicative, and closer to them. Some caregivers described replacing harsh punishment with positive, non-violent discipline strategies such as giving rewards and praise, and calmly explaining to children why their behavior was wrong. A few caregivers also reported having more developmentally appropriate expectations and feeling more love and concern for their children.

3. Impact on harsh parenting practices

We assessed a range of harsh or negative parenting practices, including the use of physical and psychological punishment. On a scale of 1 to 4 (1—Almost never, 2—Rarely, 3—Sometimes true, 4—Almost always true), caregivers reported an average baseline score of 2.13 or “rarely true” on a measure of negative parenting behaviors such as taking out anger or frustration on the child. Caregivers reported infrequent use of physical

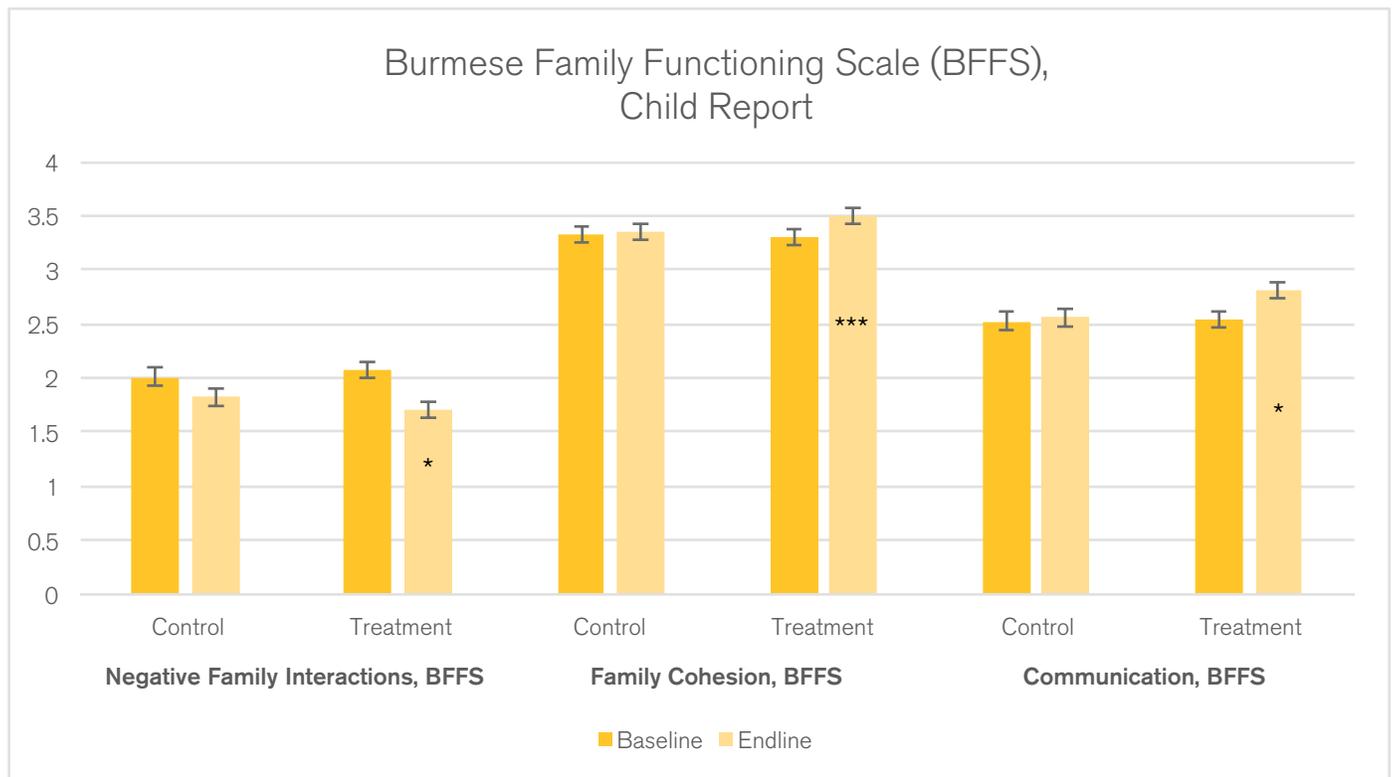
punishment at baseline, but harsh verbal or psychological punishment such as shouting at the child or calling the child a hurtful name was more common, occurring about once a month on average.

The intervention reduced negative parenting practices, including some forms of harsh punishment. Compared to those in the waitlist control group, caregivers in the treatment group reported an average decrease of 13% in negative parenting behaviors (effect size -0.38; $p < 0.01$) and children reported an average decrease of 10% (effect size -0.27; $p < 0.05$).

We used two measures to assess the frequency of harsh punishment: the Discipline Interview (Lansford et al. 2005) and the Discipline Module of the Multiple Indicator Cluster Survey (UNICEF 2005). Caregivers reported an average decrease of 13% in the use of harsh punishment overall, as measured by the Discipline Interview (effect size -0.40; $p < 0.001$). In particular, caregivers reported a 90% decrease in scaring their child into behaving well, an 18% decrease in

Figure Four. Child report of family functioning in the last 4 weeks at baseline and end-line, by study arm.

Confidence intervals: 95%; * indicates statistical significance



Results (continued)

beating their child, and a 17% decrease in swearing at their child. Children reported a small but non-significant decrease in their caregivers' use of harsh punishment overall (effect size -0.12), and a 15% reduction specifically in spanking and slapping, which was statistically significant (effect size -0.33; $p < 0.01$). Results for the second measure, the Multiple Indicator Cluster Survey, show a small, non-significant decrease in harsh discipline practices overall as reported by caregivers only (effect size -0.10). When analyzing individual items on harsh discipline, the only significant result was a 16% decrease in using a hard object to beat their child (-0.22; $p < 0.01$). Reductions in harsh or negative parenting overall were maintained at six-month follow up with treatment group participants.

Qualitative findings were consistent with the results presented above, with many caregivers describing that they stopped or decreased the use of harsh physical punishment such as beating or throwing things at the child, and were no longer shouting, swearing or using hurtful language with their children. A few respondents explained that they stopped using harsh punishment as a result of feeling more empathy for the child and learning about how harsh punishment can negatively affect their child's development.

4. Impact on family functioning

We assessed three dimensions of family functioning: cohesion, communication, and negative family interactions. On a scale of 1 to 4 (1—Almost never true, 2—Rarely true, 3—Sometimes true, 4—Almost always true), caregivers reported an average score of 3.58 on a measure of family cohesion at baseline, which included items such as having family unity and showing respect for family members. Caregivers reported an average baseline score of 2.92 for family communication, which included items on joint decision making and problem solving, and an average baseline score of 2.05 for negative family interactions such as fighting and shouting at one another.

The intervention had a positive impact on all three dimensions of family functioning. Caregivers who participated in the intervention reported a significant increase in family cohesion compared to those in the waitlist control group (effect size 0.47; $p < 0.001$), as did children (effect size 0.36; $p < 0.001$). While both caregivers and children reported an increase in positive family communication, the result was significant for the child report only (effect size 0.27; $p < 0.05$). Results also show significant reductions in negative family interactions among treatment group participants compared

to those in the waitlist control group. Caregivers reported an average decrease of 13% in negative family interactions (effect size -0.31; $p < 0.01$), while children reported an average decrease of 8% (effect size -0.24; $p < 0.05$). These reductions were maintained at follow up with treatment group participants six months post intervention.

Qualitative findings also reflect positive changes in family functioning. Results suggest that caregivers were spending more time having family discussions, with many referring to the concept of “family meetings,” which was taught and practiced during the program. Respondents described discussing with their partner and children how to make decisions about household finances and what plans to make for the future. Some also described their family as more “peaceful” and “united,” with family members showing more love and respect for one another and engaging in less conflict.

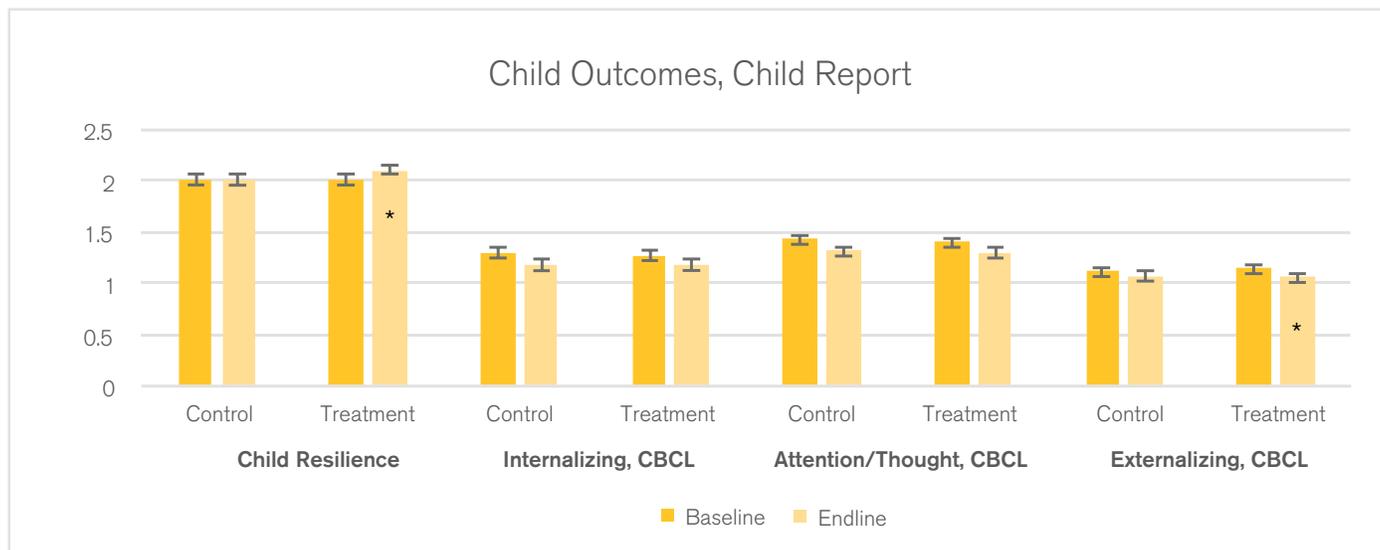
5. Impact on child mental health and resilience

We assessed three types of mental health problems in children: externalizing/behavioral problems, internalizing/emotional problems, and attention/thought problems. On a scale of 0 to 2 (0—Not true, 1—Somewhat or sometimes true, 2—Very or often true), children reported an average score of 1.13 on externalizing problems such as disobedience and aggression, 1.29 on internalizing problems such as depression and anxiety, and 1.41 on attention/thought problems such as lack of concentration. We also assessed indicators of child resilience as defined by Burmese children and caregivers during qualitative research. Caregivers reported an average score of 1.22 on the child resilience scale while children reported an average score of 1.00 at baseline. Children's view of their resilience was mixed, with 61% agreeing that it was “very true” that they have a positive attitude, yet 65% also agreeing it was “very true” that they feel hopeless about the future. While 78% of children responded that it was “very true” they enjoyed being with others, 24% felt they could not get help from family or other elders, and 42% reported feeling inferior to others “sometimes” or “often.”

The intervention decreased children's behavioral problems and improved children's attention and resilience according to either caregiver or child report, but did not have an impact on children's emotional problems. Caregivers who participated in the intervention reported a significant decrease in their children's externalizing behavior problems (effect size -0.22; $p < 0.05$) compared to those in the waitlist control group, as did children (effect

Figure Five. Child report of child mental health and resilience in the last 4 weeks at baseline and endline, by study arm.

Confidence intervals: 95%; * indicates statistical significance



size -0.12; $p < 0.05$). Caregivers also reported a significant decrease in children’s attention-related problems such as lack of concentration (effect size -0.23; $p < 0.05$), but child-reported results showed no impact on this outcome. There was no significant impact on children’s internalizing or emotional problems such as depression or anxiety; only caregivers reported a small but non-significant decrease in such symptoms (effect size -0.13). Children, but not caregivers, reported a significant, positive impact on indicators of child resilience (effect size 0.18; $p < 0.05$). Effects on children’s mental health problems and resilience—where present—were maintained at six-month follow up with treatment group participants.

In qualitative interviews, caregivers described their child as more polite, obedient and helpful after participating in the intervention. Some caregivers also observed that their child’s social interactions with peers had improved, and that delinquent behaviors such as swearing and stealing had decreased. Some respondents further described a feedback loop in which more positive caregiver–child interactions resulted in children feeling

closer to and less afraid of their caregivers, which in turn resulted in improved child behavior.

6. Perceived changes in caregivers and their relationships in the family and community

Qualitative findings suggest potential unanticipated improvements in caregiver mental health and relationships with other family and community members. Interviews with caregivers revealed potential unanticipated improvements in their own psychosocial wellbeing. Caregivers used the phrase “control the mind” or “relax the mind” to describe an improved ability to control their temper and calm down, and to consider their reaction before speaking or acting in anger. Many described using the breathing and relaxation techniques that they had learned in the intervention to help them cope with negative emotions such as anger and stress. Some also mentioned other cognitive changes, such as focusing on problem solving instead of negative emotions, changing negative thought patterns, and being more goal-oriented. Several respondents reported that they (or their male partners)

Results (continued)

had stopped or reduced alcohol consumption as a result of what they had learned in the intervention.

Caregivers also described improvements in their relationship with their partner and with others in the community.

Respondents described having fewer fights and improved communication with their partner, including more discussions around household finances and problem solving. Several respondents also observed improvements in their partners' parenting style even if their partner did not participate in the intervention, which they attributed to sharing what they had learned at each session. Relatedly, some caregivers discussed using the skills they had learned with other children in the family who had not participated in the program, and observing subsequent improvements in those children's behavior. These observations suggest that the program has the potential to promote positive changes in other family members aside from the participating caregiver or child. Finally, some caregivers described having a better relationship with neighbors and others in the community, such as engaging in less conflict.

Qualitative findings suggest potential pathways of change. First, all respondents attributed the changes in themselves, their children, and their family to the knowledge that they had gained from the intervention. Many specifically acknowledged the role of the facilitators or "teachers" in providing guidance and knowledge, suggesting that respect for the facilitators played an important role in encouraging uptake. Second, some respondents explicitly identified their increased ability to "control the mind" as the foundation to subsequent improvements in their interactions with children, partners, and community members. In particular, they attributed the decrease in use of harsh punishment and conflict with their partner and neighbors to better emotion regulation.

Group dynamics and processes did not emerge as a salient theme in the qualitative interviews, with only a few respondents mentioning sharing experiences with and learning from other participants in the program. There was also no indication that participants provided social support to one another after the end of the program beyond chance encounters in the

community. Most caregivers did not report specific or concrete strategies for remembering the knowledge and skills that they had learned in the program and maintaining the positive changes that they described. A few exceptions included caregivers who described the following strategies to reinforce learning and maintain positive change: monitoring their own and their partner's parenting behaviors; reviewing lessons from the program at family meetings; doing homework and practicing skills learned in the program regularly; and using locally available materials to construct helpful tools from the program such as behavior charts to encourage positive child behavior. In general, caregivers who described high levels of commitment to the program (e.g., leaving work early to attend the program or maintaining attendance in spite of illness or bad weather) were also better able to cite specific strategies and skills that they had learned as well as ways to maintain positive change. ■

“If my children don't listen to me, I do meditation. I don't let myself have a hot temper...[Before] I threw everything... cooking pots and plates. My children didn't dare to stay with me when I was angry... Now I try to control my temper. I was thinking if I keep doing like this, what my children will think about me. And I will grow old and one day I will die. And then I tried to calm down...they told us about that in the training. They told us to calm down by using breathing exercises, controlling our mind. If someone is angry, another one has to be patient, things like that.”

—56 YEAR OLD MOTHER

Study Strengths and Limitations

One of the main strengths of the study is the randomized design, which allows for attribution of results to the intervention. Another strength was the approach to measurement development, which used qualitative methods to translate and adapt internationally validated instruments for the local context, as well as to develop novel measures where appropriate. This approach helped to increase the cultural sensitivity of standardized instruments, thus ensuring that local constructs of parenting behavior, family functioning, and child wellbeing were adequately captured. Assessments were conducted with both caregivers and their children, which helped to triangulate results.

There are several limitations to this study. First, the assessments relied on self report, which has the potential for social desirability bias, as participants in the treatment group may have been more likely to provide responses that they believed the interviewers wished to hear. Interviewers were blinded to the treatment condition, which may have helped to reduce this bias. We were also able to triangulate results

using quantitative data from both caregiver and child report as well as qualitative data collected after participation in the intervention. However, it is important to note that qualitative interviews were conducted with a purposive subsample of participants (n=50) and should not be seen as representative of the study population.

A second limitation is the lack of a control group at the six month post-intervention follow up, which was only conducted with the treatment group due to constraints in the project timeline. Thus, while we have some indication of the maintenance of effects six months after the intervention, we are unable to attribute these longer-term effects to the intervention. Furthermore, the intervention was a universal prevention program in that it was available to all Burmese migrant families in the study sites rather than targeted at particularly high-risk subpopulations. As such, longitudinal research would be required to determine any longer-term preventive effects of the intervention throughout the participating children's adolescence and young adulthood. ■

BELOW: A family in a community of Burmese migrants in Mae Sot.



Conclusions and Recommendations for Research, Policy, and Practice

This section presents conclusions based on findings from the impact evaluation of the Happy Families Program and suggests future directions for research, policy, and practice around improving child and family wellbeing and resilience among populations affected by displacement and related adversities.

1. Parenting and family interventions can be feasible and acceptable to a low resource, displaced population given adequate contextual and cultural adaptations.

High uptake, attendance, and completion of the program, combined with qualitative feedback from participants, suggest that the intervention was feasible and acceptable to the target population. Positive feedback on program facilitators, including some qualitative data to suggest that respect and admiration for facilitators contributed to positive changes in participant behavior, also point to the feasibility of delivering an evidence-based, manualized intervention through lay workers recruited from the local community. This is particularly relevant in low-resource, displacement settings where service delivery systems are weak or non-existent and trained clinicians are scarce. Implementation of the Happy Families Program on the Thai–Burmese border contributes important learning to the field of parenting interventions, demonstrating that an evidence-based intervention developed in a high-income, Western society can be transported to a vastly different socio-cultural context and delivered with fidelity by lay facilitators, given sufficient training and supervision.

Successful implementation of the intervention and its acceptability to program participants were likely due to careful contextual and cultural adaptations based on qualitative research.³ Qualitative research with Burmese families in the study sites revealed the need for adaptations to the delivery of the intervention in order to address safety concerns and to promote attendance in spite of restrictions on participants' time and freedom of movement. These adaptations included holding all sessions in the evenings and on weekends, and in the immediate vicinity of participants' homes. Qualitative research also revealed high levels of parental stress as a salient issue in the target population requiring expansion of intervention content on stress management, including the incorporation of culturally

appropriate techniques such as breathing exercises. Cultural and religious concepts such as *metta* or “loving-kindness,” also revealed through the course of qualitative research, were used in the program manual to facilitate discussion around the negative effects of harsh punishment in a way that resonated with participants' existing beliefs. These contextual and cultural adaptations were essential to enhancing the feasibility and acceptability of the intervention, but were also performed judiciously in order to maintain the integrity of the evidence-based intervention (Kumpfer et al. 2008).

2. Brief parenting and family interventions can improve parenting practices, caregiver–child interactions, and family functioning in contexts of displacement and chronic adversity.

Results from this study show that the intervention increased positive parenting and caregiver–child interaction, decreased negative parenting behaviors including some forms of harsh punishment, increased family cohesion and communication, and reduced negative family interactions. Effect sizes were all in the small to moderate range. While such effect sizes are consistent with those found in similar studies (Kaminski et al. 2008), further implementation research is necessary to understand how to boost the impact of the intervention.

In particular, more intensive training and supervision of intervention facilitators in order to improve the quality and fidelity of intervention delivery may be key to increasing effect sizes. While participant feedback on the facilitators was generally positive, some qualitative data and fidelity monitoring results suggest that the quality and fidelity of intervention delivery may have varied across facilitators. Research on evidence-based parenting interventions such as The Incredible Years Program and Triple-P has identified high quality and continuous training, supervision, and fidelity monitoring as key ingredients to effective programs (Webster-Stratton 2004; Turner & Sanders 2005). In low-resource environments with few trained clinicians, there is a need to ensure that implementation strategies harness the local knowledge and networks of community-based lay facilitators while providing adequate training and supervision to maintain quality and fidelity. The apprenticeship model, which has been used to train and supervise lay workers to deliver mental health interventions in low-resource settings, could be a useful model to adapt (Murray et al. 2011).

³ The qualitative research report can be accessed at http://www.rescue.org/sites/default/files/resource-file/IMPACT%20Qualitative%20Research%20Report%20-%20FINAL_0.pdf.

While six-month follow up results with the treatment group indicate general maintenance of many intervention effects, qualitative findings suggest that participants would benefit from concrete strategies to reinforce learning and maintain positive effects after completion of the program. Future iterations of the intervention should include more explicit discussion of such strategies and consider the additional impact of booster sessions or parent support groups in maintaining positive effects.

3. Brief parenting and family interventions can reduce child behavioral problems, and may have the potential to promote child resilience in conditions of adversity.

Results from this study show that the intervention had a significant impact on children's externalizing behavior problems, and that the effect size—while small—was consistent with those found in similar studies (Kaminski et al. 2008). Results show weaker effects on other child psychosocial outcomes such as emotional problems, but child-reported improvements on locally-developed indicators of resilience point to the potential of the intervention to increase children's resilience to adversity in displacement settings.

The intervention was designed and delivered as a community-based, universal prevention program. As such, the focus was on intervening early to mitigate potential risk factors, thereby preventing the development of child behavioral and emotional problems in the future. Prevention programming and research have also shifted from focusing entirely on the prevention of child psychopathology to the promotion of protective factors that foster resilience (Tol et al. 2013). Investment in longitudinal research is therefore necessary to understand the potential longer-term effects on the prevention of behavioral and mental health problems and the promotion of positive developmental outcomes throughout children's adolescence and early adulthood, specifically in contexts affected by displacement and chronic adversity.

4. Brief parenting and family interventions may have the potential to promote caregiver mental health and reduce family violence.

Qualitative findings suggest that the intervention may have improved caregivers' ability to cope with stress and anger, as well as reduced conflict between partners. Research has shown that caregiver mental health has a significant influence on children's wellbeing and development; caregivers who are depressed or anxious are less able to form secure attachments with their children, which in turn increases the

risk of children developing conduct and emotional disorders (Beardslee 1998). A systematic review of the impact on parenting interventions on caregiver psychosocial health found that such interventions are effective at improving a range of psychosocial outcomes in the short term, including depression, stress, and anger (Barlow et al. 2012). These findings suggest that parenting and family interventions may have the potential to improve caregiver mental health, which in turn would likely contribute to improvements in the primary outcomes of parenting practices, caregiver-child interactions, and child wellbeing.

Qualitative findings from this study and a similar study in Liberia (Puffer et al. 2014) suggest that parenting and family interventions may have the potential to improve marital relationships and reduce marital conflict. While there is currently no evidence on the impact of parenting and family interventions on intimate partner or family violence, there is a significant body of research demonstrating the links between exposure to domestic violence and child wellbeing. A meta-analysis of 60 studies found associations between childhood exposure to domestic violence and internalizing, externalizing, and trauma symptoms in children (Evans et al. 2008). Another review found that exposure to domestic violence is associated with other forms of violence, with children living with domestic violence at increased risk of experiencing emotional, physical, and sexual abuse in childhood as well as later in life (Herrenkohl et al. 2008; Holt et al. 2008). Given these links, further research on parenting and family interventions should seek to measure impacts on marital functioning and conflict, which in turn may contribute to the prevention or reduction of behavioral and mental health problems in children.

5. Further research is necessary to uncover potential moderators and mediators of program effectiveness in order to maximize impact for the most at-risk children and families.

In addition to the question of whether a program is effective, investigating *how* it is effective and *for whom* will enable researchers and practitioners to design and implement interventions that achieve the maximum impact for the most hard-to-reach and at-risk children and families (Gardner 2010). Qualitative findings from this study suggest that one important pathway of change for this population of caregivers may be caregiver mental health, specifically emotion regulation. Mediation analyses would help ensure that theories of change are based on an understanding of the

Conclusions and Recommendations for Research, Policy, and Practice (continued)

intervention ingredients that predict key outcomes around parenting behavior and child wellbeing, thereby facilitating the design of interventions that are tailored to the observed mechanisms of change in specific populations.

There is some evidence to suggest that families facing more adversity, such as poor socio-economic status and caregiver depression, show poorer intervention outcomes in comparison to less disadvantaged or distressed families (Lundahl et al. 2006). Using moderator analyses to understand whether a program is more or less effective for different subgroups is therefore crucial to targeting those children and families that may need specialized or additional intervention. Such analyses have important implications for decisions regarding targeting and dosage (i.e., length and intensity of the intervention), which in turn influence questions of cost effectiveness and implementation at scale. Given the level of risk and scarcity of resources in conflict-affected and displacement settings, further implementation and research should focus on how to achieve the most impact for the most at-risk children and families.

Recommendations for Research

1. Conduct implementation research on how to boost and maintain intervention effects, particularly through testing the impact of various training, supervision, and delivery models.
2. Ensure that studies include longitudinal data collection to assess the maintenance of intervention effects and impacts on child outcomes through adolescence and early adulthood.
3. Investigate the impact of parenting and family interventions on other outcomes including caregiver mental health, marital functioning, and intimate partner violence.
4. Conduct mediator analyses to determine mechanisms of change that can inform the design of more effective interventions for specific populations, particularly those affected by conflict, displacement, and other adversity. Conduct moderator analyses to identify and refine targeting of subpopulations that are harder to reach or require more intensive intervention.
5. Ensure that all studies include dosage, costing, and cost effectiveness analyses in order to inform the most impactful allocation of scarce resources.

Recommendations for Policy

1. Advocate for, support, and fund the inclusion of parenting and family interventions in child protection and development policy and practice, drawing on the well-established evidence base on parenting interventions in high-income countries and the growing body of research from low- and middle-income countries.
2. Build the capacity of the local social workforce in the theory, principles, and approaches underpinning parenting and family interventions. Investigate the feasibility and effectiveness of various delivery models using the social workforce to determine how parenting and family interventions can be delivered sustainably and at scale.
3. Fund multi-year programs that combine high quality, evidence-based intervention delivery with rigorous evaluation to address outstanding research questions. Ensure that funding and program cycles allow for sufficient resources and time to undertake rigorous efficacy or effectiveness trials and longitudinal follow up for intervention research.

Recommendations for Practice

1. Ensure that intervention design and delivery is culturally and contextually grounded through the application of rigorous mixed-methods research, which purposefully sequences qualitative and quantitative data collection for both formative research and to improve understanding of intervention mechanisms.
2. Strengthen models for facilitator training, mentoring, and supervision, particularly for lay workers or paraprofessionals with minimal training and experience in low-resource settings.
3. Incorporate concrete strategies into the intervention such as home visits, booster sessions, and parent support groups to reinforce learning and maintain positive effects after the completion of the program. ■

Annex One: Psychometric Analysis

Table A.1. Results of Confirmatory Factor Analyses

	Burmese Sample				Karen Sample				Full Sample			
	Parent Report		Child Report		Parent Report		Child Report		Parent Report		Child Report	
	RMSEA*	CA#	RMSEA	CA	RMSEA	CA	RMSEA	CA	RMSEA	CA	RMSEA	CA
DI+	0.054		0.062		0.067		0.054		0.048		0.063	
Full Scale		0.71		0.77		0.71		0.77		0.71		0.78
MICS	0.122		0.117		0.189		0.117		0.117		0.085	
Full Scale		0.67		0.77		0.6		0.6		0.66		0.77
PARQ	0.048		0.056		0.067		0.09		0.047		0.06	
Warmth/Affection Subscale		0.68		0.77		0.62		0.68		0.7		0.76
Hostility/Aggression Subscale		0.69		0.71		0.48		0.63		0.67		0.7
Indifference/Neglect Subscale		0.55		0.6		0.49		0.6		0.51		0.58
Undifferentiated Rejection Subscale		0.62		0.69		0.48		0.3		0.6		0.67
CBCL/YSR	0.059		0.181		0.067		0.144		0.057		0.089	
Internalizing Subscale		0.84		0.82		0.79		0.78		0.84		0.96
Externalizing Subscale		0.75		0.69		0.71		0.6		0.75		0.88
Attention Subscale		0.86		0.87		0.8		0.84		0.85		0.96

+ DI: Discipline Interview; MICS: Multiple Indicator Cluster Survey, Harsh Punishment Subscale; PARQ: Parent-Adolescent Relationship Questionnaire
 CBCL/YSR: Child Behavior Checklist/Youth Self-Report
 * Root Mean Square Error of Approximation
 # Cronbach's Alpha
 ~ ~ Latent factor model did not converge on a solution

Table A.2. Results of Exploratory Factor Analyses

	Burmese Sample				Karen Sample				Full Sample			
	Parent Report		Child Report		Parent Report		Child Report		Parent Report		Child Report	
	RMSEA*	CA#	RMSEA	CA	RMSEA	CA	RMSEA	CA	RMSEA	CA	RMSEA	CA
Burmese Family Functioning Scale	0.059		0.055		0.067		0.103		0.055		0.052	
Negative Family Interactions Subscale		0.62		0.67		0.58		0.58		0.81		0.77
Family Cohesion Subscale		0.82		0.78		0.76		0.84		0.72		0.93
Communication/ Problem Solving Subscale		0.71		0.75		0.67		0.63		0.61		0.66
Parent Behavior Scale	0.047		0.056		0.096		0.101		0.046		0.05	
Positive Parent-Child Interaction Subscale		0.64		0.72		0.76		0.73		0.68		0.72
Parenting Structure/ Consistency Subscale		0.51		0.60		0.57		0.35		0.54		0.58
Negative Parenting Behavior Subscale		0.57		0.51		0.39		0.36		0.50		0.51
Child Resilience Scale+	0.082	0.73	0.047		0.1	0.82	0.083		0.086	0.75	0.049	
Family and Community Support Subscale				0.59				0.59				0.68
Poor Self-Esteem Subscale				0.68				0.62				0.80
Positive Adjustment/ Emotional Fxn Subscale				0.81				0.82				0.90

+ Single factor structure and corresponding cronbach's alpha and RMSEA were reported for parent data of Child Resilience Scale since fewer questions were asked to caregiver than children

* Root Mean Square Error of Approximation

Cronbach's Alpha

Annex Two: Outcome Statistics

Table A.3. Child Report

Variable ⁺	Treatment Assignment (Treated = 1)		Post-Test Indicator (Baseline = 0)		Treatment Effect (Treatment Assignment*Post-test)	
	β	Standard Error	β	Standard Error	β	Standard Error
Negative Family Interactions, Burmese Family Functioning Scale	0.0777	[0.0909]	0.126	[0.0774]	-0.244*	[0.108]
Family Cohesion, Burmese Family Functioning Scale	-0.0476	[0.0926]	-0.179*	[0.0727]	0.360***	[0.1000]
Communication, Burmese Family Functioning Scale	0.0299	[0.0920]	-0.157	[0.0822]	0.270*	[0.107]
Positive Parent–Child Interaction, Parent Behavior Scale	0.0219	[0.0922]	-0.163*	[0.0746]	0.334**	[0.108]
Parenting Consistency, Parenting Behavior Scale	-0.00453	[0.0911]	-0.161*	[0.0765]	0.284**	[0.105]
Negative Parenting Behavior, Parenting Behavior Scale	0.0512	[0.0903]	0.141	[0.0822]	-0.269*	[0.110]
Harsh Discipline, Multiple Indicator Cluster Survey	-0.0818	[0.0921]	-0.0361	[0.0944]	0.0443	[0.112]
Positive Functioning, Discipline Interview	-0.0391	[0.0924]	-0.0676	[0.0818]	0.121	[0.126]
Negative Functioning, Discipline Interview	-0.00469	[0.0913]	0.0527	[0.0805]	-0.117	[0.111]
Positive Functioning, Parental Acceptance Rejection Questionnaire	-0.0212	[0.0925]	-0.138	[0.0776]	0.265*	[0.108]
Negative Functioning, Parental Acceptance Rejection Questionnaire	0.130	[0.0921]	0.0990	[0.0742]	-0.190	[0.103]
Child Resilience Scale	-0.0294	[0.0938]	-0.0824	[0.0555]	0.175*	[0.0715]
Internalizing, Youth Self Report	-0.0542	[0.0944]	-0.0214	[0.0399]	0.0588	[0.0526]
Attention/Thought, Youth Self Report	-0.0629	[0.0939]	-0.0110	[0.0482]	0.0284	[0.0667]
Externalizing, Youth Self Report	0.0615	[0.0941]	0.0548	[0.0342]	-0.120*	[0.0502]
*p<0.05, **p<0.01, ***p<0.001						
+Note that all outcome variables standardized to a mean of 0 and standard deviation of 1						

Table A.4. Caregiver Report

Variable ⁺	Treatment Assign- ment (Treated = 1)		Post-Test Indicator (Post-test = 1)		Treatment Effect (Treatment Assign- ment*Post-test)	
	β	Standard Error	β	Standard Error	β	Standard Error
Negative Family Interactions, Burmese Family Functioning Scale	0.0657	[0.0917]	0.154*	[0.0728]	-0.311**	[0.106]
Family Cohesion, Burmese Family Functioning Scale	-0.236**	[0.0894]	-0.237***	[0.0659]	0.472***	[0.0951]
Communication, Burmese Family Functioning Scale	0.0230	[0.0885]	-0.0936	[0.0794]	0.185	[0.114]
Positive Parent–Child Interaction, Parent Behavior Scale	0.00621	[0.0887]	-0.1000	[0.0762]	0.204	[0.111]
Parenting Consistency, Parenting Behavior Scale	-0.0829	[0.0883]	-0.120	[0.0749]	0.243*	[0.109]
Negative Parenting Behavior, Parenting Behavior Scale	0.0613	[0.0906]	0.191**	[0.0737]	-0.380**	[0.118]
Harsh Discipline, Multiple Indicator Cluster Survey	0.0254	[0.0910]	0.0516	[0.0730]	-0.103	[0.105]
Positive Functioning, Discipline Interview	0.169	[0.0889]	0.00356	[0.0790]	-0.00453	[0.112]
Negative Functioning, Discipline Interview	0.102	[0.0908]	0.198*	[0.0769]	-0.399***	[0.102]
Positive Functioning, Parental Acceptance Rejection Questionnaire	-0.0802	[0.0879]	-0.0988	[0.0779]	0.203	[0.110]
Negative Functioning, Parental Acceptance Rejection Questionnaire	0.106	[0.0880]	0.148*	[0.0742]	-0.292**	[0.102]
Child Resilience Scale	0.00938	[0.0893]	-0.0279	[0.0852]	0.0600	[0.109]
Internalizing, Child Behavior Checklist	0.134	[0.0893]	0.0657	[0.0593]	-0.132	[0.0927]
Attention/Thought, Child Behavior Checklist	0.188*	[0.0884]	0.116	[0.0657]	-0.229*	[0.0990]
Externalizing, Child Behavior Checklist	0.122	[0.0891]	0.112	[0.0621]	-0.221*	[0.0967]
*p<0.05, **p<0.01, ***p<0.001						
+Note that all outcome variables standardized to a mean of 0 and standard deviation of 1						

Bibliography

- Achenbach, T. M. & Rescorla, L. (2001). *ASEBA School-Age Forms & Profiles*. Burlington: ASEBA.
- Akmatov, M.K. (2011). Child abuse in 28 developing and transitional countries—results from the Multiple Indicator Cluster Surveys. *International Journal of Epidemiology* 40: 219–227.
- Annan, J., Bundervoet, T., Seban, J. & Costigan, J. (2013). *A Randomized Impact Evaluation of Village Savings and Loans Associations and Family-Based Interventions in Burundi*. New York: International Rescue Committee.
- Barlow, J., Smailagic, N., Huband, N., Roloff, V. & Bennett, C. (2012). Group-based parent training programmes for improving parental psychosocial health (Review). *The Cochrane Library*, Issue 6;
- Beardslee W, Versage E, Gladstone T. Children of affectively ill parents: a review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*. Lippincott Williams & Wilkins, 1998; Vol. 37, Issue 11: 1134–41.
- Coulton, C.J., Korbin, J.E. & Su, M., "Neighborhoods and child maltreatment: a multi-level study," *Child Abuse & Neglect*, 1999; 23:1019–1040.
- Evans, S. E., Davies, C., & DiLillo, D. (2008). Exposure to domestic violence: A meta-analysis of child and adolescent outcomes. *Aggression and Violent Behavior* 13(2), 131–140.
- Fazel, M., Reed, R., Panter-Brick, C. & Stei, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: Risk and protective factors. *The Lancet* 379: 266–82.
- Gardner, F., Hutchings, J., Bywater, T., & Whitaker, C. (2010). Who benefits and how does it work? Moderators and mediators of outcome in an effectiveness trial of a parenting intervention. *Journal of Clinical Child & Adolescent Psychology* 39(4), 568–580.
- Gewirtz, A., Forgatch, M. & Wieling, E. (2008). Parenting practices as potential mechanisms for child adjustment following mass trauma. *Journal of Marital and Family Therapy*, 34(2): 177–192.
- Herrenkohl, T.I., Sousa, C., Tajima, E.A., Herrenkohl, R.C. & Moylan, C.A. (2008). Intersection of child abuse and children's exposure to domestic violence. *Trauma, Violence & Abuse* 9(2): 84–99.
- Holt, S., Buckley, H. & Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. *Child abuse & neglect* 32(8): 797–810.
- International Rescue Committee. (2012). *Surviving or Thriving On the Thai-Burma Border: Vulnerability and Resilience in Mae Sot, Thailand*. Bangkok: International Rescue Committee.
- Kaminski, J.W., Valle, L.A., Filene, J.H. & Boyle, C.L. (2008). A Meta-analytic Review of Components Associated with Parent Training Program Effectiveness. *Journal of Abnormal Child Psychology* 36: 567–589.
- Knerr, W., Gardner, F. & Cluver, L. (2013) Improving Positive Parenting Skills and Reducing Harsh and Abusive Parenting in Low- and Middle-Income Countries: A Systematic Review. *Prevention Science*, 14(4): 352–363.
- Kumpfer, K.L., Pinyuchon, M., Teixeira de Melo, A. & Whiteside, H.O. (2008). Cultural Adaptation Process for International Dissemination of the Strengthening Families Program. *Evaluation & the Health Professions* 31(2): 226–239.
- Lansford, J. E., Chang, L., Dodge, K. A., Malone, P. S., Oburu, P., Palmérus, K. et al. (2005). Physical discipline and children's adjustment: Cultural normativeness as a moderator. *Child development* 76(6): 1234–1246.
- Lundahl, B., Risser, H., & Lovejoy, M. C. (2006). A meta-analysis of parent training: Moderator and follow up effects. *Clinical Psychology Review* 26: 86–104.
- Luthar, S. S. (1993). Methodological and conceptual issues in research on childhood resilience. *Journal of Child Psychology and Psychiatry* 34(4): 441–453.
- Masten, A.S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist* 56: 227–238.
- Murray, L.K., Dorsey, S., Bolton, P., Jordans, M., Rahman, A., Bass, J. & Verdelli, H. (2011). Building capacity in mental health interventions in low resource countries: an apprenticeship model for training local providers. *International Journal of Mental Health Systems* 5: 30.
- Puffer, E., Green, E., Chase, R., Sim, A., Friis, E., Garcia-Rolland, E. & Boone, L. (Forthcoming). Parents Make the Difference: A randomized controlled trial of a parenting program in post-conflict Liberia.
- 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.
- Rohner, R.P. & Khaleque, A. (2005). *Handbook for the Study of Parental Acceptance And Rejection, Fourth Edition*. Storrs, CT: Rohner Research Publications.
- Rutter, M. (1985). Resilience in the face of adversity. *British Journal of Psychiatry* 147(1): 598–611.
- Sim, A. (2011). Children are puppets and parents move the strings. Concepts of Child and Family Well-Being among Burmese Migrant Children and Families in Tak Province, Thailand. Bangkok: International Rescue Committee. Available at http://www.rescue.org/sites/default/files/resource-file/IMPACT%20Qualitative%20Research%20Report%20-%20FINAL_0.pdf.
- Tol, W.A., Barbui, C., Galappatti, A., Silove, D., Betancourt, T.S., Souza, R., Golaz, A., Ommeren, M. (2011). Mental health and psychosocial support in humanitarian settings: linking practice and research. *The Lancet* 378: 1581–1591.

Bibliography (continued)

Tol, W.A., Song, S. & Jordans, M. (2013). Annual Research Review: Resilience and mental health in children and adolescents living in areas of armed conflict—a systematic review of findings in low- and middle-income countries. *Journal of Child Psychology and Psychiatry* 54(4): 445–460.

Turner, K. M., & Sanders, M. R. (2006). Dissemination of evidence-based parenting and family support strategies: Learning from the Triple P—Positive Parenting Program system approach. *Aggression and Violent Behavior*, 11(2), 176–193.

United Nations. (2006). *United Nations Secretary General's study on Violence against Children*. A/61/299.

UNICEF. (2005). Multiple Indicator Cluster Survey. New York: UNICEF.

UNICEF. (2010). *Child Disciplinary Practices at Home: Evidence from a Range of Low- and Middle-Income Countries*. New York: UNICEF.

Webster-Stratton, C. (2004). Quality training, supervision, ongoing monitoring, and agency support: Key ingredients to implementing The Incredible Years programs with fidelity. *Treatment Description*, University of Washington.

World Health Organization. (2001). *Alcohol Use Disorders Identification Test. Guidelines for Use in Primary Care*. 2nd Ed. Geneva: World Health Organization.

World Health Organization. (2002). Child Abuse and Neglect by Parents and Other Caregivers. In *World Report on Violence and Health*. Geneva: World Health Organization.

World Health Organization. (2009). *Preventing violence through the development of safe, stable and nurturing relationships between children and their parents and caregivers*. Geneva: World Health Organization.

Amanda Sim

Research, Evaluation and Learning Unit, International Rescue Committee

Jeannie Annan

Research, Evaluation and Learning Unit, International Rescue Committee

Eve Puffer

Department of Psychology and Neuroscience, Global Health Institute, Duke University

Carmel Salhi

Harvard School of Public Health

Theresa Betancourt

Harvard School of Public Health

The International Rescue Committee (IRC) responds to the world's worst humanitarian crises and helps people to survive and rebuild their lives. Founded in 1933 at the request of Albert Einstein, the IRC offers lifesaving care and life-changing assistance to refugees forced to flee from war, persecution or natural disaster. At work today in over 40 countries and 22 U.S. cities, we restore safety, dignity and hope to millions who are uprooted and struggling to endure. The IRC leads the way from harm to home.

New York

International Rescue Committee
122 East 42nd Street
New York, NY 10168-1289
USA

Washington, DC

International Rescue Committee
1730 M Street, NW
Suite 505
Washington, DC 20036
USA

London

International Rescue Committee—UK
3 Bloomsbury Place
London WC1A 2QL
United Kingdom

Brussels

International Rescue Committee—Belgium
Place de la Vieille
Halle aux Blés 16
Oud Korenhuis 16
1000 Brussels
Belgium

Geneva

International Rescue Committee
7, rue J.-A. Gautier
CH-1201
Geneva
Switzerland

Bangkok

International Rescue Committee
888/210–212 Mahatun
Plaza Bldg., 2nd Floor
Ploenchit Road
Lumpini, Pathumwan
Bangkok 10330
Thailand

Nairobi

International Rescue Committee
IKM Place
5th Ngong Avenue
Upper Hill
Nairobi
Kenya

Join the conversation



@theIRC



International Rescue Committee



Pinterest.com/theIRC



@theIRC



USAID
FROM THE AMERICAN PEOPLE

International Rescue Committee

NEW YORK | WASHINGTON, DC | LONDON | BRUSSELS | GENEVA | NAIROBI | BANGKOK

From Harm to Home | [Rescue.org](https://www.rescue.org)