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ORIGINAL PAPER

Recently-Arrived Afghan Refugee Parents' Perspectives About Parenting, Education and Pediatric Medical and Mental Health Care Services

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Abstract

Refugee children are at risk for mental/behavioral health problems but may not receive timely diagnosis or care. Parental experiences and perspectives about resources in the US may help guide interventions to improve mental/behavioral health care. In a community-academic partnership, we performed a qualitative study of recently-arrived Afghan refugee parents, using in-depth, semi-structured interviews to characterize experiences with parenting, education, and health care services. A four-person coding team identified, described, and refined themes. We interviewed 19 parents from ten families, with a median residence in the US of 24 months. Four themes emerged; parents described: (1) shifting focus as safety needs changed, (2) acculturation stress, (3) adjustment to an emerging US support system, and (4) appreciation of an engaged health care system. Health and educational providers' appreciation for the process of acculturation among newly-arrived refugee Afghan families may facilitate screening, diagnostic, and intervention strategies to improve care.

Keywords Refugee · Afghanistan · Parenting · Education · Mental and behavioral health

Background

Since 1975, the US has resettled over three million refugees, individuals forced to flee their countries because of persecution, war, or violence [1]. In 2018, 47% of the 22,405 refugees admitted to the US were children under 18 [2]. Refugee children may face trauma during pre-migration, migration, and post-migration without access to medical care. As a result, many children arrive with previously-undiagnosed medical and behavioral health needs—including depression, anxiety, and post-traumatic stress disorder (PTSD)—that require mental and behavioral health interventions with culturally-informed approaches [3, 4]. After arrival, children and families may also experience loneliness, stress, language barriers, stigma, discrimination, and financial hardship [5–9].

While children in immigrant families, of whom refugee children are a subset, have lower parent-reported prevalence of mental and behavioral health diagnoses compared with their non-immigrant peers [3, 10–13], there is a growing body of evidence that suggests underreporting, under-diagnosis, and subsequent undertreatment of mental and behavioral health conditions. Immigrant children may not receive

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adequate outpatient mental and behavioral health care; a study of first point-of-contact for mental health conditions found that immigrant patients accessed care in the emergency department more frequently than their non-immigrant peers [14].

Refugees from Afghanistan may have faced trauma related to prolonged wars without psychological support as well as barriers to acceptance of mental health support [5]. Mental health concerns noted among Afghan refugee populations include behavior changes, nightmares, irritability, survivor's guilt, frustration, hopelessness, sadness [5]. Despite rates of PTSD up to 45%, fewer than 5% obtain specialist care; it is unclear why Afghan refugee children receive less care [15].

The Afghan population in Connecticut includes many of Pashtun ethnicity who have been exposed to traumatic events and who have low maternal English proficiency—factors associated with PTSD and major depression [5]. The New Haven refugee resettlement agency, medical providers, teachers, and Afghan refugee community members expressed concerns about delays in diagnosis and care for mental and behavioral health problems. We partnered with stakeholders to conduct in-depth interviews with refugee parents to characterize parental perspectives and experiences of parenting, education, physical health, and mental/behavioral health care. We aimed to identify potential interventions to increase access to needed care and services for refugee children.

Methods

Study Design

We used community-based participatory research (CBPR) methodology, in which researchers and community stakeholders form partnerships to tackle issues related to community health improvement and knowledge production [16]. Together, we developed the aims, survey instrument, and analysis and dissemination plans. Using grounded theory methods, we conducted semi-structured, in-depth, qualitative interviews over a 6-month period in 2019–2020. The study was deemed exempt by the Yale Institutional Review Board (ID 2000025497).

Research Team

After initial discussions with stakeholders, including Afghan refugees, the New Haven refugee resettlement agency, medical providers, and educational assistants, we developed a research team consisting of a pediatric provider and health services researcher (JR), a pediatric refugee clinic director (CB), a certified medical interpreter who was a former refugee (AR), a care-coordinator and retired nurse midwife well-known in the Afghan community (KH), and a CBPR and qualitative methodology expert (MR). The coding team included the pediatric provider (JR), methodology expert (MR), a physician/certified medical interpreter with experience in qualitative work (AA), and a Master of Public Health student (JL). All research team members completed human subjects research training, and those who were new to research were guided through this training process in-person by a member of the research team. Planning, development, and analysis meetings were held in-person, and input was elicited by all team members during these meetings. Community members of the research team were compensated hourly for their time.

Participants

Participants were parents in families from Afghanistan or Pakistan (with Afghan family ties), who arrived fewer than 30 months prior to interviews and who received refugee assistance from Integrated Refugee and Immigrant Services (IRIS), the New Haven refugee resettlement agency [17]. Using partners' connections to the refugee community, purposive sampling was conducted to select for families who may have had challenges with adjustment and/or with mental/behavioral health concerns for their children. Interviews were conducted until thematic saturation was achieved, which was upon completion of 19 interviews with ten families (9 mothers and 10 fathers).

Recruitment

Potential participants were identified by members of the research team with close contact with refugee families. A script was used to invite participation. After a family agreed to participate, a multilingual interpreter (AR) called families to arrange a time and location to meet; all participants decided to meet in their homes. A $25 gift card and a small gift of food was provided to each participant.

Interview Guide Development and Measures

The semi-structured interview guide (Box 1) included questions about perspectives and experiences of parenting, education, health, physical, mental and behavioral health care before and after their arrival to the US. It sought to address multiple concerns raised by community stakeholders, such as concerns that parents may have regarding adjusting to more frequent medical visits, including preventative and follow-up visits.

Box 1 Interview guide

Life in Afghanistan
Tell me about who lived in your home in Afghanistan
What are your first memories of receiving advice about how to look after your children? (For example, how did you learn to feed your child, calm your child, and teach your child?)
How was school for your child in Afghanistan?
Tell me about a time when your child needed to go to the doctor or nurse in Afghanistan
Life in the United States
Tell me about the life was like for your child when you first arrived to the United States
Tell me about who lives in your home in the United States
To help understand what life is like in the US compared to in Afghanistan, we'd like to use these cards to learn what your child's day was like in both places. Please use one set of cards to indicate where your oldest child spent the most to time in Afghanistan. Please use the second set of cards to rank where the same child spends the most to the least amount of time in the United States. [Pictorial cards of children's activities with descriptions in Pashto and English provided]
Did you have any problems with your children since coming to the US? Tell me more
Has your child ever been naughty at school in the United States? Tell me more
Did you ever take your child to the doctor or nurse when they were not sick? Why?
Mental and Behavioral Health
[If not yet answered] Has your child(ren) had challenges since coming to the United States? [If more than one child has had difficulties] Let's talk about the oldest child's challenges
If, god forbid, your child had challenges or concerns, what is the first thing you did or would do?
What helping tools are needed for children with behavioral problems or for children who may have difficulty adjusting to life in the US?
If children, god forbid, need help with behavioral problems, the doctors or nurses can connect children to consultants, who talk to children and families to help them feel better and to help them improve their behavior. What do you think about consultants as a resource?
If, god forbid, children need help with behavioral problems, the doctors or nurses can give medicine to help them feel better and to help them improve their behavior. Would you accept medication for your children if needed?
Additional thoughts
Is there anything else you'd like to share about what we discussed today?

Additional sub-prompts were also available for each question

Interviews and Data Collection

Interviews were conducted in family homes at pre-specified times. Interviews were conducted and recorded in English and Pashto, and the English portion was professionally transcribed.

Analysis

A four-person coding team identified codes and emerging themes using Dedoose®. We used the constant comparative method to identify, refine, and describe emerging themes. All members agreed upon theme presentation and contextualization. Themes were then presented to community stakeholders, including resettlement agency providers, for further analysis and refinement.

Results

Participant Characteristics

Nineteen interviews were conducted across ten households (Table 2). Aside from one household where only the father responded, mother-father dyads were interviewed separately without the other parent present at each home; most fathers elected to complete the interview first, and the second parent was subsequently interviewed. The median time in the US was 24 months (range 12–27 months). Many ages were estimations; the female and male median reported ages were 29 and 35.5, respectively. Although all families had ties to multigenerational homes in Afghanistan, some parents were born as refugees in Pakistan (n = 4). The majority (n = 7 of 9) of the female respondents reported no formal schooling outside of the home, and some (n = 4 of 10) of the male respondents reported only elementary school education. All female respondents (n = 9) reported working as housewives before and after arrival to the US. Many male respondents (n = 6 of 10) reported working for the US army, and all reported employment in the US. All respondents spoke Pashto fluently and many were multilingual, with varying degrees of fluency in English, Dari, Farsi, and Urdu.

Themes from Qualitative Interviews

After analysis, four major themes emerged, each of which corresponded to system-level parenting and resource needs that

Table 2 Respondent characteristics (N = 19)

Gender—female	n = 9
Time in US: median	24 months
Time in US: range	12–27 months
Age	
Female median reported age	29 years
Male median reported age	35.5 years
Parental country of origin	
Afghanistan	n = 15
Pakistan (grandparents from Afghanistan)	n = 4
Highest level of education—female	
No education	n = 7
5th grade	n = 1
9th grade	n = 1
Highest level of education—male	
No education	n = 0
1st–5th grade	n = 4
High school	n = 3
College	n = 3
Occupation in Afghanistan or Pakistan	
Housewife (all females)	n = 9
Interpreter	n = 6
Construction	n = 1
Landlord	n = 1
Taxi driver	n = 1
Vendor/store keeper	n = 1
Occupation in US	
Housewife (all females)	n = 9
Machine operator	n = 2
Cashier	n = 2
Driver	n = 1
Painter	n = 1
Landscaper	n = 1
Assembler	n = 1
Animal technician at lab	n = 1
Amazon packager	n = 1
Languages spoken	
Pashto	n = 19
English (some to proficient)	n = 14
Dari	n = 8
Farsi	n = 5
Urdu	n = 3

may affect access to care. Some representative quotations are included below, and all representative quotations can be found in Table 3.

Theme 1: A Shift in Parental Focus as Basic Needs, Especially Safety Needs, Changed

Parents described that their previous central parenting focus, safety for them and their children, had shifted in the US:

> We were afraid that they [the Taliban] would kidnap our kids.
> *-Father, 27, one year in US*

On arrival to the US, parents described that their safety concerns were allayed. A sense of relief was one of the first memories that many parents shared when asked to describe adjustment to life in the US. When asked to describe differences between the US and their home country, most parents, both mothers and fathers, described improved safety for their children in the US. This father described that, since basic physiologic and safety needs were being met, there were fewer problems and a greater focus on children's play.

> Here they don't have to worry about food or shelter or school. They have a good home, they have toys. There's a park nearby, there are stores we can go to. There's Wi-Fi and internet, so they don't have as many problems here.
> *-Father, 39, two years in US*

Theme 2: Acculturation Stress, Including Ambivalence of Newly Omnipresent Technology and Concern About Maintaining Traditions

When asked about the differences in how children spend their time in the US compared with Afghanistan, nearly every mother and father described increased time on phones and tablets. They expressed mixed feelings about the time children spent on screens in the US. One father expressed wavering and evolving opinions about screen time, while a mother described difficulty controlling her children's use of these devices (Table 3).

Parents perceived that it was difficult for their children to maintain religious observances, in part, because such observances might make them feel isolated. When discussing concerns for their children and adjustment to life in the US, some parents described difficulty maintaining traditions, including at school. One mother stated:

> When they're home they always do the five prayers on time. It's five times a day. But when they're at school it becomes difficult, because they need to wash before they pray and there's no specific place in the school where they can do that, or time to go wash their face and hands and feet and then go pray.
> *-Mother, age unknown to her, two years in US*

Table 3 Themes and representative quotations from qualitative interviews

Theme 1: Shift in parental focus as basic needs, especially safety needs, changed	"We were afraid that they [the Taliban] would kidnap our kids." -*Father, 27, one year in US* "Here they don't have to worry 6about food or shelter or school. They have a good home, they have toys. There's a park nearby, there are stores we can go to. There's Wi-Fi and internet, so they don't have as many problems here." -*Father, 39, two years in US*
Theme 2: Acculturation stress, including ambivalence of newly omnipresent technology and concern about maintaining traditions	"I used to dislike it when they would sit and go on the tablets. But more recently, I've stopped being upset about it because … the remote wasn't working… My daughter…fixed it for me by going on her tablet and looking up some videos of how to fix it. … I think it depends on what they're watching and what they're doing on the tablets. Even if they're playing certain games, I think it kind of sharpens their mind and gives them skills of how to use a computer." -*Father, 38, two years in US* "I tried really hard to try to turn him away from going on the iPad so much, but then I just give up and I don't know. I take it away from him but then when I turn back, he's on it again." -*Mother, age unknown to her, two years in US* "When they're home they always do the five prayers on time. It's five times a day. But when they're at school it becomes difficult, because they need to wash before they pray and there's no specific place in the school where they can do that, or time to go wash their face and hands and feet and then go pray." -*Mother, age unknown to her, two years in US* "Something that's been challenging for my daughter is her wearing her hijab to school, because back home all the kids wear it … She feels a little awkward in class to be the only one who's wearing it." -*Father, 36, two years in US*
Theme 3: Adjustment to an emerging US support system	"In Afghanistan, the whole family lives together, so whoever was home, they would help out in taking care of the child." -*Father, 31, two years in US* "The experience of becoming separated from your family; it's difficult."—*Father, 38, two years in US* "[My daughter] was very sad and she missed her family, her cousins, and her grandmother. Slowly, she adapted and she's very happy about school."—*Mother, 27, two years in US* "When we first came, it was very difficult, because the children back home, they grow up in a very free way. When they come here, it's like being in a cage for them when they're inside of the house. They're not used to that." -*Mother, 34, > two years in US* "The best thing is to know your neighbors and know your community. There are a lot of new families that are coming in … They might not know something that you know. If you see that their kids are having trouble adjusting, you can show them a few things around, like where the park is and the store is, getting them some toys or some bicycles." -*Father, 38, two years in US*
Theme 4: Trust in an involved health system in the US	"The hospitals here work differently from the ones in Afghanistan. They have a system of prevention here. Even if your child is not sick, they go to the doctor for a normal checkup. I remember I took my daughter to her appointment. She wasn't sick, but when they examined her, they found out that her lead level was high. … We were able to take care of it." -*Father, 38, two years in US* "If there's an issue we discuss it with the doctors and they bring it up with the teachers at school. In a way, they're both helping. The hospitals also connected to [the refugee resettlement agency], so those people also get involved and they try to help us." -*Father, 39, 1.5 years in US*

As shown in the representative quotations in Table 3, some parents described concerns about isolation as a result of trying to uphold traditional beliefs, such as wearing a hijab in school while others, including the quoted father, described that their children could learn to maintain their own traditions while respecting the traditions of others (Table 3).

Theme 3: Adjustment to an Emerging US Support System

All parents contrasted the multi-generational support they had in Afghanistan or Pakistan with the nuclear family structure in the US. Many described feelings of isolation when they first came to the US, and some (more fathers than mothers) described a growing local support system and self-efficacy from their role in it.

As parents described (Table 3), in contrast to the isolation they felt upon arrival to the US, in Afghanistan or Pakistan, there was a robust support from extended family, that included parenting and discipline:

> In Afghanistan, the whole family lives together, so whoever was home, they would help out in taking care of the child.
> *-Father, 31, two years in US*

Parents described that this displacement from large family homes meant the children felt stuck in a small home:

> When we first came, it was very difficult, because the children back home, they grow up in a very free way. When they come here, it's like being in a cage for them when they're inside of the house. They're not used to that.
> *-Mother, 34, > two years in US*

On the other hand, some parents described how, after being in the US for a while, a new community support structure emerged. One father described his self-efficacy in supporting newer refugee families:

> The best thing is to know your neighbors and know your community. There are a lot of new families that are coming in … They might not know something that you know. If you see that their kids are having trouble adjusting, you can show them a few things around, like where the park is and the store is, getting them some toys or some bicycles.
> *-Father, 38, two years in US*

Theme 4: Trust in an Involved Health System in the US

All parents reported that, before coming to the US, their families utilized health care in urgent situations but not for routine visits. Furthermore, they shared that there was no connection between the health providers and the education system or other services. Regarding this change to more frequent, coordinated health visits, parents expressed appreciation:

> The hospitals here work differently from the ones in Afghanistan. They have a system of prevention here. Even if your child is not sick, they go to the doctor for a normal checkup. I remember I took my daughter to her appointment. She wasn't sick, but when they examined her, they found out that her lead level was high. … We were able to take care of it.
> *-Father, 38, two years in US*

> If there's an issue we discuss it with the doctors and they bring it up with the teachers at school. In a way, they're both helping. The hospitals also connected to [the refugee resettlement agency], so those people also get involved and they try to help us.
> *-Father, 39, 1.5 years in US*

Discussion

In this qualitative study of Afghan refugee parental perspectives, key themes included parents' description of: (1) a shift in parental focus as immediate safety concerns were no longer the chief priority; (2) acculturation stress from maintaining traditions while adjusting to a new environment; (3) initial isolation in the US, a contrast to prior intergenerational family support, with an evolving transition to local support systems within which parents described personal self-efficacy; and (4) an appreciation and understanding of the greater role of the US health care system, including connections between education and health systems.

Our data show that parents shared a sense of relief that their prior concerns about threats to the safety of their children had improved in the US, thus allowing them to shift their principal concerns away from basic physiologic and safety needs. Safety forms part of the base of Maslow's hierarchy of needs. With these needs met, and according to Maslow's framework [18], parents can broaden their goals for their children, shifting away from safety and security and towards supporting their children to develop and to thrive—including by recognizing and supporting emerging mental and behavioral health needs of their children.

Our findings that parents are concerned about the challenges children face upholding traditional practices are consistent with prior research of immigrant communities. Previous studies of immigrant youth from multiple backgrounds have demonstrated that, while youth can acculturate in many ways, those who are able to integrate aspects of their family and new cultures may experience improved psychologically and sociocultural adaptation [19]. However, integration has been found to be especially challenging for first generation immigrant children, who are more likely to experience isolation and victimization than their non-immigrant peers in the classroom [20]. Furthermore, acculturation stress has been found to be associated with adverse consequences in many immigrant populations, including depression in Chinese adolescents [21] and internalizing symptoms and decreased

family function in Latinx children [22, 23]. These findings underscore the importance of identifying and mitigating acculturation stress.

One specific source of acculturation stress, prolonged screen time, was raised by most parents and is especially concerning because excessive screen time can be associated with problems related to development, sleep, weight, and mental health [24, 25]. This is one stressor on which providers can intervene by giving evidence-based guidance and strategies for newly-resettled refugees to develop healthy screen habits.

Parents in this study reported that they initially felt isolated in the US. Such lack of support may affect the mental and physical health of every member of the family; social isolation is associated with increased odds of many adverse events, including mortality [26]. An early, established support system can result in less isolation for parents and children alike and create collective support and resilience for the family [27].

The themes from this study reflect the influence of multiple systems on children's development and access to care, a model exemplified by Bronfenbrenner's Ecological Framework of Childhood Development (Fig. 1) [28–30]. Through discussion, parents described the role of each component of Bronfenbrenner's Framework, including (1) family, neighbors and classmates (*microsystem*); (2) community (*mesosystem*); (3) health care, educational and refugee resettlement institutions (*exosystem*); and (4) and structural entities (refugee system, safety structures) (*macrosystem*). A key element of Bronfebrenner's ecological systems theory is the interconnectedness and interplay of the various systems [26], which was evident in our discussions with parents. Health and educational providers should work within these intertwined systems to provide a supportive environment for refugee children, especially when establishing interventions for mental and behavioral health care.

In this study, families described their acceptance and trust in the support offered by these systems, indicating an opportunity to expand resources for families. Many examples of successful school and community programs to support refugee mental health have been studied, ranging from psychoeducation to clinical management to art-based interventions to reflective exercises [31]. Future initiatives can take advantage of these opportunities for mental health screening, education, and interventions across institutions.

Limitations

This study had several limitations. This is a study with a specific population: recently-arrived refugee families from Afghanistan and Pakistan. However, findings may be studied and applied with other refugee populations closely connected with partner community organizations. Generalizability may

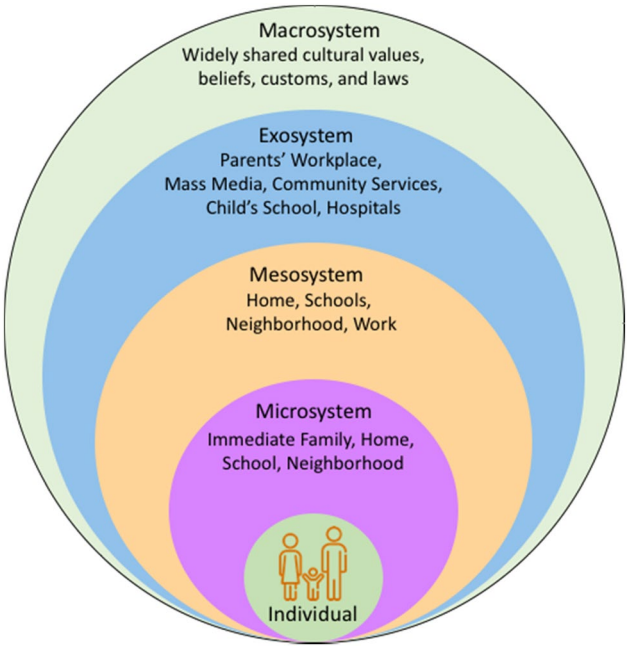

Fig. 1 Bronfebrenner ecological systems theory

be limited in regions without close proximity to refugee clinics or resettlement agencies. Additionally, this study was initially developed to assess mental and behavioral health concerns in the refugee population, but because there were so few refugees engaged in mental and behavioral health services, there was limited information about these specific concerns. Nonetheless, parental perspectives on parenting, education, and health care can guide improvement for all care, including mental and behavioral health care, and these discussions can guide future research and educational approaches related to mental health perspectives.

Conclusions

In this qualitative study, we identified parental perspectives that can inform interventions to address gaps in access to screening and needed care for refugee children. While we aimed to explore parental perspectives specifically related to mental and behavioral health care, parents expressed other concerns which took precedence shortly after arrival into the US. As a result of these discussion and the themes which emerged, we identified several areas of opportunity for intervention to support mental and behavioral health. These include: (1) guidance for parents as their focus shifts from concerns about safety to opportunities for their children to thrive in home and educational settings and (2) mitigation of isolation to ease acculturation stressors, which may take the form of connections between newly-arrived refugee families and those who have been in the US for over one

year. We recommend that targeted interventions that reflect parental priorities are trialed and studied to improve access to needed screening, care, and interventions for Afghan refugee families.

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