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Mothers who are Refugees: An analysis of trauma, social support, and parenting efficacy.

by

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Undergraduate Honors Thesis
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at the University of Vermont.

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Committee Chair: Dr. Jeanne Shea
Committee Member: Dr. Shamila Lekka
Dedication

This work is dedicated to my Nonna:

Thank you for nurturing my curiosity and inspiring me to always learn.

Ti voglio benissimo.

Acknowledgements

I would like to thank my advisor Dr. Timothy Stickle for supporting and challenging me throughout this entire process. Your ability to balance between serious and fun, between grad school programs and leather boots, between SPSS and bluegrass, is what kept my spirits high in times of academic anxiety. Thank you to Dr. Shamila Lekka and Dr. Jeanne Shea for being part of my committee, you both inspire me intellectually and personally. Thank you to Anne Brassel for allowing me to be a part of her fascinating research. Finally, thank you to the mothers who gave their time and effort to participate in this study.
Introduction

Sociopolitical conflict in regions of Africa and Asia has led to unprecedented numbers of refugees worldwide; as violence and hardship persist in war-torn countries, this number continues to rise. Adverse experiences such as forced migration, traumatic events, and resettlement in negative environments put refugees at a significantly higher risk for psychological disorders than the general population (Fazel, Wheeler, & Danesh, 2005). Thus, a comprehensive and culturally sensitive understanding of refugee mental health is imperative for the wellbeing of refugees and the entire host community. Maternal mental health is one specific aspect of community health that requires research and intervention, yet policy makers and healthcare professionals must understand the complicated facets of maternal mental health in order to adequately address issues and create solutions for refugees.

The current research is an exploratory study that aimed to understand the complex relationships among trauma, social support, and parenting efficacy among mothers who are refugees in Burlington, Vermont. These aspects of maternal mental health have been studied extensively in western populations, and western-derived psychological concepts have primarily been applied to refugee populations in research and clinical settings. However, culturally constrained conceptions of trauma, parenting, and social structure make the application of popular western understandings to refugee populations limited and, in some cases, inappropriate. The study aimed to incorporate cultural factors and specific circumstances in the investigation of maternal mental health in refugee populations. As a researcher, I also sought to maintain an awareness of my position as a privileged outsider, of the inaccurate perspectives I may have, and of the power dynamics that I may elicit throughout the study.
Literature Review

The study is informed by a synthesis of literature regarding the interaction of study variables in western populations, and the individual study variables in non-western and refugee populations.

**Trauma.** According to a meta-analysis of mental health among refugees, refugees are ten times more likely to endorse criteria for post-traumatic stress disorder (PTSD) than members of the host community (Fazel et al., 2005). Trauma history among refugees often involves repeated and prolonged traumas across multiple dimensions of the refugee experience. During the preflight period, people endure physical, sexual, and emotional violence as a result of socio-political warfare; typical experiences of this phase include bodily injury, rape, witness of murder, imprisonment, and/or torture (Mollica, Mollica, McDonald, Massagli, & Silove, 2004). Once refugees escape their home communities or countries, they are often met with difficult conditions in refugee camps, physical hardships, malnutrition, a lack of accessible health services, and more (Robertson, Savik, Moore, Mohammed, & Hoffman, 2016). Strict regulations on immigration can also make the transition to safety difficult, as refugees must often navigate complex bureaucratic procedures to comply with the host country.

In the resettlement country, refugees often face issues of structural violence, such as unemployment, racial discrimination, and language barriers (Robertson, 2016). These systemic disadvantages perpetuate poverty and segregation between the host community and new community members. Substandard living conditions as a result of poverty also negatively impact physical and mental health among refugees (Mollica, 2014). Relocation to the host country can also weaken or tear down the social and cultural foundations that provide refugees with feelings of stability and connectedness (Robertson, Halcon, Savik, Johnson, & Spring, 2006).
Strict female gender roles can further exacerbate the trauma experience; a lack of education, language skills, and perceived self-control intensifies feelings of isolation and powerlessness among female refugees (Robertson, 2006). Caring for children and the home can also contribute to negative emotions, stress, role rigidity, and lack of perceived control among female refugees. This gender dynamic puts women at a higher risk for psychological disturbances, including severe trauma symptoms (Kira, Smith, Lewandowski, & Templin, 2010).

The majority of trauma-related research uses the diagnosis of Post-Traumatic Stress Disorder (PTSD) as a framework for symptomatology. PTSD is characterized by prolonged intrusive recollections of a stressor, avoidance of stimuli related to the stressor, negative cognitions regarding one’s world and oneself, and hyperarousal (Friedman, 2016). This diagnosis and its assumed context are culturally constrained to western populations, and may not encompass the full experience of refugee trauma (Brassel, 2017). Additionally, it has been argued that PTSD is shaped by the practices with which it is diagnosed, studied, treated, and represented, which renders the disorder completely inapplicable across cultures (Young, 1995).

In conclusion, research that has studied trauma among refugees in terms of PTSD provides an incomplete understanding of the issue. To advance understanding, future research in refugee populations must consider the cultural constraints of trauma and utilize a more comprehensive and culturally informed model of trauma.

**Parenting Efficacy.** There is a considerable amount of literature regarding the relationship between parenting efficacy (one’s self-perceived ability to parent) and maternal trauma in western populations. For example, in a study of female survivors of childhood sexual trauma, mothers consistently reported lower parenting control and perceived parenting competence compared to those without trauma history (Fitzgerald, Shipman, Jackson, McMahon,
Mothers with trauma history are more likely to view their life circumstances as uncontrollable and themselves as ineffective, which could partially explain lower parenting self-efficacy (Muzik, Rosenblum, Alfafara, Schuster, & Miller 2015). Although the literature consistently indicates that trauma history is related to lower parenting efficacy in western populations, further research is needed to understand this relationship in mothers who are refugees.

**Social Support.** Past research provides evidence that social support is inextricable from mental health, and that a high perception of social support has many psychological benefits. In a study of mothers with PTSD, social support was negatively associated with cumulative trauma, frequency of trauma, PTSD symptom severity, and parenting stress scores (Wilson, 2012). Social support was also found to enhance parenting efficacy among new mothers by reducing the difficulty of parenting and increasing the odds of goal achievement (Leerkes & Burney, 2007).

Consistent with cognitions of mistrust and isolation, trauma survivors often perceive a distinct lack of social support. Evidence suggests that mothers with trauma history feel less supported in their parental role, and feel they do not have adequate resources to parent effectively (Fitzgerald, 2013; Muzik, 2015). Support-seeking behaviors may also be negatively affected by trauma, because lowered self-esteem as a result of trauma may cause survivors to feel they are undeserving of help (Muzik, 2015). Moreover, the betrayal trauma (trauma inflicted by a trusted other) often experienced by refugees can lead to lowered interpersonal trust, which may further inhibit support-seeking behaviors (Latrice, 2013). There is some literature on social support among relocated refugees, but little that specifically explores support in the parenting role (Green, 2013; Robertson, 2006).
Current Study

The current study investigates the relationships among trauma symptoms, social support in the parenting role, and parenting self-efficacy in mothers who are refugees in the greater Burlington, VT area. I aimed to extend the literature by using a culturally-informed measure of trauma, and incorporating non-western and refugee-specific psychosocial factors in data analysis, to answer the following research question: Is social support in the parenting role a protective factor against the negative effects of trauma on parenting efficacy in mothers who are refugees?

Hypotheses

I hypothesized that social support in the parenting role (SSPR) would moderate the relationship between trauma symptoms and parenting efficacy, and that high SSPR would be associated with greater parenting efficacy, regardless of trauma symptom severity.

Method

I designed and collected the data for the following correlational study, in conjunction with a larger related study, to explore the interaction between trauma, social support, and parenting efficacy among mothers who are refugees. All data were self-reported by participants during structured interviews conducted by myself or the principal investigator of the larger, parent study.

Recruitment and Interviews

Participants were recruited by community outreach workers at local refugee community centers, and through the Connecting Cultures Clinic, a refugee mental health clinic at the University of Vermont. Recruitment methods were informed by a team of community stakeholders and refugee elders. This team also evaluated the interpretability of items in
measures of SSPR and trauma, and worked with the principal investigator of the parent study to optimize the translation of certain questionnaire items.

The study was approved by the university IRB, and all participants provided informed consent to participate. Measures were orally administered by the principal investigator or myself, and participants who were not fluent in English were provided an interpreter through the Connecting Cultures Clinic. Interpreters were trained on study procedures and measures by the principal investigator of the larger study. The mothers received monetary compensation for their participation.

**Participants**

Participants were 22 mothers who are refugees living in the greater Burlington, VT area. Mothers ranged in age from 19 to 43 (M=29). All mothers had an infant between the ages of four and 12 months, and anywhere from one to eight total children (M=3). Most participants were married (N=18). Many were unemployed or not authorized to work (N=8), but most held part-time jobs (N=11).

Over half of participants came from East-African countries of origin, such as Kenya (N=5) and Somalia (N=9). Participants’ countries of origin also included Democratic Republic of Congo (N=1), Iraq (N=1), and Bhutan (N=5). Participants’ first languages included Mai Mai (N=11), Nepali (N=5), Arabic (N=2), Somali (N=1), Kizua (N=1), and English (N=1). Participants’ religions included Islam (N=16), Hinduism (N=5), and Christianity (N=1).

**Measures**

**Trauma.** The Harvard Trauma Questionnaire-Revised (HTQ-R; Mollica et al., 2004) was used to measure maternal trauma symptomatology. The HTQ-R is a three-part measure that assesses (1) traumatic events, (2) occurrence of head injury, and (3) trauma symptoms. Symptom
items 1-16 are based on the Diagnostic and Statistical Manual of Mental Disorders’ diagnosis of PTSD (American Psychiatric Association, 2013); items 17-40 were culturally informed, according to Mollica et al. (2004). DSM-V-informed items include criteria for the diagnosis of post-traumatic stress disorder (recurrent nightmares, trouble sleeping); culturally-informed items include symptoms that might not present in western cultures, but that are common in non-western cultures or refugee populations (feeling guilty for having survived, feeling no trust in others, troubled by physical problems). However, these items may not be sufficiently culturally specific, as they do present in western populations and might not present consistently across all non-western populations.

The current study utilized the total trauma score, which consists of 40 symptoms. For these items, participants rate the severity at which they experienced each symptom in the past week on a 4-point Likert Scale (1: Not at all; 4: Extremely). Possible scores range from 40 – 160, with higher scores indicative of greater distress. The HTQ-R has good evidence of reliability, with inter-rater reliability of .93 for trauma events, and .98 for trauma-related symptoms; test-retest reliability was calculated at .89 for trauma events and .92 for trauma symptoms. Internal consistency is high, with Cronbach’s alpha of .90 for trauma events, and .96 for trauma symptoms (Mollica et al., 1992).

**Social Support.** The Parenting Support From Family and Friends Scale (PSFF) measured perceived social support in the parenting role. The PSFF includes 28 statements that assess the mothers perceived practical support (My friends/family would pick my child up from school if needed.), informational support (My friends/family have good ideas about parenting.), and venting support (I feel comfortable talking to friends/family about parenting issues.). Participants rated the truth of each statement on a 4-point Likert Scale (1: Strongly Disagree 4: Strongly
Agree). Total score ranges from 28 – 112, with higher scores indicating greater support. Reliability analysis of the PSFF reported internal consistency at .94 (Bonds, Gondoli, Sturge-Apple, & Salem, 2002). According to a search of the literature, this measure has not been used in refugee populations, but Bonds et al. (2002) have been cited by studies of ethnically diverse and immigrant populations (Cheah, Yu, Hart, Ozdemir, Sevgi, & Sun, 2016; Riina, Lippert, & Brooks-Gunn, 2016).

**Parenting Efficacy.** The Parenting Sense of Competence Scale (PSOC) (Gibaud & Wandersman, 1978, cited in Ohan, Leung, & Johnson 2000) evaluated parenting self-efficacy. The PSOC is a self-report measure developed by Gibaud and Wandersman (1978). Nine items measure Satisfaction (Being a mother is rewarding), seven measure Efficacy (I easily solve parenting problems). Participants rated the truth of 17 statements on a 4-point Likert scale (1: Strongly Disagree, 4: Strongly Agree). Total score ranges between 17 and 68, with higher scores indicating higher parenting efficacy. Levels of internal consistency for the PSOC have been reported at .82 for Satisfaction, and .88 for Efficacy (Ohan et al., 2000). This measure was developed for western populations, and was also translated and adapted for Chinese mothers (Ngai, Chan, & Holroyd, 2007). To my knowledge, the PSOC has not been used with refugee populations.

**Results**

Descriptive statistics were computed for study variables: trauma symptoms ($M=68.9; SD= 32.3$), social support ($M=85.5 ; SD=11.9$), and parenting self-efficacy ($M=53.8; SD= 8.9$). Sample means suggest, on average, that there was a relatively low level of reported trauma symptoms (although there was a high degree of variability, with scores ranging from 40 – 156), a moderate level of perceived social support, and a high level of perceived parenting efficacy.
Bivariate correlations were used to assess the correlations between trauma symptoms, social support, and parenting self-efficacy. Trauma symptoms and social support were not significantly correlated ($r=.271$, $p=.234$), nor were social support and parenting self-efficacy ($r=-.235$, $p=.306$). Trauma symptoms and parenting self-efficacy were significantly correlated ($r=-.586$, $p<.05$). See Appendix D, Tables 3 and 4 for descriptive statistics and correlations of all study variables.

Multiple regression analysis was used to test whether trauma and social support were associated with participant’s reports of parenting self-efficacy (Table 1) The results of the analysis found that trauma symptoms and social support together account for 32% of the variance in parenting self-efficacy ($R^2=.32$, $F(3,17)=2.63$). Trauma and support showed an interaction in their association with parenting efficacy in the predicted direction, though this association fell just short of the conventional level of significance ($p=.08$).

**Table 1**

<table>
<thead>
<tr>
<th></th>
<th>R</th>
<th>R-sq</th>
<th>F</th>
<th>df-1</th>
<th>df-2</th>
<th>p</th>
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<tr>
<td></td>
<td>0.563</td>
<td>0.3169</td>
<td>2.629</td>
<td>3</td>
<td>17</td>
<td>0.0836</td>
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**Table 2**

<table>
<thead>
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<th>Support</th>
<th>Effect</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>0.0831</td>
<td>0.1559</td>
<td>0.5331</td>
<td>0.6</td>
</tr>
<tr>
<td>Medium</td>
<td>-0.0526</td>
<td>0.0836</td>
<td>-0.6297</td>
<td>0.54</td>
</tr>
<tr>
<td>High</td>
<td>-0.1884*</td>
<td>0.0744</td>
<td>-2.5313</td>
<td>.022*</td>
</tr>
</tbody>
</table>

* Significant at the $p < .05$ level.
We probed the interaction among the variables by computing simple slopes (Table 2) and plotting the relationship between trauma and efficacy at low (1 SD below the mean), average, and high (1 SD above the mean), levels of trauma, as recommended by Aiken & West (1991) (Appendix E, Figure 1). In participants with low social support, there was a non-significant positive slope between trauma and parenting efficacy (effect = .08, p = .6). Although it was not statistically significant, the effect aligned with predictions. In participants with high social support, there was a significant negative slope between trauma and parenting efficacy (effect = -.1884, p < .05), in contrast to prediction.

**Discussion**

**Correlations**

The correlations between trauma symptoms and social support in the parenting role (SSPR), and between parenting self-efficacy and SSPR, were not consistent with predictions. Parenting self-efficacy was negatively correlated with SSPR (r = -.235, p = .306). Trauma symptoms were positively correlated with SSPR, with higher levels of trauma associated with higher support (r = .271, p = .234). Although the observed positive correlation between trauma and SSPR was not significant, its direction interestingly contradicts the empirical literature, which indicates that trauma decreases support-seeking behaviors and perceived social support (Fitzgerald, 2013; Muzik, 2015). A synthesis of the literature suggests there are psychosocial mechanisms that shape the relationship between trauma and social support differently across cultures.

Many participants in this study are from East-African countries of origin, so it could be that the collectivist social norms found in many East-African cultures protect against the socially isolating nature of trauma (Green, 2013). Research has found that collectivist cultures endorse
social structures that elicit support-seeking behaviors, so it could be that collectivist structures protect against lowered perceived social support after trauma (Fijneman, Willemsen, & Poortinga, 1996). Research has also found that familism, or strong identification with and attachment to family, predicts levels of social support among families (Campos, Aguilera, Ulman, & Schetter, 2014). Perhaps shared trauma history among family members increases familism and social support, thus explaining the positive correlation between trauma and support found in this study.

Consistent with the literature and with predictions was the finding that trauma symptoms were significantly negatively correlated with parenting self-efficacy ($r=-.586$, $p<.05$). Although the relationship has been extensively explored in western and non-refugee populations, this study is among the first to establish a correlation among participants who are refugees (Fitzgerald et al., 2005; Muzik et al., 2015). This finding adds to the growing body of literature regarding the secondary effects of trauma in refugees, and establishes a relationship between complex trauma and parenting in refugee populations. The perspective of this study is unique in that it focuses on the effects of trauma on self-perceived maternal mental health, rather than on parenting styles or transgenerational trauma.

**Regression**

As noted above, there was an interesting pattern of results when testing the interaction between trauma and efficacy at different levels of support. At high levels of social support, trauma was significantly and negatively related to parenting efficacy ($effect=-.1884$, $p <.05$), at low levels of social support, trauma was positively related to efficacy ($effect=.08$, $p=.6$). This pattern suggests that social support is differentially associated with parenting efficacy depending on severity of trauma symptoms. Specifically, that social support may be a protective factor
against lowered parenting efficacy among mothers with low levels of trauma symptoms, but a risk factor for mothers with high trauma symptoms. A synthesis of the literature provides various hypotheses as to why this may be.

**High support.** Highly supportive families may be high in expressed emotion, which involves emotional over-involvement, critical comments, and hostility towards a family member with psychological disturbances. Research has found that expressed emotion is related to negative outcomes for people with psychological disorders (Meneghelli, Alpi, Pafumi, Patelli, Preti, & Cocchi, 2009). If the families of high trauma/high support mothers are also high in expressed emotion, and if the negative psychological effects of expressed emotion influence perceived parenting efficacy, then perhaps expressed emotion explains the negative association between support and efficacy among high trauma/high support mothers.

Highly supportive families might also elicit rigid familial role expectations that could be damaging to mothers’ psychological well-being. According to research by Walsh et al. (2003), families that allow for flexibility around roles bolster resilience among family members, so perhaps role rigidity impedes the formation of resilience. It could be that support increases role rigidity, that role rigidity impedes the formation of resilience, and that a lack of resilience leaves mothers vulnerable to the negative effects of trauma, such as lowered parenting efficacy.

**Low support.** Contrary to prediction, mothers with high trauma symptoms and low support showed high parenting efficacy. This relationship could be partially explained by the use of emotion-focused coping mechanisms (which aim to reduce emotional, rather than pragmatic, stress) among high trauma/low support mothers (Carver, Scheier, & Weintraub, 1989). The parent study of this one found that emotion-focused coping (EFC) was positively related to trauma symptomology, suggesting that high trauma encourages these mothers to utilize emotion-
focused coping (Brassel, 2017). Although western thought dismisses EFC as ineffective, strengths-based research has found that emotion-focused coping is associated with reduced psychosocial distress for individuals with unchangeable stressors, such as refugees (Cooper, Katona, Orrell, & Livingston, 2008). Thus, the positive association between trauma and efficacy at low levels of support may be explained by mothers’ use of coping mechanisms that bolster their emotional wellbeing and protect their parenting self-efficacy.

The association also suggests the possibility that high trauma/low support mothers have a survivor mentality that allows them to thrive, regardless of their negative circumstances. For example, one qualitative study by Pulvirenti and Mason (2011) argues that refugees are resilient by nature because they were able to survive and escape their country of origin. It could be that the compounded stress of high trauma and low social support causes these resilient women to mount an especially strong psychological defense against their circumstances and thrive in spite of them. Some mothers might even thrive because of their past circumstances – in a qualitative study of single mothers who are refugees, Lenette, Brough, & Cox found that knowing they survived such dangerous conditions gave these women the strength to overcome day-to-day challenges of resettlement and motherhood (2012).

In mothers with low support and high trauma, the pride in being a child’s sole caregiver may also explain high levels of perceived efficacy. The sense of sole responsibility for a child could encourage these already resilient mothers to care for their child, to perceive their caretaking as satisfactory relative to their limited resources, and to develop a sense of pride in their parenting.
Limitations

**Statistical power.** As with all studies, the results of this study should be interpreted with an awareness of methodological, statistical, and social limitations. The sample size of the study was relatively small, the variability for trauma symptoms and social support in the parenting role was relatively large, and the sample was unrepresentative of the entire population of mothers who are refugees in Burlington, VT. Though these factors lowered statistical power, the effects of trauma and social support in the parenting role on parenting efficacy may be statistically significant in a larger sample with greater power to detect true effects.

The sample was also influenced by a sampling bias present in the study’s recruitment methods. Participants were recruited at local refugee community centers, meaning that mothers who do not visit these centers, who are perhaps less involved in the community, are less likely to participate in the study. Thus, mothers who participated in this study might have larger and more cohesive social networks than the entire population, which could have resulted in higher-than-average levels of reported SSPR. Participants were also recruited through the Connecting Cultures Clinic, meaning that some participants may have been in therapy while others were not. Therapy was not accounted for as a confounding variable, though it may have affected results across all measures.

**Bias.** Self-report biases could also have affected participant’s responses and overall data. Mothers may have altered their responses to increase social desirability and acceptance, resulting in decreased reporting of trauma symptoms, increased reported SSPR, and increased reported parenting efficacy. This mechanism could be the unconscious bias that is present in many instances of self-report, or a conscious effort to avoid further efforts at intervention by the clinic.
Levels of SSPR may have been influenced by self-report biases in participants who have recently left their country of origin. These mothers may underestimate current levels of SSPR due to their relative lack of social network and support in Vermont compared to their country of origin. Mothers may also perceive their parenting efficacy differently depending on their levels of trauma and SSPR. That is to say, mothers with low support may overestimate their parenting efficacy due to their ability to parent with a relative lack of resources, while mothers with high support may adjust their self-perceived parenting efficacy to account for the help they receive.

Interpersonal dynamics between the participant and the researcher, the interpreter, or the family members who were present during the interview may also have influenced participant’s responses. The implicit exertion of power by the researchers (both white and well-educated) could have elicited participant answers thought to confirm our beliefs, or influenced mothers to portray themselves as more high-functioning. In a handful of interviews, mothers brought another family member in addition to their baby. Gender roles, social norms, and even fear may have inhibited participants from responding truthfully to all measures when parents, siblings, or older children were present. Power disparities between the participant and the interpreter could also have altered participant responses.

The use of western-derived measures for SSPR and parenting efficacy may have affected participant responses as well. Although the HTQ-R is claimed to be culturally informed, it may not be sufficient to provide a truly accurate trauma score across cultures. Firstly, although the measure does include some typically non-western symptoms, these symptoms may not be applicable to all other cultures simply because they are not wholly western-derived. Second, many of the items that are categorized as non-western, such as powerlessness or self-blame, are in fact present in western populations with trauma history. The assessment of dissociation as a
symptom could also be inappropriate for many participants, as it may be seen as an effective
coping strategy for participants. According to the aforementioned research by Young (1995), the
mere inclusion of PTSD-informed criteria in the HTQ-R decreases its ability to detect trauma
symptoms among non-western populations.

Implications and Future Research

Although researchers often focus on negative outcomes and pathology, resilience and
coping are equally important areas of focus. The results of this study have implications for a
strengths-based approach to future research, intervention, and therapies for refugees.
Psychologists should continue to value the protective factors and coping mechanisms that
refugees themselves report to be helpful, and encourage survivor-centered healing on the
individual and group level (Mollica, 2014). In terms of maternal mental health, researchers
should further explore the effects of emotion-focused coping and familial roles on parenting
efficacy in refugee populations.

Future research should also continue to take into consideration the cultural constraints of
maternal mental health. Academics who wish to study maternal mental health among refugees
should focus on creating, standardizing, and implementing psychological measures that are
specific to refugees, but that also have space for individualized cultural considerations. Future
studies regarding maternal mental health among refugees should also aim to focus on one
specific culture/country of origin and use the appropriate and corresponding measures. Ideas
about motherhood, parenting, and trauma vary greatly among cultures, and accounting for this
variance by studying one culture at a time, and then comparing across cultures, will help exclude
these confounding variables.
The results of this study illustrate the complex relationship between trauma and parenting efficacy, and the need to account for sociocultural factors. Although the current results were somewhat limited by low statistical power, it is important to note that the data supported only a small aspect the hypotheses I formed based on western literature. Factors specific to mother's’ country of origin, complicated trauma histories, and structural violence in the host country are just some of variables that affect the aforementioned relationship differently in refugee populations. If anything, these findings underline the responsibility of researchers and policy-makers to conduct non-assuming, non-western-derived, culturally competent studies and interventions.
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Appendix A

Harvard Trauma Questionnaire - Revised (Mollica et al. 1992)

The following are symptoms that people sometimes have after experiencing hurtful or terrifying events in their lives. Please decide how much the symptoms bothered you in the past week; not at all (1), a little (2), quite a bit (3), extremely (4). DSM-V Criteria (1-16); Additional Items (17-40).

1. Recurrent thoughts or memories of the most hurtful or terrifying events
2. Feeling as though the event is happening again
3. Recurrent nightmares
4. Feeling detached or withdrawn from people
5. Unable to feel emotions
6. Feeling jumpy, easily startled
7. Difficulty concentrating
8. Trouble sleeping
9. Feeling on guard
10. Feeling irritable, having outbursts of anger
11. Avoiding activities that remind you of the events
12. Inability to remember parts of the most hurtful or traumatic events
13. Less interest in daily activities
14. Feeling as if you don’t have a future
15. Avoiding thoughts or feelings associated with the traumatic or hurtful events
16. Sudden emotional or physical reaction when reminded of the most hurtful or traumatic events
17. Feeling that you have less skills than you had before
18. Having difficulty dealing with new situations
19. Feeling exhausted
20. Bodily pain
21. Troubled by physical problems
22. Poor memory
23. Finding out or being told by other people that you have done something you cannot remember
24. Difficulty paying attention
25. Feeling as if you are split into two people and one of you is watching what the other is doing
26. Feeling unable to make daily plans
27. Blaming yourself for things that have happened
28. Feeling guilty for having survived
29. Hopelessness
30. Feeling ashamed of the events that have happened to you
31. Feeling that people do not understand what happened to you
32. Feeling others are hostile to you
33. Feeling that you have no one to rely upon
34. Feeling that someone you trusted betrayed you
35. Feeling humiliated by your experience
36. Feeling no trust in others
37. Feeling powerless to help others
38. Spending time thinking why these events happened to you
39. Feeling that you are the only one who suffered these events
40. Feeling a need for revenge
Appendix B

Parenting Support from Family and Friends Scale (Bonds et al. 2002)
The items in each subscale are listed separately, the administered measure consists of all 38 items listed in random order. The original measure included items that had to be reverse coded, but the current study used a reworded version in which no items had to be reverse coded. Read each statement below and decide whether you strongly disagree (1), disagree (2), agree (3) or strongly agree.

Practical Support
1. My friends would pick my child up from school if I needed them to.
2. My family would pick my child up from school if I needed them to.
3. My friends would babysit for my child if I needed them to.
4. My family would babysit for my child if I needed them to.
5. If I needed them to, my friends would help with my daily chores to make parenting easier.
6. If I needed them to, my family would help with my daily chores to make parenting easier.
7. My friends would loan me money if I needed it.
8. My family members would loan me money if I needed it.
9. If I were sick, my friends would help me with day-to-day care of my child.
10. If I were sick, my family would help me with day-to-day care of my child.

Informational Support
1. My friends are good at helping me solve parenting problems.
2. Members of my family are good at helping me solve parenting problems.
3. I get good ideas about parenting from friends.
4. I get good ideas about parenting from my family members.
5. My friends offer good advice about how to set limits for my child.
6. My family members offer good advice about how to set limits for my child.
7. My friends are very knowledgeable when it comes to parenting issues.
8. My family members are very knowledgeable when it comes to parenting issues.
9. My friends have good ideas about activities I can do with my child.
10. My family members have good ideas about activities I can do with my child.
11. My friends are able to give helpful hints as to how I should deal with my fussy/crying child.
12. My family members are able to give helpful hints as to how I should deal with my fussy/crying child.

Venting Support
1. I have friends that I could go to with a parenting problem and not feel funny/bad/embarrassed about it later.
2. I have family members that I could go to with a parenting problem and not feel funny/bad/embarrassed about it later.
3. I have friends I can talk to when I just want to talk about my stress about parenting.
4. I have family members I can talk to when I just want to talk about my stress about parenting.
5. I can talk openly with my friends about parenting problems I may have.
6. I can talk openly with my friends about parenting problems I may have.
Appendix C

Parenting Sense of Competence Scale (Gibaud-Wallston & Wandersman, 1978)

Please rate the extent to which you agree or disagree with each of the following statements; strongly disagree (0), disagree (1), agree (3), strongly agree (4). Items labeled $R$ indicate reverse coding.

1. I know how my actions affect my child, which makes it easy for me to solve parenting problems.
2. Even though being a parent could be rewarding, I am frustrated right now with raising a baby. ($R$)
3. I feel like I haven’t accomplished a lot no matter what time of day it is. ($R$)
4. I feel like my child takes advantage of me and uses me. ($R$)
5. My mother was a better mother than me. ($R$)
6. If a new mom wanted to learn how to be a good parent, I would be a good person for her to watch.
7. It’s easy being a parent and I easily solve parenting problems.
8. It’s hard to be a parent because you don’t know if you’re doing a good job. ($R$)
9. Sometimes I feel like I am not getting anything done. ($R$)
10. I am the type of mother I think I should be. ($R$)
11. I am the best person to figure out what is upsetting my child. ($R$)
12. My talents are in other areas, not parenting. ($R$)
13. I feel comfortable being a mother.
14. I would want to be a better parent if it was more interesting. ($R$)
15. I have all the skills I need to be a good mother.
16. Being a parent makes me anxious. ($R$)
17. Being a good mother is rewarding.
Appendix D

Table 3

Descriptive Statistics

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<th>M</th>
<th>SD</th>
<th>Range</th>
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<tr>
<td>Support</td>
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<td>Efficacy</td>
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Table 4

Correlations Between Variables

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<th>Support</th>
<th>Efficacy</th>
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<tbody>
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<td>-0.586*</td>
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<tr>
<td>Support</td>
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<tr>
<td>Efficacy</td>
<td>-0.586*</td>
<td>-0.235</td>
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* Significant at the p < .05 level.
Appendix E

Figure 1

*Conditional Effects of X on Y at Values of the Moderator*

![Graph showing conditional effects of X on Y at different values of the moderator.](image-url)