# Developing an Empirically-Based Conceptual Model of the Intergenerational Impact of War:

# A Mixed Methods Study with Syrian Refugees in Lebanon

*Thesis submitted in partial fulfilment of the degree of Doctor of Philosophy in Social Intervention by stand-alone papers at the University of Oxford*

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## PUBLICATIONS AND PRESENTATIONS ARISING FROM THIS THESIS

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Annan, J., **Sim, A.**, Puffer, E., Salhi, C. & Betancourt, T.S. (2016). Improving mental health outcomes of Burmese migrant and displaced children in Thailand: A community-based randomized controlled trial of a parenting and family skills intervention. *Prevention Science, 18,* 793-803.

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## DECLARATION OF AUTHORSHIP

I, Amanda Sim, hereby declare that this thesis is my own work, except where otherwise stated.

Signed: 

Date: 24 April 2019

Place: Port Moresby, Papua New Guinea

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## THESIS ABSTRACT

**Background:** There is emerging evidence of an "intergenerational impact of war" (Betancourt et al., 2015) among conflict-affected families. However, research on parental and family-level variables that may mediate the relationship between caregiver and child mental health remains scarce. The objective of this DPhil thesis is to elucidate the role of parenting in the transgenerational transmission of war-related trauma and adversity, and investigate the variables that influence parental mental health and parenting behaviour during displacement. Results will provide a theoretical and empirical basis for further development of parenting and psychosocial interventions for Syrian refugees in Lebanon.

**Methods:** This DPhil thesis is comprised of three interrelated papers from a mixed methods study examining the intergenerational impact of war. The qualitative component of the thesis (DPhil Paper 1) consists of group and individual interviews with Syrian refugee parents (n=39) and children (n=15) in Lebanon. Interviews were transcribed and analysed using a grounded theory approach to examine the pathways linking the effects of war and displacement to parenting and child adjustment. The quantitative component of the thesis (DPhil Papers 2 and 3) consists of a cross-sectional survey with Syrian refugee mothers in Lebanon (n=291). In DPhil Paper 2, structural equation modelling is used to test a conceptual model linking mothers' exposure to war and daily stressors to maternal mental health problems, harsh parenting, and child psychosocial difficulties. DPhil Paper 3 examines the role of mothers' perceived social support in promoting their psychological and parenting resilience, defined as better than expected mental health and parenting behaviour given level of exposure to war trauma. Psychological and parenting resilience are operationalised using the residual approach,

which assesses the difference between mothers' actual score on mental health and harsh discipline measures, and the score predicted by their level of trauma exposure. Linear regression models are used to test for associations between mothers' perceived social support and their psychological and parenting resilience.

**Results:** In DPhil Paper 1, qualitative results show three interrelated pathways linking daily displacement stressors to different dimensions of parenting. First, economic hardship prevents parents from meeting their children's basic needs and forces adaptation strategies that impair positive parent-child interactions; second, parental psychological distress contributes to harsh parenting; and third, perceptions and experiences of insecurity in the community result in increased parental control. Greater economic resources and social support emerged as potential protective factors for maintaining positive parenting despite exposure to war and displacement-related adversity.

In DPhil Paper 2, results from the structural equation model show that greater exposure to war-related events is directly associated with increased maternal post-traumatic stress (PTS) and general psychological distress, as well as indirectly via mother's experience of daily stressors. Mothers' general psychological distress, but not PTS, is directly associated with more negative parenting behaviour and child psychosocial difficulties. The combined effects of parental rejection and harsh punishment mediate the association between maternal general psychological distress and child psychosocial difficulties. Model fit statistics indicate that the measurement and structural models provide a good fit to the data.

In DPhil Paper 3, regression analyses show that mothers' perceived social support is associated with both psychological and parenting resilience, including after

controlling for relative socioeconomic disadvantage, maternal education, and age and sex of child. Exploratory analyses further suggest that emotional support, but not instrumental support, is associated with mothers' psychological resilience.

**Conclusion:** This DPhil thesis contributes to the growing evidence base on the mechanisms underlying the intergenerational effects of war, focusing on parenting as a crucial link between parental and child psychosocial wellbeing. Results from both the qualitative and quantitative components of the thesis suggest that daily stressors related to displacement, in addition to past exposure to war trauma, have significant deleterious effects on parental mental health, which in turn contribute to negative parenting behaviour and child psychosocial outcomes. Social support may be a potential modifiable factor for promoting positive caregiver mental health and parenting in a context of past war trauma and ongoing displacement. Implications for policy and practice include greater emphasis on psychosocial and parenting support for war-affected caregivers, nested within and alongside structural interventions that improve refugees' social and material ecology.

This research is particularly timely and relevant given the enormous scale of the Syrian refugee crisis, and the shift in policy and practice towards family-based approaches to child protection and development in humanitarian contexts. Strengths of the thesis include the use of mixed methods to model the mechanisms underlying the intergenerational impacts of war and displacement, as well as the focus on modifiable factors that may promote parental resilience. Results should be viewed in light of several limitations, however, including the reliance on single-informant, self-reported data, and the cross-sectional survey design which precludes causal inference. Further research incorporating multi-method, multi-informant experimental or longitudinal designs is necessary to trace the linkages between family-level variables and children's

developmental trajectories, and inform interventions to support parental, child, and family resilience during displacement.

# CHAPTER I. INTRODUCTION

## *1.1 Background*

The number of people forcibly displaced by war, violence, and persecution reached a record 68.5 million worldwide in 2017, more than the entire population of the United Kingdom (United Nations High Commissioner for Refugees, 2018a). The war in Syria has resulted in a displacement crisis of unprecedented scale, accounting for the largest refugee population globally. Over half of the country's 22 million pre-war population has been displaced since 2011 (United Nations Office for the Coordination of Humanitarian Affairs, 2018). Approximately 6.3 million Syrians are refugees in other countries, another 6.3 million are internally displaced, and 4.5 million continue to live in areas of active conflict within Syria (UNHCR, 2018b). Contrary to the media focus on the refugee influx into Europe, neighbouring countries including Lebanon, Jordan, and Turkey bear the brunt of the Syrian displacement crisis. In Lebanon alone, there are almost one million Syrian refugees registered with the United Nations, approximately one-sixth of the entire Lebanese population (UNHCR, 2018a). Around half of Syrian refugees are under the age of 18 and 40% are under the age of 12 (Sirin & Rogers-Sirin, 2015). Urgent action is needed to protect an entire generation of Syrian children from potentially severe and lifelong harm to their psychosocial wellbeing and development.

Research with conflict-affected populations globally has shown that exposure to war and displacement can have serious adverse effects on mental health and psychosocial functioning. A meta-analysis of 181 surveys, including 81,866 adult refugees and other conflict-affected persons from 40 countries, reported weighted prevalence rates of 30.6% for post-traumatic stress disorder (PTSD) and 30.8% for

depression (Steel et al., 2009). Childhood exposure to war-related trauma and adversity is also linked to deleterious effects on psychosocial wellbeing, with several systematic reviews finding elevated rates of PTSD, depression, and other emotional and behavioural problems among children and youth, including children under 6 years (Attanayake et al., 2009; Bronstein & Montgomery, 2011; Slone & Mann, 2016).

Historically, research on refugee mental health has focused on the individual psychological sequelae of direct exposure to war trauma. There is now, however, growing awareness of the links between individual war exposure and the broader ecological context, particularly the impact of war and displacement on caregiver and family-level variables (Betancourt & Khan, 2008; Miller & Jordans, 2016). Recent studies have found evidence of associations between caregiver and child mental health outcomes, over and above individual exposure to trauma, in multiple conflict-affected populations (Panter-Brick, Grimon, & Eggerman, 2014; Betancourt, McBain, Newnham, & Brennan, 2015; Meyer, Steinhaus, Bangirana, Onyango-Mangen, & Stark, 201; Bryant et al., 2018). This shift in research focus has been accompanied by growing interest in family-based approaches to child protection and psychosocial development among policymakers and practitioners working in humanitarian contexts (Murphy, Rodrigues, Costigan, & Annan, 2017). However, while there is emerging consensus on the need to promote children's mental health in the context of their caregiving environment, the mechanisms underlying the intergenerational impact of war remain largely unexplored (Betancourt et al., 2015).

*1.2 Aims and structure of thesis*

The overall aim of this DPhil thesis is to develop and test an empirically-based conceptual model of the intergenerational impact of war. The thesis uses a risk and resilience framework (Masten, 2015) to pose three overarching research questions:

1) How does the experience of war and displacement affect parenting behaviour and child psychosocial adjustment?

2) Does parenting behaviour mediate the relationship between parental and child mental health?

3) Can social support promote the psychological and parenting resilience of war-affected caregivers?

Research for this thesis was conducted with Syrian refugees in Lebanon. The immense scale of displacement resulting from the Syrian conflict, and the potentially severe and longlasting effects on the wellbeing of current and future generations, make the need for research-driven intervention development particularly urgent. While family-based strategies in general, and parenting interventions in particular, are becoming a central pillar of psychosocial programming for conflict-affected families, rigorous research on the processes influencing parenting behaviour in this vulnerable population remains scarce (Murphy et al., 2017). The ultimate aim of this research, therefore, is to contribute to a theoretical and empirical foundation for further development of family-based interventions in conflict settings. The thesis also contributes to an ongoing paradigm shift in the literature on refugee mental health, from a historical emphasis on trauma-focused psychopathology, towards an ecological perspective on the processes influencing the psychosocial outcomes of refugee parents and children.

This DPhil thesis consists of six chapters, including three stand-alone papers as required by the DPhil-by-publication track at the Department of Social Policy and Intervention at the University of Oxford.

**Chapter I. Introduction** provides background to the research problem and its significance, and describes the aims and structure of the DPhil thesis as well as the role of the DPhil candidate in completing all aspects of research design, implementation, analysis, and write-up for this thesis. This chapter also provides an overview of the theoretical and empirical literature relevant to the research questions addressed in this thesis, including the mental health impacts of war and displacement, trauma-focused and psychosocial approaches to mental health, the intergenerational impact of war, determinants of parenting, and parental resilience during war and displacement. Finally, the chapter concludes with a description of the hypothesised conceptual model of the intergenerational impact of war and displacement, which is the focus of this thesis.

**Chapter II. Overview of Thesis Methodology** begins with a description of the methodological approaches used in this thesis, namely mixed methods, model building, and operationalising resilience. The chapter then provides a detailed description of the study setting, participants, and measures used in both the qualitative and quantitative components of the study, as well as the partnership established with the International Rescue Committee (IRC) in Lebanon to conduct fieldwork. Finally, the chapter discusses the ethical and safety issues that arose during the course of this research, and the strengths and limitations of the thesis.

**Chapter III. DPhil Paper 1** presents findings from the qualitative component of the thesis examining the effects of war and displacement on parenting behaviour, parent-child relationships, and child psychosocial wellbeing. A grounded theory approach was

used to develop a conceptual model of the pathways linking war and displacement to parenting and child adjustment, based on the lived experiences of Syrian refugee parents and children in Lebanon. Qualitative results were used to inform the quantitative component of the thesis, which is presented in Chapters IV and V.

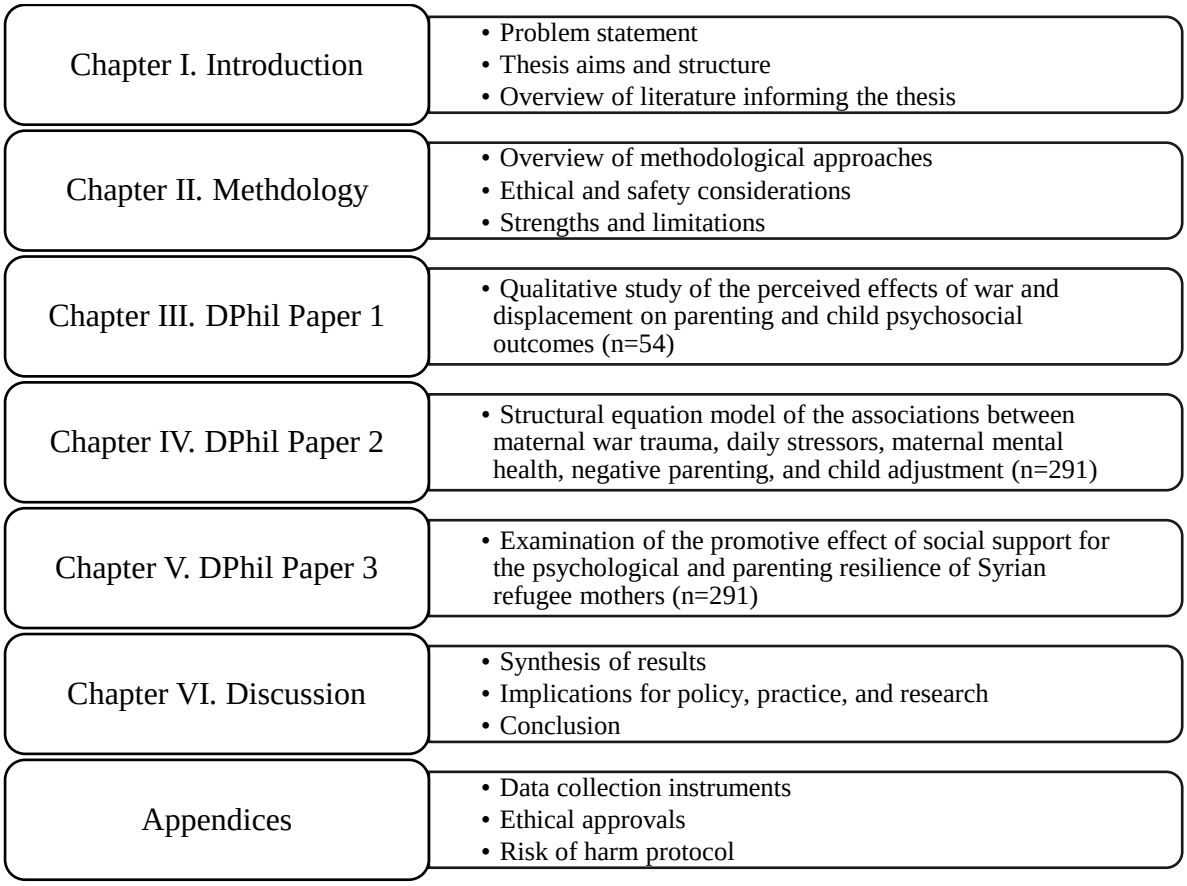
**Chapter IV. DPhil Paper 2** presents a structural equation model testing associations between mothers' exposure to war trauma and daily stressors, maternal mental health, harsh parenting, and child psychosocial problems. Results showed that greater exposure to war trauma was directly associated with poorer maternal mental health, as well as indirectly via daily stressors. Mothers' general psychological distress, but not PTS, was directly associated with more negative parenting and child psychosocial problems, while negative parenting mediated the relationship between maternal distress and child psychosocial problems.

**Chapter V. DPhil Paper 3** examines the role of perceived social support in promoting the psychological and parenting resilience of Syrian refugee mothers. Resilience was operationalised as better than expected mental health and parenting outcomes given mothers' level of war trauma exposure. Results showed that greater social support was associated with greater psychological and parenting resilience, with exploratory analyses suggesting that emotional support may be particularly important for mothers' psychological resilience.

**Chapter VI. Discussion** synthesises and integrates the qualitative and quantitative results from the three papers to propose the following conclusions: (1) current daily stressors, along with past war trauma, are a key determinant of parental mental health and parenting behaviour; (2) negative parental and child mental health outcomes are linked via impairments to parenting quality; and, (3) attempts at adaptation are

constrained by the environment, but social support may be a pathway to parental resilience. The chapter and thesis conclude with a discussion of implications for policy, practice, and future research, as well as a description of dissemination activities undertaken thus far to maximise the impact and uptake of this research.

**Figure 1. Logic and structure of thesis**




*1.3 Role of the candidate*

I was responsible for all aspects of research design, implementation, analysis, and write-up for this thesis. These aspects included: conceptualising the research questions; developing the research design; designing data collection procedures and tools; training data collection staff; monitoring data collection and data quality; cleaning and analysing

data; writing manuscripts reporting results; and, disseminating research findings to policy, practitioner, and academic audiences.

Leveraging my prior professional experience with the International Rescue Committee (IRC), I developed and proposed the research study to IRC leadership, and secured their approval to conduct the study in collaboration with the team in Lebanon. I also worked with the IRC to obtain funding from the UNICEF office in Lebanon to support the study. Finally, I wrote and submitted three papers to peer-reviewed journals, revised the papers based on reviewer comments, and integrated them into a cohesive DPhil thesis under the supervision of Professors Frances Gardner and Lucy Bowes.

### *1.4 Overview of theoretical and empirical literature*

#### *Mental health impacts of war and displacement*

There is a substantial body of evidence on the prevalence of mental health problems among conflict-affected populations, and the association between war exposure, PTSD, and other psychopathologies among adults and children. Prevalence estimates of mental disorders among refugees and other conflict-affected persons vary widely due to methodological and contextual factors. For example, in their systematic review and meta-analysis of 181 surveys comprising 81,866 adult refugees and other conflict-affected persons in 40 countries, Steel and colleagues (2009) found rates of reported PTSD ranging from 0% to 99% and 3% to 85.5% for depression. In general, however, studies show that refugees have poorer outcomes than non-refugee comparison groups across a range of psychopathology measures (Porter & Haslam, 2005; Fazel, Wheeler, & Danesh, 2005). Current residency status also plays a crucial role in determining mental health outcomes. The meta-analytic review by Steel and

colleagues (2009) found that displaced populations and those currently residing in refugee camps had higher rates of depression than refugees resettled to high-income countries.

Studies have found that children and youth affected by armed conflict are also at high risk of experiencing psychological difficulties. In a systematic review and meta-analysis of 17 studies comprising 7,920 children, Attanayake et al. (2009) reported a pooled estimate of 47% diagnosed with PTSD, 43% with depression, and 27% with anxiety. While the majority of studies have been with school-aged children and adolescents, a systematic review comprising 35 studies and a total of 4,365 children found that children as young as 0 to 6 years suffer from a range of behavioural and emotional symptoms related to war exposure, including post-traumatic stress, anxiety, aggressiveness, and sleep problems (Slone & Mann, 2016).

The risk and resilience model provides a useful overarching framework for understanding the mental health impacts of war and displacement (Masten, 2015). Informed by developmental systems theory (Ford & Lerner, 1992), the transactional model (Sameroff & Fiese, 2000), and the ecological model of development (Bronfenbrenner, 1977), the risk and resilience perspective views child adjustment and adaptation as a dynamic process involving the interaction of risk and protective factors at multiple levels of the child's social ecology over time (Masten, 2001; Fraser, Richman & Galinksky, 1999). A risk factor is "any event, condition, or experience that increases the probability that a problem will be formed, maintained, or exacerbated" (Fraser & Terzian, 2005, p. 5). Risk factors may be individual characteristics such as personality traits or biological predispositions (e.g. difficult temperament; genetic risk for mental disorder), specific life experiences or events (e.g. child abuse; death of a parent), or proximal and distal contextual factors (e.g. harsh parenting; disadvantaged

neighbourhood; child protection policy environment) (Fraser et al. 1999; Trentacosta et al., 2008). Protective factors, on the other hand, are individual or environmental variables associated with positive outcomes in the context of adversity, such as high self-efficacy, positive parent-child relationship, and strong social support networks (Smokowski, 1998).

In their conceptual framework of the determinants of mental health of forcibly displaced children, Reed and colleagues (2012) integrate the risk and resilience model with a temporal perspective on the different phases of displacement. Refugees can be exposed to risk during the pre-flight (e.g. bomb raids), flight (e.g. separation from family), and resettlement (e.g. acculturative stress) stages of forced migration (Lustig et al., 2004; Reed et al., 2012). Furthermore, risk exposure can occur at the individual, family, community, and societal levels. For example, the destruction of community-level social support structures and the cultural and linguistic challenges experienced by refugees fleeing their home country may exacerbate mental health problems resulting from individual violence exposure. A number of studies have also found evidence of a dose-response effect for the amount and severity of war-related trauma exposure and the risk of developing emotional and behavioural problems (Attanayake et al., 2009; Reed et al., 2012; Werner, 2012). This finding is consistent with a cumulative risk model, which posits that the presence of multiple risk factors in childhood greatly increases the risk of poor physical and mental health outcomes throughout the life course (Rutter et al., 1976; Sameroff, 2000; Masten & Cicchetti, 2010; Chapman et al., 2004).

*Trauma-focused and psychosocial approaches to mental health in conflict settings*

Historically, the field of refugee mental health has been dominated by an emphasis on war trauma exposure in the pre-flight phase of displacement and resulting psychopathology, mainly in the form of PTSD. The past decade, however, has seen a burgeoning debate between proponents of this trauma-focused model, and advocates of a psychosocial approach to understanding and addressing the needs of conflict-affected populations (Miller & Rasmussen, 2010; Neuner, 2010). While the trauma-focused model emphasises exposure to war-related events such as physical assault and the destruction of one's home as the key determinant of poor mental health, the psychosocial perspective focuses on the stressful social and material conditions resulting from armed conflict and displacement, such as poverty, discrimination, and the destruction of social networks. In an attempt to bridge the divide between these two approaches, Miller & Rasmussen (2010) proposed a conceptual model in which the daily stressors resulting from war and displacement mediate the effect of direct war exposure on mental health outcomes. They further argue for a sequenced, integrated model of intervention in which the alleviation of daily stressors are prioritised first, based on the assumption that improvements in the social and material environment will reduce psychological distress. Individuals whose symptoms do not improve may then require more specialised clinical interventions, although treatment should address other forms of distress beyond PTSD, such as depression and impaired social functioning.

As a rejoinder, Neuner (2010) questioned the causal direction of the relationship between daily stressors and mental health, arguing that psychological distress, and specifically PTSD, may actually cause or exacerbate daily stressors. Healing war trauma through specialised mental health interventions would thus minimise potential stress generation effects (Hammen, 2006), enabling individuals to engage more

positively and productively with their environment. While exposure to war trauma and resulting psychopathology remain a popular area of research, the growing prominence of the psychosocial approach has resulted in an emergent body of evidence on the importance of daily stressors for refugee mental health. A meta-analytic review of factors associated with the mental health of displaced populations concluded that post-displacement conditions, such as living in institutional accommodation and having restricted economic opportunities, were associated with worse mental health outcomes (Porter & Haslam, 2005). Similarly, results from a study with 2,399 refugees resettled in Australia suggested that while both pre-migration traumatic events and post-migration stressors were positively associated with PTSD and severe mental illness, post-migration resettlement-related stressors were the most important correlates of mental health (Chen, Hall, Ling, & Renzaho, 2017). Findings from this study, as well as research with conflict-affected populations in Jordan and Nepal (Jordans, Semrau, Thornicroft, & van Ommeren, 2012), support the conceptual model elaborated by Miller & Rasmussen (2010) in which daily stressors mediate the relationship between war exposure and mental health.

A complementary line of research suggests that certain types of traumatic or stressful experiences may be associated with specific mental health problems. For example, a systematic review of the long-term mental health of refugees found that while greater exposure to pre-flight traumatic experiences and post-displacement stress were consistently associated with PTSD, depression, and anxiety, lower socio-economic status post-displacement was particularly associated with depression (Bogic, Njoku, & Priebe, 2015). Similarly, Panter-Brick and colleagues (2011) found specific risk pathways among schoolchildren in Afghanistan, for whom family-level variables best predicted emotional and behavioural difficulties, while exposure to traumatic

events best predicted post-traumatic stress symptoms. Taken together, the literature suggests the need for an integrated perspective that includes both cumulative risk and specific risk pathways to understand the psychosocial outcomes of conflict-affected individuals (Fraser et al., 1999).

*The intergenerational impact of war*

The concept of an intergenerational impact of war is one example of a risk pathway that can influence the developmental trajectories of conflict-affected children. The notion that war-related trauma may be transmitted across multiple generations emerged from clinical studies with Holocaust survivors and their families, which observed psychological disturbances among first generation survivors that were theorised to contribute to poorer outcomes for their children (Danieli, 1998). While empirical evidence of this effect is equivocal, the notion of a "legacy" of trauma remains compelling (van IJzendoorn, Bakermans-Kranenburg, & Sagi-Schwartz, 2003). In particular, research with Vietnam War veterans and their offspring, and the introduction of PTSD into clinical nomenclature and diagnosis, have revived interest in the multigenerational effects of war trauma exposure (Dekel & Goldblatt, 2008).

In contrast to studies with Holocaust survivors and military veterans, in which the successive generation was not directly exposed to the traumatic experience, research in conflict settings in low- and middle-income countries (LMICs) has been with families with shared exposure to war. Even after controlling for individual trauma exposure, these studies have found evidence of intergenerational mental health effects. For example, prospective, longitudinal studies in Sierra Leone, Afghanistan, and Pakistan found that caregiver and family-level variables such as parental mental health, family acceptance, and domestic violence predicted adolescent anxiety, depression,

and post-traumatic stress symptoms over a one to four-year period (Betancourt et al. 2015; Panter-Brick et al. 2014). Cross-sectional studies with war-affected adolescents and caregivers in Uganda and the Democratic Republic of Congo have found a similar relationship between caregiver and child mental health outcomes (Meyer et al., 2017; Glass et al., 2018). Transgenerational effects of war trauma may also be apparent in young children, with one systematic review finding associations between maternal and child PTSD and other emotional and behavioural problems among children under 6 years (Slone & Mann, 2016).

While there is growing evidence of intergenerational mental health effects among conflict-affected families, the mechanisms through which war exposure and trauma-related symptomology are transmitted remain unclear. A 2012 meta-analysis of the association between parental and child PTSD symptoms suggested several possible mechanisms such as shared genetic diathesis, parental modelling and reinforcement of anxious or avoidant behaviours, and decreased positive parent-child interactions (Morris, Gabert-Quillen, & Delahanty, 2012). There is some evidence of genetic predisposition and epigenetic processes as potential mechanisms of direct transmission. For example, a twin study including more than 4,000 Vietnam War veterans found that almost 30% of the variance in PTSD may be genetically determined (True et al., 1993). Gene by environment interactions have also been found in relation to a range of traumatic or stressful life events and the occurrence of PTSD or depression (Caspi, 2003). These interactions may render war-affected children more psychologically and biologically vulnerable to trauma and stress.

There is also evidence of indirect transmission of war-related trauma via disturbances in family dynamics, particularly increased dysfunctionality in parenting and parent-child interactions. Research with military veterans, for example, suggests

that war exposure and resulting PTSD increase the propensity for harsh parenting and family violence, which in turn contribute to psychosocial difficulties among their offspring (Rosenheck & Fontana, 1998). A review of studies with Vietnam War veterans found that those with PTSD were more likely to use corporal punishment than those without PTSD (Dekel & Goldblatt, 2008). Other studies have found that veterans with PSTD are less involved in family activities, experience difficulties with attachment and intimacy, and report more negative parenting behaviours (Ruscio, Weathers, King, & King, 2002; Gewirtz, Polusny, DeGarmo, Khaylis, & Erbes, 2010). The associations between parental trauma exposure, trauma symptomology, and harsh parenting have also been demonstrated with families in other war-affected contexts including Sri Lanka (Catani, Jacob, Schauer, Kohila & Neuner, 2008), northern Uganda (Saile, Ertl, Neuner & Catani, 2014), and resettled refugees in The Netherlands (Van Ee, Kleber & Mooren, 2012). Most notably, a population-based prospective cohort study of refugees resettled in Australia found that caregivers' trauma history and post-migration difficulties were associated with greater subsequent PTSD, which in turn was associated with greater harsh parenting and in turn, higher levels of child emotional and behavioural problems (Bryant et al., 2018).

PTSD is the most commonly cited mechanism through which parental traumatisation impairs caregiving behaviour. PTSD as an explanatory model for family violence centres on symptoms such as anger, hyperarousal, and irritability heightening the risk for harsh parenting (Timshel, Montgomery, & Dalgaard, 2017; Rees, Thorpe, Tol, Fonseca, & Silove, 2015; Hinton, Rasmussen, Nou, Pollack & Good, 2009). In addition, avoidance-related PTSD symptoms such as emotional numbing and withdrawal may result in lack of emotional attunement and availability. Traumatic experiences may also impair parent-child relationships by disrupting internal

attachment representations of the self as caregiver, thereby debilitating parents' ability to respond sensitively to children's cues (De Haene, Grietens & Veershueren, 2010). For example, a prospective longitudinal study with war-exposed Israeli mother-child dyads found that mothers' anxiety-provoking, frightening or fearful behaviors during trauma reminders predicted onset and chronicity of psychopathology among their children (Halevi, Djalovski, Vengrober & Feldman, 2016).

Due perhaps to the historical dominance of a trauma-focused model of mental health – and by extension, parenting – among conflict-affected families, evidence is scarce on how parenting may be affected by other forms of psychological distress beyond PTSD. There is now a body of research demonstrating direct and indirect associations between stressful material and social conditions post-migration, and refugee mental health problems such as depression (Jordans et al., 2012; Chen et al., 2017). Furthermore, evidence from disadvantaged communities in non-war settings suggests that chronic stressors such as poverty and discrimination, also ubiquitous in refugee contexts, increase the risk of harsh parenting via poor parental mental health (Elder & Caspi, 1988; Conger, Ge, Elder, Lorenz, & Simons, 1994; Leventhal & Brooks-Gunn, 2000). Given the critical role of parenting in promoting healthy child adjustment, there is a need for more nuanced analysis of the pathways through which war trauma and daily stressors influence parenting behaviour, including via multiple effects on caregiver mental health. The following section provides an overview of the theoretical and empirical literature on the determinants of parenting, with special emphasis on the risk factors most pertinent to war and displacement.

*Determinants of parenting in war*

Parenting is a complex and multidimensional construct commonly framed in terms of two broad domains: *positive parenting* referring to warmth, responsiveness, and appropriate limit-setting, and *negative parenting* referring to harsh, inconsistent, and over-reactive parenting behaviours (Taraban & Shaw, 2018). A substantial body of research from diverse socioeconomic and cultural groups consistently highlights parenting behaviour as a crucial predictor of child psychosocial and developmental outcomes (Wyman et al., 1999; Trentacosta et al., 2008; Putnick et al., 2015). For instance, a longitudinal study in 8 countries including Thailand, Kenya, Italy and the United States found that corporal punishment predicted increases in children's anxiety and aggression over time, while maternal warmth predicted decreases in those outcomes (Lansford et al., 2014).

For children living in high-risk environments, research suggests that parenting may mediate the relation between risk exposure and children's internalising and externalising problems. Trentacosta et al. (2008) found that cumulative contextual risk predicted less nurturing and involved parenting, which in turn predicted children's internalising and externalising problems. Similarly, Dumka and colleagues (1997) found that the presence of multiple risk factors was related to more inconsistent discipline, which mediated the relation between cumulative risk and children's emotional and behavioural problems. There is also some evidence that positive parenting may buffer the effects of cumulative risk. In a study by Wyman et al. (1999), emotionally responsive, competent parenting was a direct, proximal predictor of resilience in children facing adversity, and mediated more distal caregiver characteristics such as education and relational history. Studies in war-affected settings have found similar results on the protective effect of parental support. In Sri Lanka, for

example, the experience of war and tsunami for children with high levels of parental care was not associated with increased internalising problems compared to children with low levels of parental care (Sriskandarajah, Neuner, & Catani, 2015). Similarly, greater parental support was associated with reduced diagnosis of PTSD and reduced severity of symptoms among war-affected children in Gaza (Thabet, Ibraheem, Shivram, Winter, & Vostanis, 2009).

Belsky's (1984) classic process model of parenting provides a useful theoretical framework for examining the determinants of parenting during war and displacement. Murphy and colleagues (2017), for example, drew on Belsky's model to develop an integrative conceptual model of parenting in war that highlights parenting knowledge and skills, parents' mental models, and parent stress and psychological wellbeing as key determinants of parenting behaviour. In Belsky's model, there are three subsystems that determine parenting behaviour: parent characteristics, child characteristics, and contextual sources of stress and support. Parent-level predictors of parenting, considered by Belsky to be the most influential, include the parent's own developmental history, personality, and psychopathology. Evidence of a relationship between parental exposure to trauma and parenting behaviour is of particular interest when examining parenting in conflict settings. Research on the effects of trauma on parenting has focused primarily on parents' own histories of childhood physical and sexual abuse. The concept of an intergenerational cycle of violence emerged from empirical findings suggesting that children who experience abuse are at higher risk of becoming perpetrators of abuse in adulthood. For example, Cohen and colleagues (2008) found that cumulative maternal trauma was a significant predictor of abuse potential, punitiveness, psychological aggression, and physical discipline. Banyard and colleagues (2003) examined interpersonal trauma exposure in both childhood and

adulthood, and found associations with decreased parenting satisfaction, increased use of physical punishment, greater neglect, and more history of protective service reports. Interestingly, in multivariate analyses, adult trauma rather than childhood abuse accounted for the variance in parenting, suggesting that the experience of traumatic events in adulthood can also have powerful effects on parenting behaviour.

In conflict and natural disaster settings where trauma exposure occurs on a massive scale, evidence suggests a similar link between parental traumatisation and harsh parenting. In northern Uganda, Saile et al. (2014) found that male guardians' PTSD symptom severity and female guardians' war trauma exposure increased both parental and child reports of maltreatment. Similarly, post-traumatic stress symptoms among male and female asylum seekers and refugees in the Netherlands were negatively associated with the quality of parent-child interactions (Van Ee et al., 2012; Van Ee, Sleijpen, Kleber & Jongmans, 2013). In a study with families affected by war and tsunami in Sri Lanka, Catani et al. (2008) suggested that the association between children's previous war exposure and family violence may be explained by parents' own trauma exposure, which may increase the risk of further perpetration of violence in the home. In order to unpack the association between trauma exposure and family violence, Rees et al. (2015) conducted a qualitative study with mothers in East Timor experiencing explosive anger. Their findings suggest support for a post-conflict cycle of violence model in which patriarchal values combined with paternal psychological distress induced by war trauma contribute to intimate partner violence, which in turn leads to women experiencing explosive anger, ultimately resulting in the perpetration of violence against children.

In contrast to the small but compelling evidence base on the effects of parental traumatisation on parenting behaviour, there is a dearth of research on how other forms

of parental psychological distress, such as depression and anxiety, affect parenting in conflict settings. There is, however, a robust body of research from non-war settings on the effects of depression on parenting behaviour. For example, a meta-analytic review of 46 observational studies found a medium effect of maternal depression on negative parenting (Lovejoy, Graczyk, O'Hare, & Neuman, 2000). While there are fewer studies on paternal depression, a meta-analytic review of 28 studies found that father's parenting is comparably affected by depression (Wilson & Durbin, 2010). Depression may compromise parents' cognitions, behaviour, and affect, which in turn reduces their ability to respond to their children's socio-emotional needs (Hammen, 1997). Negative rumination, a key feature of depression, may also limit the amount of mental space available for attending to children's needs (Lovejoy et al., 2000). Other mental health problems such as anxiety have received less attention, but are likely to also influence parenting behaviour. Laskey & Cartwright-Hatton (2009) examined the role of parental anxiety in relation to discipline style and child internalising problems. Their findings showed significant correlations between both parental anxiety and child internalising symptoms with ineffective discipline and negative beliefs about parenting. The association between parental anxiety and child internalising symptoms was mediated by harsh discipline, suggesting again that parenting is a crucial mechanism underlying the association between parental and child mental health. These findings suggest that parental depression and anxiety, in addition to PTS, are likely to increase negative parenting in conflict settings as well.

Child characteristics constitute another important driver of parenting behaviour in Belsky's process model. A review of the literature did not reveal any studies of child-level determinants of parenting in conflict settings. However, studies from non-war settings suggest that child characteristics are an important influence on parenting. For

example, meta-analyses of adoption and twin studies have found that 23-40% of variance in parenting can be accounted for by genetic contributions of the child (Avinun & Knafo, 2013; Klahr & Burt, 2014). Child temperament – biologically-based differences in reactivity and behavioural style – has been extensively studied in relation to both parenting behaviour, and child emotional and behavioural problems (Rothbart, Ahadi & Evans, 2000). Temperamentally difficult children are typically more challenging for caregivers to manage, thereby increasing parental frustration and the risk of harsh parental response or the withdrawal of attention (Paulussen-Hoogeboom, Stams, Hermanns, & Peetsma, 2007). Particularly relevant to conflict settings, the child's tendency to react to environmental stressors with high levels of negative emotionality, including anger, sadness and fear, has been linked to higher levels of harsh parenting and lower levels of positive parenting (Paulussen-Hoogeboom et al., 2007). This finding suggests that certain children may be particularly vulnerable to the negative impacts of war and displacement, a phenomenon termed "differential susceptibility" by Belsky (2007), which in turn may increase the risk of harsh parenting. Child temperament is likely to have bidirectional and cyclical effects as well, with harsh, inconsistent parenting contributing to children's negative emotionality, which in turn escalates negative parental response (Patterson, 1982).

The social context domain of Belsky's model refers to social determinants of parenting such as socio-economic status, social support, and the quality of the marital or intimate partner relationship. Socio-economic stressors such as economic hardship and pressure have been associated with negative parenting behaviour (Conger et al., 1994; Yeung, Linver, & Brooks-Gunn, 2002; Gershoff, Aber, Raver, & Lennon, 2007). Neighbourhood effects have also been associated with less positive parenting behaviours (Leventhal & Brooks-Gunn, 2000). For example, Klebanov and colleagues

(1994) found that neighbourhood poverty was associated with less maternal warmth and responsiveness after controlling for family conditions. Similarly, in their longitudinal study of low-income, single African-American mothers, Kotchick and colleagues (2005) found that neighbourhood stress resulted in more negative parenting over time through its effect on maternal mental health. Minority status, another contextual risk that is often linked with low socio-economic status, also appears to amplify the negative effects of poor parental mental health on parenting (Taraban & Shaw, 2018). For example, a meta-analysis of the relationship between paternal depression and parenting found an association for non-Caucasian fathers only (Wilson & Durbin, 2010). Evidence of the negative effects of socioeconomic and neighbourhood disadvantage on parenting behaviour is particularly relevant to displacement settings, which are typically characterised by poverty and exposure to harassment and discrimination due to refugee status.

Social support from family and friends, however, has been found to moderate the association between neighbourhood stress and parenting, suggesting that social support may be a protective factor for parenting in conditions of adversity. Higher levels of social support has been found to predict positive parenting, as well as buffer against risk factors such as neighbourhood disadvantage (Kotchick et al., 2005; Lee, Anderson, Horowitz, & August, 2009). Several studies have shown that mothers with more social support exhibit more nurturing and sensitive parenting, and are less likely to use punitive strategies to discipline children (McLoyd, 1990; Crnic, Greenberg, Robinson, & Ragozin, 1984).

Social support has been defined as "social relationships that provide (or can potentially provide) material and interpersonal resources that are of value to the recipient, such as counselling, access to information and services, sharing of tasks and

responsibilities, and skill acquisition" (Thompson, Flood, & Goodvin, 2006, p. 2). The multidimensional nature of social support is reflected in the various approaches used to define and operationalise the construct. For example, social support can be conceptualised in terms of functional support – i.e. the degree to which interpersonal relationships serve particular functions. These functions include emotional and instrumental support, where emotional support involves providing care and empathy, and instrumental support involves providing assistance through giving of one's time, skills or other resources (Cohen & Hoberman, 1983). Social support can also be conceptualised in terms of its structural aspects, namely the existence, quantity and interconnectedness of social networks (Ell, 1984).

There are two main models to explain how social support may relate to parenting: the main effects model, and the buffering model (Thompson et al., 2006). The main effects model posits that social support has a positive effect on parenting behaviour, irrespective of exposure to stress. In the buffering model, social support is hypothesised to protect against the negative effects of adversity, so that parents living in stressful conditions would benefit more from social support than those living in more benign environments. Some studies have also found reverse-buffering effects, whereby the benefits of social support are dampened under particularly stressful conditions (Auerbach, Bigda-Peyton, Eberhart, Webb, & Ho, 2011). For example, a study with low-income, single mothers found that the positive influence of social support in promoting nurturing parenting and reducing punitive strategies diminished as neighbourhood conditions worsened (Ceballo & McLoyd, 2002). In communities where poverty or violence is rife, support seeking may backfire as neighbours may be too overloaded to respond positively to requests for support or assistance (Garbarino & Sherman, 1980). These studies suggest that the relationship between social support and

parenting may be dependent on the context, as well as the quality, source, and content of that support. For refugee populations, social support is often a scarce resource given that the destruction of social networks and structures is a corollary of war and displacement. It is likely, therefore, that many refugee parents are least able to benefit from the protective qualities of social support at a time when they need it the most.

The family stress model integrates these separate lines of research on associations between economic pressure, parental mental health, social support, parenting, and child outcomes to theorise how poverty affects child outcomes via its impact on family processes (Conger et al., 1994). The model postulates that low income leads to material hardship, which takes a major toll on parents' mental health and partner relationships, which in turn impairs parenting behaviour and ultimately child adjustment. Another theory of the relationship between income, parenting, and child outcomes is the investment perspective, which posits that higher income enables parents to purchase materials, services, and enriching environments or experiences that contribute to positive child developmental outcomes (Yeung et al., 2002). Studies investigating the family stress and investment perspectives have found different pathways between income and specific child outcomes, with the association between income and child cognitive skills mediated by parental investment, while the association between income and child social and emotional outcomes was mediated by increased parental stress and more negative parenting behaviour (Yeung et al., 2002; Gershoff et al., 2007). Both the family stress model and the investment model are useful frameworks for theorising the multiple linkages between socioeconomic adversity, and child cognitive, social, and emotional outcomes in conflict settings.

Since Belsky's pioneering model of the process of parenting, theory and research on determinants of parenting behaviour have become increasingly sophisticated. In

particular, there is now more evidence of interactions among the different subsystems proposed in Belsky's model, especially the moderating role of contextual factors such as socioeconomic and minority stress (Taraban & Shaw, 2018). In their meta-analysis of the relationship between maternal depression and positive parenting, Lovejoy et al. (2000) found a moderate negative effect only among mothers who were financially disadvantaged. Another illustration of the moderating effect of socioeconomic status comes from a meta-analytic review of the association between child negative emotionality and parenting. Using data from 62 studies and a total of 7,613 mother-child dyads, Paulussen-Hoogeboom et al. (2007) found that the association between child negative emotionality and less supportive parenting was stronger for low-SES compared to middle-SES parents, and reversed for high-SES samples. In other words, mothers who had more financial resources were better able to adapt their parenting behaviour to respond to the needs of their temperamentally challenging child, while economically-stressed mothers experienced more difficulty in maintaining positive parenting. Taken together, these findings suggest that contextual stressors such as poverty and discrimination, also common features of conflict and displacement settings, compound the negative effects of poor parental mental health and child temperament on parenting behaviour.

*Parental resilience during war and displacement*

An important corollary of understanding the determinants of parenting behaviour is to examine the factors and processes that contribute to positive parenting in spite of exposure to risk. Indeed, pioneers in the study of resilience have argued that by focusing exclusively on risk factors and negative outcomes, scholars had neglected an important perspective and set of phenomena – namely, that not all at-risk individuals develop problems, and some function better than expected given their level of risk exposure

(Rutter, 1985; Werner & Smith, 1982). While definitions of resilience vary, they broadly refer to a dynamic process encompassing positive mental health and developmental outcomes in the context of significant threat or adversity (Luthar, Cicchetti, & Becker, 2000). Originally conceptualised as an innate quality or individual trait in certain exceptional children, resilience is now commonly understood to be a dynamic and transactional process involving the interaction of risk and protective factors at multiple levels of the individual's social ecology, influenced by place and culture and evolving throughout time and developmental stages (Masten & Cicchetti, 2015). Resilience processes and outcomes may differ across domains, with a high-risk individual performing well and demonstrating resilience in one domain (e.g. academic achievement) but not another (e.g. peer relationships) (Luthar et al., 2000). Evidence of uneven functioning across different domains highlights the need for specificity when examining and reporting on resilience outcomes, with researchers increasingly using terms such as "educational resilience" (Wang, Haertel, & Wahlberg, 1994) and "family resilience" (Walsh, 2002).

Resilience research in non-war as well as war settings has focused almost exclusively on the outcomes of children, with very little known about how some parents are able to do well despite considerable odds (Luthar, Sawyer & Brown, 2006; Tol, Song, & Jordans, 2013). Theoretical and empirical treatment of parental resilience is limited despite widespread recognition of the importance of parental factors in predicting child adjustment. In their conceptualisation of parental resilience, Gavidia & Payne (2015) define the construct as "the capacity of parents to deliver competent, quality parenting to children despite adverse personal, family, and social circumstances." Parents' psychological functioning, self-efficacy, family functioning, and social connectedness are presented as key concepts contributing to parental

resilience. Understanding the processes contributing to positive parental mental health and parenting in spite of the risks engendered by war and displacement is crucial to developing interventions to promote the resilience of parents, and ultimately their children. As Cicchetti and Garmezy asked, "What individual, familial, or societal factors stem the trajectory from risk to psychopathology, thereby resulting in adaptive outcomes even in the presence of adversity?" (1993, p. 497).

This thesis examines the role of one particular factor – social support – in promoting parental resilience in the domains of mental health and parenting behaviour. According to Luthar et al. (2006), there are four main criteria for determining which factor or set of factors should be prioritised for investigating resilience processes and outcomes. First, there should be particular attention paid to factors that are salient in that particular context or that affect a large number of people in that group. Second, risk modifiers that are malleable or amenable to change through interventions should be prioritised. Third, there should be more focus on factors that are enduring or that continue to exert their effects for a lengthy period of time. Finally, research should be aimed at factors that are generative of other assets and that catalyse other protective processes.

Social support in the context of war and displacement fulfil all of these criteria. The degradation of social support networks, as evidenced by family separation and the destruction of community-based educational and religious institutions, is a direct consequence of war that affects millions of displaced people around the world. There is evidence that social support can have enduring, positive effects on mental health, functioning, and parenting behaviour in conditions of adversity. For example, social support has been linked to fewer depressive symptoms among children and youth who were medically or psychiatrically ill, abused, or low-income (Rueger, Malecki, Pyun,

Aycock, & Coyle, 2016), and higher levels of prosocial behaviour and adaptive functioning among former child soldiers in Sierra Leone (Betancourt et al., 2010). Research has also found associations between social support and more positive parent-child interactions and reduced risk of child abuse among parents experiencing economic hardship (Green, Furrer & McAllister, 2007; Ajduković, Rajter, & Rezo, 2018), and mothers with a history of childhood abuse (Jaffee et al., 2013; Tracy, Salo, & Appleton, 2018). Given the robust relationship between mental health and parenting, it is likely that social support can also have cascading effects on resilience processes, for example by promoting positive parenting via improved caregiver mental health. Most importantly, social support is potentially modifiable through intervention. For example, a cluster randomised trial of a parenting intervention targeting maternal wellbeing and child development in northern Uganda found positive effects on maternal mental health, parenting practices, and child cognitive outcomes, with mother's perceived social support mediating intervention effects on maternal depressive symptoms (Singla, Kumbakumba, & Aboud, 2015). Among humanitarian practitioners, there is considerable interest in social support interventions such as peer-to-peer parenting support groups for refugee mothers in Lebanon (Mercy Corps, n.d.), and a group-based psychosocial intervention for promoting social support for Syrian refugee and Jordanian youth (Panter-Brick et al., 2018). However, there remains very little evidence on whether and how social support can promote the psychological and parenting resilience of war-affected caregivers.

### *1.5 Conceptual model of the intergenerational impact of war and displacement*

Drawing on the theoretical and empirical literature reviewed above, this thesis uses mixed methods to develop and test a conceptual model of the intergenerational impact of war among Syrian refugees in Lebanon. Grounded in developmental systems

theory, the model is based on the principle that "the integration of actions—of the individual on the context and of the multiple levels of the context on the individual (individual ←→ context) – constitute the fundamental unit of analysis in the study of the basic process of human development" (Lerner, 2006, p. 44). Within this developmental systems view, children and parents are "fused" in a multilevel system involving historical, social, and cultural environments (Lerner, Rothbaum, Boulos & Castellino, 2002). Parents, as individual actors in the developmental system, and their parenting behaviours, are thus influenced by and simultaneously influence other levels of the developmental system.

The conceptual model presented in this thesis begins with the distal, antecedent variable – i.e. exposure to war – proceeding through its consequences of displacement-related daily stressors, and ultimately impinging on the child through its cascading effects on parental mental health and parenting behaviour (Figure 2). Social support is included in the model as a hypothesised promotive factor for parental resilience in two domains: mental health and parenting. The determinants of parenting are complex and multidimensional, with intersecting drivers ranging from individual childhood experiences to sociocultural norms. In this thesis, the conceptual model focuses on specific pathways linking trauma exposure, social and economic adversity, and parental mental health to parenting behaviour, and ultimately, child psychosocial adjustment. Specifically, the model examines the following:

a. Direct and indirect effects of war trauma exposure and displacement-related daily stressors on poor parental mental health;

b. Different dimensions of parental mental health, namely post-traumatic stress and general psychological distress;

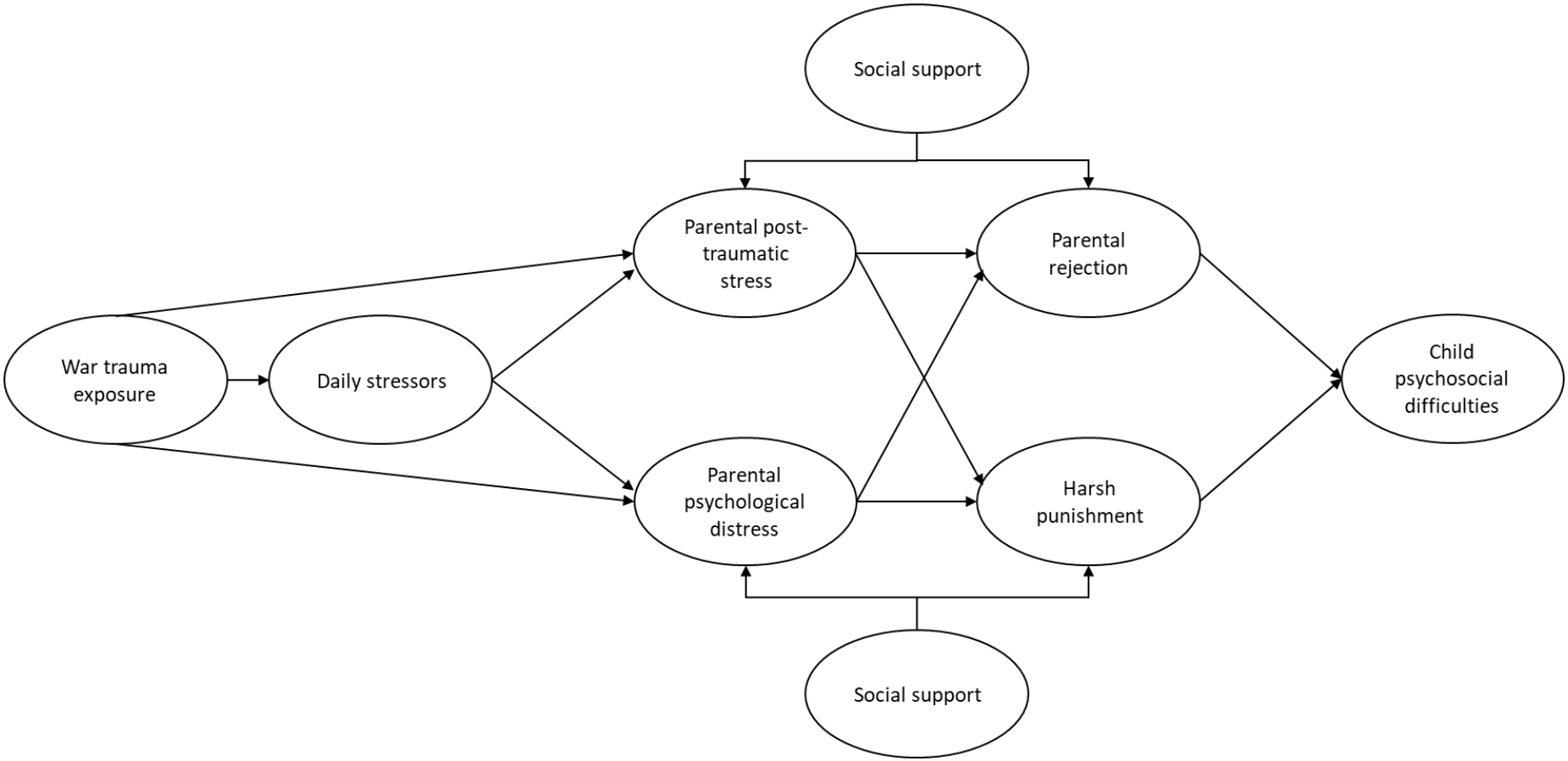
c. Associations between different dimensions of parental mental health and negative parenting behaviour, namely parental rejection and harsh punishment;

d. Negative parenting as a mediator of the relationship between parental and child psychosocial outcomes; and,

e. The relationship between social support and psychological and parenting resilience to war trauma.

In developing and testing this integrative model of the intergenerational impact of war, the thesis brings together disparate bodies of research including the mental health impacts of war and displacement, the relationship between parental mental health and parenting, and the effects of poor parental mental health and negative parenting on child outcomes. Integration of this literature from war as well as non-war settings serves to illuminate the complex pathways through which conflict and displacement affect child psychosocial adjustment.

**Figure 2. Conceptual model of the intergenerational impact of war focusing on the pathways linking trauma exposure, daily stressors, and parental mental health to parenting behaviour and child psychosocial adjustment**



*1.6 References*

Ajduković, M., Rajter, M., & Rezo, I. (2018). Individual and contextual factors for the child abuse potential of Croatian mothers: The role of social support in times of economic hardship. *Child Abuse & Neglect, 78*, 60–70.

Attanayake, V., McKay, R., Joffres, M., Singh, S., Burkle, F., & Mills, E. (2009). Prevalence of mental disorders among children exposed to war: a systematic review of 7,920 children. *Medicine, Conflict and Survival*, *25*(1), 4–19.

Auerbach, R. P., Bigda-Peyton, J. S., Eberhart, N. K., Webb, C. A., & Ho, M.-H. R. (2011). Conceptualizing the Prospective Relationship Between Social Support, Stress, and Depressive Symptoms Among Adolescents. *Journal of Abnormal Child Psychology*, *39*(4), 475–487.

Avinun, R., & Knafo, A. (2013). The Longitudinal Israeli Study of Twins (LIST)—An Integrative View of Social Development. *Twin Research and Human Genetics*, *16*(1), 197–201.

Banyard, V. L., Williams, L. M., & Siegel, J. A. (2003). The Impact of Complex Trauma and Depression on Parenting: An Exploration of Mediating Risk and Protective Factors. *Child Maltreatment*, *8*(4), 334–349.

Belsky, J. (1984). The Determinants of Parenting: A Process Model. *Child Development*, *55*(1), 83–96.

Belsky, J., Bakermans-Kranenburg, M. J., & van IJzendoorn, M. H. (2007). For Better and For Worse: Differential Susceptibility to Environmental Influences. *Current Directions in Psychological Science*, *16*(6), 300–304.

Betancourt, T. S., Borisova, I. I., Williams, T. P., Brennan, R. T., Whitfield, T. H., De La Soudiere, M., … Gilman, S. E. (2010). Sierra Leone's Former Child Soldiers: A Follow-Up Study of Psychosocial Adjustment and Community Reintegration: Sierra Leone's Former Child Soldiers. *Child Development*, *81*(4), 1077–1095.

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

Betancourt, T. S., McBain, R. K., Newnham, E. A., & Brennan, R. T. (2015). The intergenerational impact of war: longitudinal relationships between caregiver and child mental health in postconflict Sierra Leone. *Journal of Child Psychology and Psychiatry*, *56*(10), 1101–1107.

Bogic, M., Njoku, A., & Priebe, S. (2015). Long-term mental health of war-refugees: a systematic literature review. *BMC International Health and Human Rights*, *15*(1).

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, *32*(7), 513.

Bronstein, I., & Montgomery, P. (2011). Psychological Distress in Refugee Children: A Systematic Review. *Clinical Child and Family Psychology Review*, *14*(1), 44–56.

Bryant, R. A., Edwards, B., Creamer, M., O'Donnell, M., Forbes, D., Felmingham, K. L., … McFarlane, A. C. (2018). The effect of post-traumatic stress disorder on refugees' parenting and their children's mental health: a cohort study. *The Lancet Public Health*, *3*(5), e249–e258.

Card, N. A., & Barnett, M. A. (2015). Methodological Considerations in Studying Individual and Family Resilience: Methodological Considerations. *Family Relations*, *64*(1), 120–133.

Caspi, A. (2003). Influence of Life Stress on Depression: Moderation by a Polymorphism in the 5-HTT Gene. *Science*, *301*(5631), 386–389.

Catani, C., Jacob, N., Schauer, E., Kohila, M., & Neuner, F. (2008). Family violence, war, and natural disasters: A study of the effect of extreme stress on children's mental health in Sri Lanka. *BMC Psychiatry*, *8*(1).

Ceballo, R., & McLoyd, V. C. (2002). Social support and parenting in poor, dangerous neighborhoods. *Child Development*, *73*(4), 1310–1321.

Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective Disorders*, *82*(2), 217–225.

Chen, W., Hall, B. J., Ling, L., & Renzaho, A. M. (2017). Pre-migration and post-migration factors associated with mental health in humanitarian migrants in Australia and the moderation effect of post-migration stressors: findings from the first wave data of the BNLA cohort study. *The Lancet Psychiatry*, *4*(3), 218–229.

Cicchetti, D., & Garmezy, N. (1993). Prospects and promises in the study of resilience. *Development and Psychopathology*, *5*(4), 497–502.

Cohen, L. R., Hien, D. A., & Batchelder, S. (2008). The Impact of Cumulative Maternal Trauma and Diagnosis on Parenting Behavior. *Child Maltreatment*, *13*(1), 27–38.

Cohen, S., & Hoberman, H. M. (1983). Positive Events and Social Supports as Buffers.pdf. *Journal of Applied Social Psychology*, *13*(2), 99–125.

Collishaw, S., Hammerton, G., Mahedy, L., Sellers, R., Owen, M. J., Craddock, N., … Thapar, A. (2016). Mental health resilience in the adolescent offspring of parents with depression: a prospective longitudinal study. *The Lancet Psychiatry*, *3*(1), 49–57.

Conger, R. D., Ge, X., Elder, G. H., Lorenz, F. O., & Simons, R. L. (1994). Economic Stress, Coercive Family Process, and Developmental Problems of Adolescents. *Child Development*, *65*(2), 541.

Crnic, K. A., Greenberg, M. T., Robinson, N. M., & Ragozin, A. S. (1984). Maternal stress and social support: Effects on the mother-infant relationship from birth to eighteen months. *American Journal of Orthopsychiatry*, *54*(2), 224–235.

Danieli, Y. (1998). *International handbook of multigenerational legacies of trauma*. New York: Plenum Press.

De Haene, L., Grietens, H., & Verschueren, K. (2010). Adult attachment in the context of refugee traumatisation: the impact of organized violence and forced separation on parental states of mind regarding attachment. *Attachment & Human Development*, *12*(3), 249–264.

Dekel, R., & Goldblatt, H. (2008). Is there intergenerational transmission of trauma? The case of combat veterans' children. *American Journal of Orthopsychiatry*, *78*(3), 281–289.

Dumka, L. E., Roosa, M. W., & Jackson, K. M. (1997). Risk, Conflict, Mothers' Parenting, and Children's Adjustment in Low-Income, Mexican Immigrant, and Mexican American Families. *Journal of Marriage and the Family*, *59*(2), 309.

Elder, G. H., & Caspi, A. (1988). Economic Stress in Lives: Developmental Perspectives. *Journal of Social Issues*, *44*(4), 25–45.

Ell, K. (1984). Social networks, social support, and health status: a review. *Social Service Review*, *58*(1), 133–149.

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

Ford, D. H., & Lerner, R. M. (1992). *Developmental systems theory: An integrative approach*. Thousand Oaks, CA: SAGE Publications.

Fraser, M. W., Galinsky, M., & Richman, J. M. (1999). Risk, protection, and resilience: Toward a conceptual framework for social work practice. *Social Work Research*, *23*(3), 131.

Fraser, M. W., & Terzian, M. A. (2005). Risk and resilience in child development: Principles and strategies of practice. In *Child Welfare for the Twenty-First Century: A Handbook of Practices, Policies and Programs*. Columbia University Press.

Garbarino, J., & Sherman, D. (1980). High-Risk Neighborhoods and High-Risk Families: The Human Ecology of Child Maltreatment. *Child Development*, *51*(1), 188.

Gavidia-Payne, S., Denny, B., Davis, K., Francis, A., & Jackson, M. (2015). Parental resilience: A neglected construct in resilience research: Parental resilience: A neglected construct. *Clinical Psychologist*, *19*(3), 111–121.

Gershoff, E. T., Aber, J. L., Raver, C. C., & Lennon, M. C. (2007). Income Is Not Enough: Incorporating Material Hardship Into Models of Income Associations With Parenting and Child Development. *Child Development*, *78*(1), 70–95.

Gewirtz, A. H., Polusny, M. A., DeGarmo, D. S., Khaylis, A., & Erbes, C. R. (2010). Posttraumatic stress symptoms among National Guard soldiers deployed to Iraq:

Associations with parenting behaviors and couple adjustment. *Journal of Consulting and Clinical Psychology*, *78*(5), 599–610.

Glass, N., Kohli, A., Surkan, P. J., Remy, M. M., & Perrin, N. (2018). The relationship between parent mental health and intimate partner violence on adolescent behavior, stigma and school attendance in families in rural Democratic Republic of Congo. *Global Mental Health*, *5*.

Goodman, S. H., & Gotlib, I. H. (Eds.). (2002). *Children of depressed parents: Mechanisms of risk and implications for treatment.* Washington: American Psychological Association. Retrieved from http://content.apa.org/books/10449-000

Green, B. L., Furrer, C., & McAllister, C. (2007). How Do Relationships Support Parenting? Effects of Attachment Style and Social Support on Parenting Behavior in an At-Risk Population. *American Journal of Community Psychology*, *40*(1–2), 96–108.

Halevi, G., Djalovski, A., Vengrober, A., & Feldman, R. (2016). Risk and resilience trajectories in war-exposed children across the first decade of life. *Journal of Child Psychology and Psychiatry*, *57*(10), 1183–1193.

Hammen, C. (1997). Children of depressed parents. In *Handbook of children's coping* (pp. 131–157). Boston, MA: Springer.

Hammen, C. (2006). Stress generation in depression: Reflections on origins, research, and future directions. *Journal of Clinical Psychology*, *62*(9), 1065–1082.

Hinton, D. E., Rasmussen, A., Nou, L., Pollack, M. H., & Good, M.-J. (2009). Anger, PTSD, and the nuclear family: A study of Cambodian refugees. *Social Science & Medicine*, *69*(9), 1387–1394.

Jaffee, S. R., Bowes, L., Ouellet-Morin, I., Fisher, H. L., Moffitt, T. E., Merrick, M. T., & Arseneault, L. (2013). Safe, Stable, Nurturing Relationships Break the Intergenerational Cycle of Abuse: A Prospective Nationally Representative Cohort of Children in the United Kingdom. *Journal of Adolescent Health*, *53*(4), S4–S10.

Jordans, M. J. D., Semrau, M., Thornicroft, G., & van Ommeren, M. (2012). Role of current perceived needs in explaining the association between past trauma exposure and distress in humanitarian settings in Jordan and Nepal. *The British Journal of Psychiatry*, *201*(4), 276–281.

Kandemir, H., Karataş, H., Çeri, V., Solmaz, F., Kandemir, S. B., & Solmaz, A. (2018). Prevalence of war-related adverse events, depression and anxiety among Syrian refugee children settled in Turkey. *European Child & Adolescent Psychiatry*.

Klahr, A. M., & Burt, S. A. (2014). Elucidating the etiology of individual differences in parenting: A meta-analysis of behavioral genetic research. *Psychological Bulletin*, *140*(2), 544–586.

Klebanov, P. K., Brooks-Gunn, J., & Duncan, G. J. (1994). Does Neighborhood and Family Poverty Affect Mothers' Parenting, Mental Health, and Social Support? *Journal of Marriage and the Family*, *56*(2), 441.

Kotchick, B. A., Dorsey, S., & Heller, L. (2005). Predictors of parenting among African American single mothers: Personal and contextual factors. *Journal of Marriage and Family*, *67*(2), 448–460.

Lansford, J. E., Sharma, C., Malone, P. S., Woodlief, D., Dodge, K. A., Oburu, P., … Di Giunta, L. (2014). Corporal Punishment, Maternal Warmth, and Child Adjustment: A Longitudinal Study in Eight Countries. *Journal of Clinical Child & Adolescent Psychology*, *43*(4), 670–685.

Laskey, B. J., & Cartwright-Hatton, S. (2009). Parental discipline behaviours and beliefs about their child: associations with child internalizing and mediation relationships. *Child: Care, Health and Development*, *35*(5), 717–727.

Lee, C.-Y. S., Anderson, J. R., Horowitz, J. L., & August, G. J. (2009). Family income and parenting: The role of parental depression and social support. *Family Relations*, *58*(4), 417–430.

Lerner, R. M., Rothbaum, F., Boulos, S., & Castellino, D. R. (2002). Developmental Systems Perspective on Parenting. In *Handbook of parenting* (2nd ed, pp. 315–344). Mahwah, N.J: Erlbaum.

Lerner, R. M. (2006). Resilience as an Attribute of the Developmental System: Comments on the Papers of Professors Masten & Wachs. *Annals of the New York Academy of Sciences*, *1094*(1), 40–51.

Leventhal, T., & Brooks-Gunn, J. (2000). The neighborhoods they live in: The effects of neighborhood residence on child and adolescent outcomes. *Psychological Bulletin*, *126*(2), 309–337.

Lovejoy, M. C., Graczyk, P. A., O'Hare, E., & Neuman, G. (2000). Maternal depression and parenting behavior: A meta-analytic review. *Clinical Psychology Review*, *20*(5), 561–592.

Lustig, S. L., Kia-Keating, M., Knight, W. G., Geltman, P., Ellis, H., Kinzie, J. D., … Saxe, G. N. (2004). Review of child and adolescent refugee mental health. *Journal of the American Academy of Child & Adolescent Psychiatry*, *43*(1), 24–36.

Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, *71*(3), 543–562.

Luthar, S. S., Sawyer, J. A., & Brown, P. J. (2006). Conceptual Issues in Studies of Resilience: Past, Present, and Future Research. *Annals of the New York Academy of Sciences*, *1094*(1), 105–115.

Masten, A. S. (1994). Resilience in individual development: Successful adaptation despite risk and adversity. In *Educational resilience in inner-city America: Challenges and prospects* (pp. 45–72). Hillsdale, NJ: Erlbaum.

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, *56*(3), 227–238.

Masten, A. S. (2015). *Ordinary Magic: Resilience in Development*. New York: Guilford Press.

Masten, A. S., & Cicchetti, D. (2010). Developmental cascades. *Development and Psychopathology*, *22*(3), 491–495.

Masten, A. S., & Cicchetti, D. (2015). Resilience in development: Progress and transformation. In *Developmental Psychopathology* (3rd ed., Vol. 4: Risk, Resilience and Intervention, pp. 271–333). New York: Wiley.

McLoyd, V. C. (1990). The Impact of Economic Hardship on Black Families and Children: Psychological Distress, Parenting, and Socioemotional Development. *Child Development*, *61*(2), 311.

Mercy Corps. (n.d.). One mother to another, Syrian refugees learn to cope. Retrieved May 22, 2018, from https://www.mercycorps.org/articles/lebanon-syria/one-mother-another-syrian-refugees-learn-cope

Meyer, S. R., Steinhaus, M., Bangirana, C., Onyango-Mangen, P., & Stark, L. (2017). The influence of caregiver depression on adolescent mental health outcomes: findings from refugee settlements in Uganda. *BMC Psychiatry*, *17*(1).

Miller, K. E., & Jordans, M. J. D. (2016). Determinants of Children's Mental Health in War-Torn Settings: Translating Research Into Action. *Current Psychiatry Reports*, *18*(6).

Miller, K. E., & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. *Social Science & Medicine*, *70*(1), 7–16.

Morris, A., Gabert-Quillen, C., & Delahanty, D. (2012). The Association Between Parent PTSD/Depression Symptoms and Child PTSD Symptoms: A Meta-Analysis. *Journal of Pediatric Psychology*, *37*(10), 1076–1088.

Murphy, K. M., Rodrigues, K., Costigan, J., & Annan, J. (2017). Raising children in conflict: An integrative model of parenting in war. *Peace and Conflict: Journal of Peace Psychology*, *23*(1), 46–57.

Neuner, F. (2010). Assisting war-torn populations – Should we prioritize reducing daily stressors to improve mental health? Comment on Miller and Rasmussen (2010). *Social Science & Medicine*, *71*(8), 1381–1384.

Panter-Brick, C., Dajani, R., Eggerman, M., Hermosilla, S., Sancilio, A., & Ager, A. (2018). Insecurity, distress and mental health: experimental and randomized controlled trials of a psychosocial intervention for youth affected by the Syrian crisis. *Journal of Child Psychology and Psychiatry*, *59*(5), 523-541.

Panter-Brick, C., Goodman, A., Tol, W., & Eggerman, M. (2011). Mental health and childhood adversities: a longitudinal study in Kabul, Afghanistan. *Journal of the American Academy of Child & Adolescent Psychiatry*, *50*(4), 349–363.

Panter-Brick, C., Grimon, M.-P., & Eggerman, M. (2014). Caregiver-child mental health: a prospective study in conflict and refugee settings. *Journal of Child Psychology and Psychiatry*, *55*(4), 313–327.

Patterson, G. R. (1982). *Coercive Family Process* (Vol. 3). Chicago: Castaglia Publishing Company.

Paulussen-Hoogeboom, M. C., Stams, G. J. J. M., Hermanns, J. M. A., & Peetsma, T. T. D. (2007). Child negative emotionality and parenting from infancy to preschool: A meta-analytic review. *Developmental Psychology*, *43*(2), 438–453.

Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: a meta-analysis. *JAMA*, *294*(5), 602–612.

Putnick, D. L., Bornstein, M. H., Lansford, J. E., Malone, P. S., Pastorelli, C., Skinner, A. T., … Oburu, P. (2015). Perceived mother and father acceptance-rejection predict four unique aspects of child adjustment across nine countries. *Journal of Child Psychology and Psychiatry*, *56*(8), 923–932.

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.

Rees, S., Thorpe, R., Tol, W., Fonseca, M., & Silove, D. (2015). Testing a cycle of family violence model in conflict-affected, low-income countries: A qualitative study from Timor-Leste. *Social Science & Medicine, 130*, 284–291.

Rosenheck, R., & Fontana, A. (1998). Transgenerational effects of abusive violence on the children of Vietnam combat veterans. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies, 11*(4), 731–742.

Rosenheck, R., & Nathan, P. (1985). Secondary traumatization in children of Vietnam veterans. *Hospital & Community Psychiatry, 36*(5).

Rothbart, M. K., Ahadi, S. A., & Evans, D. E. (2000). Temperament and personality: Origins and outcomes. *Journal of Personality and Social Psychology, 78*(1), 122–135.

Rueger, S. Y., Malecki, C. K., Pyun, Y., Aycock, C., & Coyle, S. (2016). A meta-analytic review of the association between perceived social support and depression in childhood and adolescence. *Psychological Bulletin, 142*(10), 1017–1067.

Ruscio, A. M., Weathers, F. W., King, L. A., & King, D. W. (2002). Male war-zone veterans' perceived relationships with their children: The importance of emotional numbing. *Journal of Traumatic Stress, 15*(5), 351–357.

Rutter, M. (1985). Resilience in the Face of Adversity: Protective Factors and Resistance to Psychiatric Disorder. *The British Journal of Psychiatry, 147*(6), 598–611.

Rutter, M., Tizard, J., Yule, W., Graham, P., & Whitmore, K. (1976). Isle of Wight studies, 1964-1974. *Psychological Medicine, 6*(2), 313–332.

Saile, R., Ertl, V., Neuner, F., & Catani, C. (2014). Does war contribute to family violence against children? Findings from a two-generational multi-informant study in Northern Uganda. *Child Abuse & Neglect, 38*(1), 135–146.

Sameroff, A. J. (2000). Dialectical processes in developmental psychopathology. In *Handbook of developmental psychopathology* (2nd ed., pp. 23–40). New York: Kluwer Academic/Plenum Publishers.

Sameroff, A. J., & Fiese, B. H. (2000). Transactional regulation: The developmental ecology of early intervention. In *Handbook of early childhood intervention* (pp. 135–159). Cambridge: Cambridge University Press.

Singla, D. R., Kumbakumba, E., & Aboud, F. E. (2015). Effects of a parenting intervention to address maternal psychological wellbeing and child development and growth in rural Uganda: a community-based, cluster-randomised trial. *The Lancet Global Health*, *3*(8), e458–e469.

Sirin, S. R., & Rogers-Sirin, L. (2015). *Educational and Mental Health Needs of Syrian Refugee Children*. Washington, DC: Migration Policy Institute.

Slone, M., & Mann, S. (2016). Effects of War, Terrorism and Armed Conflict on Young Children: A Systematic Review. *Child Psychiatry & Human Development*, *47*(6), 950–965.

Smokowski, P. R. (1998). Prevention and Intervention Strategies for Promoting Resilience in Disadvantaged Children. *Social Service Review*, *72*(3), 337–364.

Sriskandarajah, V., Neuner, F., & Catani, C. (2015). Parental care protects traumatized Sri Lankan children from internalizing behavior problems. *BMC Psychiatry*, *15*(1).

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & Van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *JAMA*, *302*(5), 537–549.

Taraban, L., & Shaw, D. S. (2018). Parenting in context: Revisiting Belsky's classic process of parenting model in early childhood. *Developmental Review, 48*, 55–81.

Tekeli-Yesil, S., Isik, E., Unal, Y., Aljomaa Almossa, F., Konsuk Unlu, H., & Aker, A. T. (2018). Determinants of Mental Disorders in Syrian Refugees in Turkey Versus Internally Displaced Persons in Syria. *American Journal of Public Health*, *108*(7), 938–945.

Thabet, A. A., Ibraheem, A. N., Shivram, R., Winter, E. A., & Vostanis, P. (2009). Parenting Support and PTSD in Children of a War Zone. *International Journal of Social Psychiatry*, *55*(3), 226–237.

Thompson, R. A., Flood, M. F., & Goodvin, R. (2006). Social support and developmental psychopathology. In *Developmental Psychopathology* (pp. 1–37). Hoboken, New Jersey: John Wiley & Sons.

Timshel, I., Montgomery, E., & Dalgaard, N. T. (2017). A systematic review of risk and protective factors associated with family related violence in refugee families. *Child Abuse & Neglect*, *70*, 315–330.

Tol, W. A., Song, S., & Jordans, M. J. D. (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.

Tracy, M., Salo, M., & Appleton, A. A. (2018). The mitigating effects of maternal social support and paternal involvement on the intergenerational transmission of violence. *Child Abuse & Neglect*, *78*, 46–59.

Trentacosta, C. J., Hyde, L. W., Shaw, D. S., Dishion, T. J., Gardner, F., & Wilson, M. (2008). The relations among cumulative risk, parenting, and behavior problems during early childhood. *Journal of Child Psychology and Psychiatry*, *49*(11).

United Nations High Commissioner for Refugees. (2018a). *Global Trends: Forced Displacement in 2017*. Geneva.

United Nations High Commissioner for Refugees. (2018b). Syria Regional Refugee Response. Retrieved July 10, 2018, from http:// data.unhcr.org/syrianrefugees/regional.php#_ga=2. 87672475.2089617872.1497030295–2087191681. 1489940027.

United Nations Office for the Coordination of Humanitarian Affairs. (2018, February). Syrian Arab Republic. Retrieved February 13, 2018, from http://www.unocha.org/syria.

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

van Ee, E., Sleijpen, M., Kleber, R. J., & Jongmans, M. J. (2013). Father-Involvement in a Refugee Sample: Relations between Posttraumatic Stress and Caregiving. *Family Process*, *52*(4), 723–735.

Van Ijzendoorn, M. H., Bakermans-Kranenburg, M. J., & Sagi-Schwartz, A. (2003). Are children of Holocaust survivors less well-adapted? A meta-analytic investigation of secondary traumatization. *Journal of Traumatic Stress*, *16*(5), 459–469.

Werner, E. E. (2012). Children and war: Risk, resilience, and recovery. *Development and Psychopathology*, *24*(2), 553–558.

Werner, E. E., & Smith, R. S. (1982). *Vulnerable but invincible: a longitudinal study of resilient children and youth*. New York: McGraw-Hill.

Wilson, S., & Durbin, C. E. (2010). Effects of paternal depression on fathers' parenting behaviors: A meta-analytic review. *Clinical Psychology Review*, *30*(2), 167–180.

Wyman, P. A., Cowen, E. L., Work, W. C., Hoyt-Meyers, L., Magnus, K. B., & Fagen, D. B. (1999). Caregiving and developmental factors differentiating young at-risk urban children showing resilient versus stress-affected outcomes: A replication and extension. *Child Development*, *70*(3), 645–659.

Yeung, W. J., Linver, M. R., & Brooks-Gunn, J. (2002). How Money Matters for Young Children's Development: Parental Investment and Family Processes. *Child Development*, *73*(6), 1861–1879.

# CHAPTER II. OVERVIEW OF THESIS METHODOLOGY

## *2.1 Mixed methods*

The overall methodology of this thesis is underpinned by a mixed methods approach. The recency of the Syrian refugee crisis, and the challenges of conducting research in countries affected by the crisis, means that rigorous empirical research with this population remains nascent. There is emerging data on the prevalence of war trauma exposure and mental disorders among Syrian refugees (Aoun, Joundi, & El Gerges, 2018; Eruyar, Maltby, & Vostanis, 2018; Kandemir et al., 2018; Tekeli-Yesil et al., 2018). However, little is known about links to parenting and child psychosocial adjustment. While there is growing evidence of the intergenerational effects of war from research conducted in other conflict settings, the mechanisms underlying these effects remain largely unexplored.

The mixed methods approach is particularly useful when examining phenomena or processes in a new or under-researched population or context, as it affords "multiple ways of seeing and hearing" (Greene, 2007, p. 20). By combining both qualitative and quantitative methods in a strategic, sequential manner, we are able to develop and test a conceptual model that is based not only on extant theory and research, but also on the perceptions, opinions, and lived experiences of refugees themselves. Creswell and Clark (2007) describe six major mixed methods designs that can be employed depending on the objectives of the study: convergent parallel; explanatory sequential; exploratory sequential; embedded; transformative; and multi-phase. This thesis uses the exploratory sequential design, which consists of two phases or components: first, qualitative data collection and analysis to identify emerging themes and questions, followed by quantitative data collection to test hypotheses resulting from the qualitative

phase (Creswell & Clark, 2007). The intent of the two-phase design is that the results of the first, qualitative component can inform the development of the second, quantitative component. For example, this design is often used to develop and test a new instrument, or in the case of this thesis, to identify important variables to examine quantitatively in relation to other constructs in a model. The final stage of the design involves analysis of how the qualitative and quantitative strands build on each other to enhance interpretation of results and ultimately contribute to emergent theory.

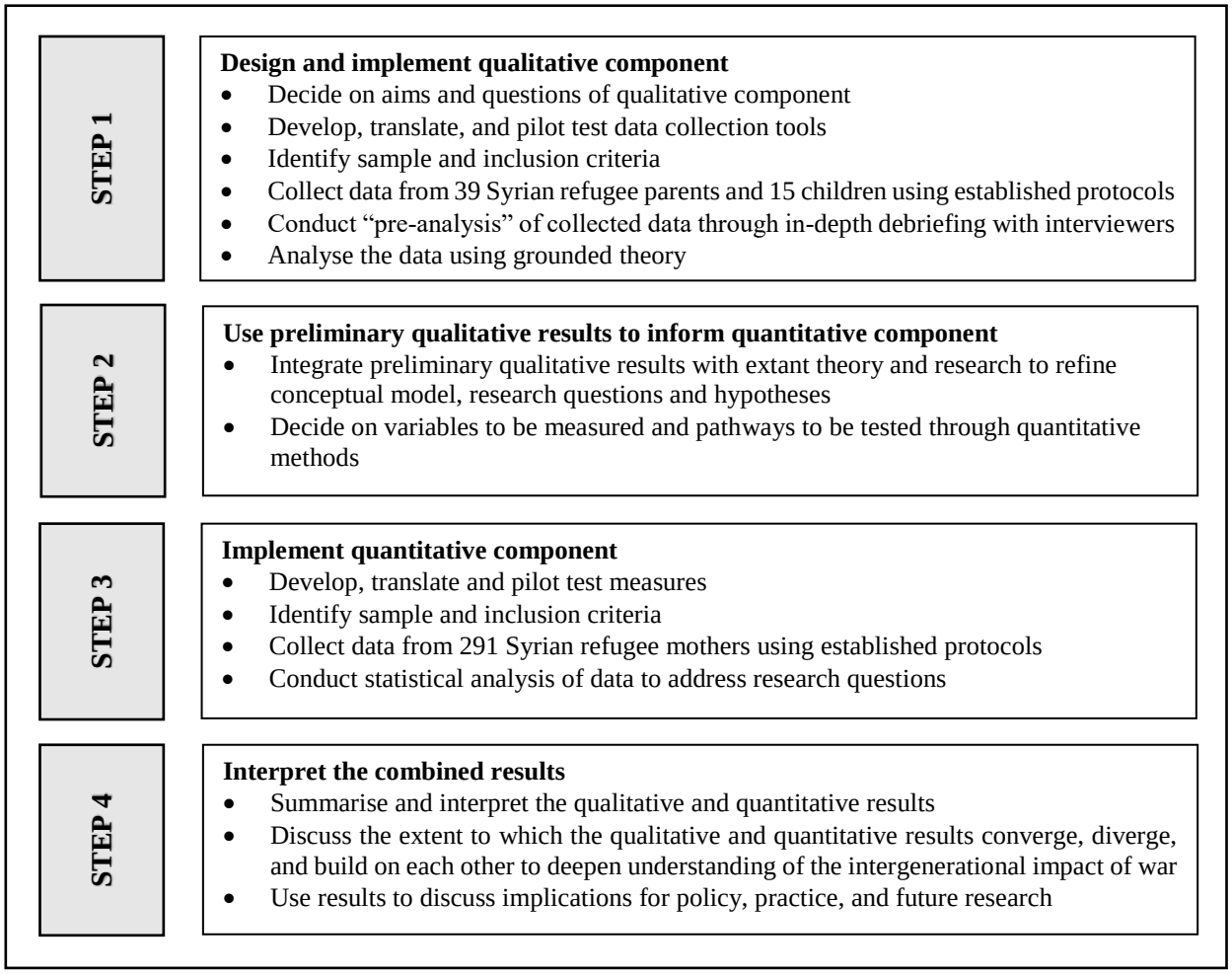
The exploratory sequential design was selected for the thesis because there is currently no published research on the determinants of parenting among Syrian refugees that could complement the use of theory in formulating relevant research questions and hypotheses. Beginning the study with a broad qualitative inquiry into the parenting behaviours of Syrian refugees, and the risk and protective factors influencing those behaviours, would help to generate research questions that are informed by the lived experiences of Syrian parents and children, as well as by theory and research from other conflict settings. This model is referred to as the "theory-development variant" of the exploratory sequential design, as the qualitative phase is used to identify variables and relationships between variables that can then be tested through quantitative methods (Creswell & Clark, 2007).

As the exploratory sequential design begins qualitatively, Creswell and colleagues (2003) suggest that it is best suited to exploring a phenomenon. The philosophical assumptions behind this design shifts from one phase to another. During the first, qualitative phase, constructivist principles dominate as multiple perspectives and the lived experience of a phenomenon are prioritised. After moving to the second, quantitative phase, the underlying assumptions shift to post-positivism to identify and measure variables using statistical methods. Thus, as stated by Creswell & Clark,

"multiple worldviews are used in this design, and the worldviews shift from one phase to the other phase" (2007, p. 87).

Figure 3 summarises how the exploratory sequential design was used to address the research questions posed in this thesis. First, the design starts with the collection and analysis of qualitative data from Syrian refugee families to explore *from their perspectives* how the experience of war and displacement affected and continues to affect parenting and parent-child relationships. The second step is the point of interface between the qualitative and quantitative methods, in which results from the qualitative phase are used to identify the variables and pathways to be tested in the emergent conceptual model. In the third step, quantitative methods are used to test the model and related research questions with a new sample of participants. Finally, as presented in the Discussion chapter, there is an analysis of the ways in which the qualitative and quantitative results interact with and build on each other to contribute to an integrated, contextualised understanding of the intergenerational impact of war.

**Figure 3. Exploratory sequential design as implemented in this thesis** (adapted from Creswell & Clark, 2007)




In the exploratory sequential design, qualitative data analysis should be completed before the quantitative phase begins. However, funding and programmatic constraints encountered during the course of the thesis resulted in more overlap between Steps 1, 2, and 3 in Figure 3 than intended, making the research design a combination of concurrent and sequential in practice. Collection of survey data for the quantitative component was tied to the baseline assessment of the IRC's parenting intervention, which had to begin by August 2016 due to funding and programme implementation timelines. Transcription and translation of the qualitative data, however, were only completed several months later, thus precluding a thorough analysis of the data to

inform the development of the quantitative component, as envisioned in Step 2 of the research design. In order to accommodate the time constraints while still maintaining the integrity of the sequential design to the extent possible, a "pre-analysis" was conducted consisting of detailed debriefings with interviewers. After each day of data collection during the qualitative phase, I conducted in-depth debriefing sessions in which the interviewers and note-takers consulted their notes to summarise participant responses to each question. Together, the group engaged in a collaborative process of identifying emerging themes, points of contradiction or disagreement, as well as questions for further exploration through subsequent focus groups and interviews. This strategy of conducting field-based group analysis of qualitative data to identify and select priority issues for exploration through subsequent rounds of data collection was adapted from a methodology developed by the Applied Mental Health Research Group at the Johns Hopkins Bloomberg School of Public Health. Examples of studies that have used this methodology include Betancourt et al. (2011) and Meyer et al. (2013).

Initial themes from the preliminary analysis of the qualitative data included: emphasis on displacement-related daily stressors such as poverty and lack of legal documentation; elevated levels of parental stress; long work hours for low pay resulting in parental fatigue, stress and reduced parent-child interaction; change in gender and economic roles due to the entry of mothers into the workforce; lack of safe recreational spaces for children resulting in increased frustration and aggression among both children and parents; increase in child behaviour problems such as aggression; increase in harsh parenting; and, relative economic security and social support as potential sources of resilience. These preliminary findings, combined with extant theory and empirical research from other conflict settings, informed the development of research questions and hypotheses to be explored through the quantitative component of the

study. These included: the relative contribution of past war trauma and current displacement-related stressors to parental mental health and parenting behaviour; dimensions of parental mental health beyond post-traumatic stress; the role of parenting behaviour in mediating associations between parental and child mental health; and, social support as a source of parental resilience.

*2.2 Model building*

The primary aim of the thesis is to develop and test an empirically-based conceptual model of the intergenerational impact of war. The analytic approaches for both the qualitative and quantitative components, therefore, are explicitly geared towards model-building. In the qualitative component of the research design, grounded theory is the methodological approach informing data collection, analysis, and interpretation. In grounded theory, the aim from the outset is to construct middle-range theories that are derived from the data themselves (Charmaz, 2006). Empirical data, rather than *ex ante* theoretical frameworks or hypotheses, form the foundation of the resulting model, and analysis of these data generates the concepts constructed as part of the model. Grounded theory is used in the qualitative component of this thesis because of its explicit goal of model-building and its emic perspective, particularly necessary in this study setting given the scarcity of research on parenting among Syrian refugees to date. In particular, this thesis adopts the position advocated by Charmaz, which states that neither data nor theories are "discovered." Rather, any theoretical rendering offers an interpretive, constructed portrayal of the studied world rather than an exact picture of it (Charmaz, 2006).

Results from the qualitative component, combined with the extant literature reviewed in Chapter 1, formed the foundation of the conceptual model depicted in

Figure 2. Structural equation modelling (SEM) is the main data analytic technique used in the quantitative component of the research to examine the hypothesised model and pattern of relationships among constructs. Moving away from the constructivist, phenomenological perspective of the qualitative component to a post-positivist stance in the quantitative component, SEM techniques were applied to the measurement of constructs, assessment of fit of the hypothesised model, and estimation of path coefficients. While the qualitative and quantitative components of the thesis adopt different epistemological stances and methods, both share an overall objective of modelling the processes that link the experience of war to child and family-level outcomes.

### *2.3 Operationalising resilience*

As described in the literature review in Chapter 1, the concept of resilience has gained increasing prominence among scholars and practitioners seeking to shift from a deficit-based to a strengths-based approach to understanding and promoting children's adaptation to adversity. How to define, operationalise, and measure resilience was a key methodological question that was carefully considered in this thesis. As Luthar and colleagues (2000) describe, the study of resilience has been challenged by varying definitions of key terms, conflation of concepts, inconsistent use of terminology, and substantial differences in the operationalisation and measurement of key constructs. One key issue is the distinction between main effect models and interactive models, also known as promotive and protective effects respectively. Each model asks a different question about resilience processes and outcomes. The main effect model asks, among high-risk individuals, what distinguishes those who do well from those who do less well? The interaction model, on the other hand, seeks to detect moderating effects, asking, what attributes or factors are associated with positive outcomes at high, but not

necessarily at low, levels of risk? In early conceptualisations of resilience, the term "protective" was reserved only for effects involving interactions – in other words, when the protective effect was only evident or more evident in conditions of high risk versus low risk. However, the term protective factor has since been used interchangeably to refer to main effects and moderating effects, resulting in confusion around the exact mechanism under investigation (Luthar et al., 2006).

In this thesis, the term "promotive" is used to refer to within-group main effects, while "protective" refers to an interaction effect in which a particular factor or set of factors moderates the effect of adversity among high-risk, but not low-risk groups. When results are generated from examination of main effects, they can be relatively robust, with effect sizes as high as 10-20% (Luthar et al., 2000). However, studies seeking to detect interaction effects tend to produce small (2-5%), unstable effects that are highly impacted by sample size and poor reliability of measured variables, thus leading some researchers to caution against the reliance on statistical interactions to operationalise resilience (Card & Barnett, 2015). Furthermore, Luthar et al. (2006) argue for more *within-group* analyses with discrete groups of individuals at risk in order to illuminate what makes a difference for *those* individuals, rather than whether certain factors matter more for a particular group compared to other groups. Examining the factors and processes that underlie resilience among individuals from specific backgrounds with unique social, economic, political, and cultural challenges will better enable the design of intervention strategies to promote positive adaption to risk (Luthar et al., 2006).

Another conceptual and methodological issue concerns the domain-specificity of resilience, and how to evaluate adaptive functioning across different domains. Judgments of resilience often vary depending on the outcome measure, so that a child

may exhibit positive adaptation in the domain of academic achievement, but struggle with social relationships with peers (Cicchetti & Garmezy, 1993). Instead of overall resilience, then, it would be more useful to discuss specific domains of positive adaption, such as academic resilience or emotional resilience, thereby acknowledging that individuals may exhibit resilience in certain domains but not others.

Furthermore, the evaluation of resilience may vary according to develomental stage and sociocultural context. As Masten (1994, p. 19) noted: “Resilience implies a qualitative evaluation of functioning based substantially on normative expectations for adaptations that vary according to age and environmental context. The markers of good psychosocial development, developmental tasks, change as a function of age and vary across culture.” For example, in studies conducted in Western, industralised societies, adaptation is often judged based on the performance of developmental tasks such as academic achievement and peer acceptance, and measured using standardised instruments with norms and cut-points established from prior research with an equivalent population of children. One approach to operationalising resilience, referred to as the person-centred or categorical approach, then uses such cut points to classify subsets of individuals as "resilient" or "non-resilient." For example, Jaffee and colleagues (2007) categorised resilient children as those whose teacher-reported antisocial behaviour problems fell within the “normal range” for similarly-aged and same-sexed children.

A dilemma arises, however, when operationalising resilience in a study population for whom validated norms and cut points do not exist. In the context of the Syrian refugee crisis, what constitutes positive adaptation to risk in the domains of maternal mental health and parenting? The residual approach, as employed by Kim-Cohen et al. (2004), Bowes et al. (2010), and Collishaw et al. (2016) among others,

provides a potentially useful method for operationalising resilience without imposing arbitrary cut points on data from under-researched populations. This method derives a measure of resilience by regressing the selected outcome on risk exposure, and coding the residual scores so that positive residual scores indicate resilience, or fewer than expected problems given level of risk exposure. For example, a study of genetic and environmental contributions to children's resilience to socio-economic deprivation measured the continuum from resilience to vulnerability using the difference between children's actual score on an outcome (either antisocial behaviour or IQ) and the score predicted by their level of deprivation (Kim-Cohen et al., 2004). Thus, children whose actual IQ score was higher than their predicted score had a positive residual reflecting resilience, and children whose actual IQ was lower than their predicted score had a negative residual reflecting vulnerability. This approach allows researchers to examine why some individuals have better or worse outcomes taking into account the level of risk they experience, and has the added advantage of modelling variability in risk exposure, promotive factors, and outcomes as continua (Card & Barnett, 2015).

This thesis uses the residual approach to investigate a model of parental resilience in which the risk factor is exposure to war trauma, the outcomes are maternal psychological distress and harsh parenting, and the promotive factor is mothers' perceived social support. Resilience is defined as *better than expected outcomes given level of risk exposure*, and social support is the variable examined for its hypothesised role in promoting psychological and parenting resilience among this highly vulnerable refugee population. As discussed in the Introduction, social support was selected because of its salience in the displacement context, its potential modifiability, and its growing prominence as a target of intervention in refugee settings. Social support also emerged in the qualitative findings as a potential source of resilience for refugee

parents, illustrating how the sequential mixed methods design served to identify variables and questions for further investigation through quantitative methods.

*2.4 Study setting*

The war in Syria has produced a humanitarian crisis of devastating proportions. The United Nations estimates that over half of Syria's 22 million pre-war population has been displaced (UNOCHA, 2018). Approximately half of the Syrian refugee population is under the age of 18 and 40% are under the age of 12, highlighting the risk of potentially severe and lifelong harm to the psychosocial wellbeing and development of an entire generation of Syrian children (Sirin & Rogers-Sirin, 2015). Lebanon hosts the highest number of refugees per capita in the world, with one in six people living as a refugee (UNHCR, 2018). As of August 2018, there were 976,002 Syrian refugees registered with the United Nations High Commissioner for Refugees (UNHCR) in Lebanon, (UNHCR, 2018). This number does not include refugees waiting to be registered since the Government of Lebanon instructed UNHCR to suspend refugee registrations in May 2015. Lebanon is located in the Middle East and bordered by the Mediterranean Sea to the west, Syria to the north and east, and Israel to the south. The country was engulfed in a civil war from 1975 to 1990 that resulted in an estimated 250,000 casualties and the exodus of almost one million people. Today, the fragile peace in Lebanon is threatened by a paralysed political system and the state's weakening ability to provide basic services (International Crisis Group, 2015). Lebanon is not a signatory to the 1951 Refugee Convention or its 1967 Protocol. Consequently, all procedures for entering and remaining in the country are based on local law and regulations.

**Figure 4. Map of Lebanon** (UNOCHA, 2011)




Map Sources: OCHA, SDATL, UNCS.
*The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.* Map created in June 2011.

While Lebanon had previously maintained an open-door policy for Syrian refugees, in January 2015 the Government of Lebanon established restrictive border policies, followed by a freeze on registering refugees with the UNHCR (UNHCR, UNICEF & WFP, 2017). In particular, the government issued onerous regulations governing the renewal of residency permits, including payment of an annual fee of US$200, provision of certified copies of a lease agreement, and proof of financial support. As most refugee are unable to afford the fee and cannot provide the necessary supporting documentation, many have lapsed residency visas and are subject to arrest or detention (Human Rights Watch, 2016). According to the 2017 Vulnerability Assessment of Syrian Refugees in Lebanon, an annual representative survey of

registered Syrian refugee households, 74% of Syrian refugees aged 15 and above do not have legal residency (UNHCR et al., 2017).

The same household survey suggests that Syrian refugees in Lebanon are becoming increasingly vulnerable on a range of economic, social, and health indicators. Refugees are spending less every year, reporting per capita monthly expenditures of US$ 98, a drop of US$ 6 compared to 2016 and US$ 9 since 2015. Three-quarters of refugee households were living under the poverty line in 2017, and 77% of refugee households reported having experienced a lack of food or lack of money to buy food during the 30 days prior to the survey. Two thirds of Syrian refugees reported adopting crisis and emergency coping strategies, such as selling household goods or withdrawing children from school. In 2017, the primary school completion rate among Syrian refugee children was only 11%. Unlike in neighbouring host countries such as Jordan, there are no official refugee camps for Syrians in Lebanon, and refugees are dispersed in local communities throughout the country. In 2017, 73% of refugee households lived in residential buildings, 17% occupied improvised shelters in informal tented settlements, and 9% lived in non-residential structures, such as garages, farms and shops.

Recently, there have been several published studies of mental health problems among Syrian refugees in the Middle East region which give some indication of prevalence and severity. For example, data from a random sample of 450 Syrian refugees living in North Lebanon and aged between 14 and 45 years showed that 47.3% reported three or more PTSD symptoms (Aoun et al., 2018). A non-probability cross-sectional survey of 286 adult Syrian refugees in Turkey estimated that 65% had major depressive disorder, 29.8% had PTSD, and 38.8% had generalised anxiety disorder (Tekeli-Yesil et al., 2018). Studies with Syrian refugee children and youth report

similarly high rates of mental health disturbance. A cross-sectional study with 273 Syrian refugee parent-child dyads in Turkey reported that 50.2% of children scored above the clinical cut-off for the likelihood of suffering from PTSD, while 24% were rated by their parents as falling in the 'high' to 'very high' range of the SDQ total difficulties scale (Eruyar et al., 2018). Baseline data from a randomised controlled trial of a psychosocial intervention for 817 Syrian refugee and Jordanian youth found that 44% had scores predictive of PTS (Panter-Brick et al., 2018). Other studies also suggest other mental health symptoms such as depression and anxiety among Syrian refugee children. For example, a survey of 355 Syrian children in Turkey reported that 47.9% had symptoms of clinical depression, and 53.2% of clinical anxiety, with over a quarter of children reporting symptom scores suggestive of comorbid depression and anxiety disorders (Kandemir et al., 2018).

Findings from the 2017 Vulnerability Assessment of Syrian Refugees in Lebanon suggest that the majority of Syrian children experience violent discipline. As reported by the head of household, 78% of children under 18 were subjected to harsh physical or verbal discipline, including yelling and shouting (54%), spanking (31%), slapping the child on the hand, arm or leg (28%) or face (12%), shaking the child (19%), and hitting the child's body with an implement (8.2%) (UNHCR et al., 2017). Non-violent, positive discipline strategies were also reported, with 60% explaining why the behaviour was wrong, 40% taking away privileges, and 26% giving the child something else to do. Interestingly, when asked if they believed that physical punishment was necessary to bring up a child properly, only one in four heads of households agreed, suggesting that there may be a potential entry point for interventions to change parenting attitudes and behaviours.

*2.5 Participants*

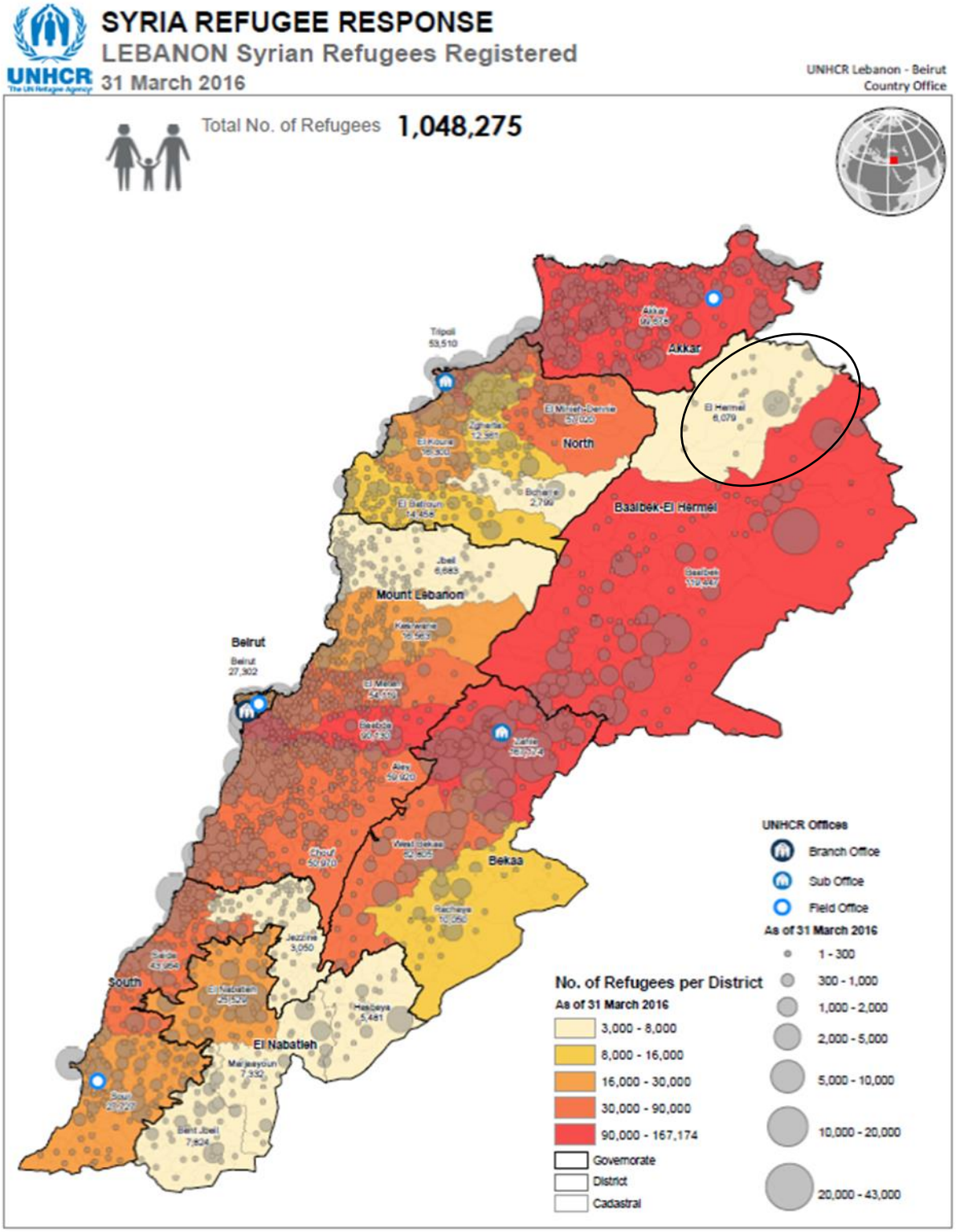
Study participants were Syrian refugee parents and children displaced in Lebanon. In both the qualitative and quantitative phases, participants were recruited by local staff from the IRC's Child Protection and Women's Protection and Empowerment programmes. Staff used existing strategies for recruiting refugees into programme activities, including: community outreach meetings in refugee settlements and shelters; parent-teacher meetings at schools; home visits; and, referrals by teachers, health workers, community leaders, and community volunteers.

*Qualitative phase*

Data collection for the qualitative component of the thesis was conducted in the northern district of Hermel in April and November 2016 (see Figure 5). The partner organisation has an established child protection programme in Hermel, thereby enabling staff to recruit participants and conduct data collection. Furthermore, Hermel was deemed by IRC security personnel to be a secure location for a foreign researcher to visit, which was essential for training staff and monitoring data collection activities.

Inclusion criteria for caregivers in the qualitative phase included: at least 18 years of age; parent or primary caregiver to at least one child aged 2 to 9 years; of Syrian origin; and currently displaced to Lebanon as a result of the war. As one of the objectives of the study was to inform recommendations for the IRC's parenting intervention, which targeted caregivers of children aged 2 to 9 years, this criterion was also used for the qualitative study. Children aged between eight and 12 years were eligible for inclusion based on previous field experience suggesting difficulty engaging younger children in focus group discussions.

**Figure 5. Map of registered Syrian refugees in Lebanon with qualitative data collection site Hermel circled** (UNHCR, 2016)



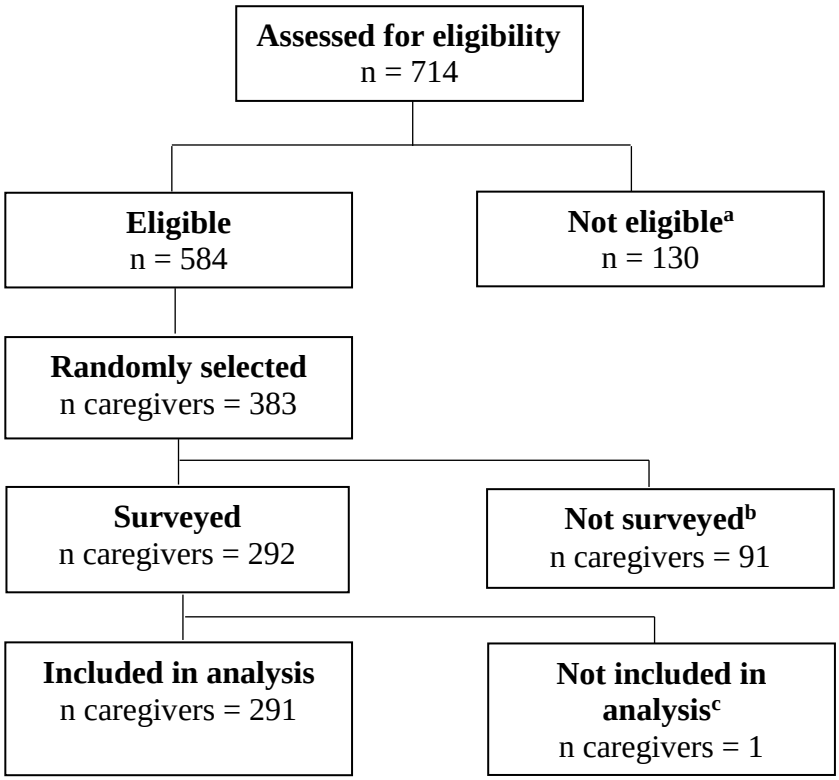
In total, the qualitative component of the study included four focus groups with mothers and fathers (n=29), two focus groups with children (n=15), and ten individual interviews with parents. Adult participants ranged in age from 18 to 60, with a mean age of 31.3 years. Approximately half of the participants were female. All participants were married and the number of children per household ranged from one to five. The majority of adult participants had some primary school education (74.4%) and were engaged in paid work (69.2%), almost all as day labourers. Approximately 72% of participants were living in rented apartments with the remainder in informal tented settlements. The mean age of child participants was 9.2 years and half were female. All child participants, with one exception, were reported by parents to be their biological children. At the time of data collection, the length of displacement in Lebanon ranged from six to 59 months, with an average of 42.2 months.

*Quantitative phase*

Data collection for the quantitative component of the thesis began in August 2016 and ended in May 2017. IRC field staff used existing strategies to recruit caregivers, including: community outreach meetings in refugee settlements and shelters; parent-teacher meetings at schools; home visits; and, referrals by teachers, health workers, community leaders, and community volunteers. Caregivers were recruited to participate in the IRC's parenting skills intervention, a 10-week programme aimed at increasing positive parenting practices, reducing harsh punishment, and improving caregiver and child psychosocial wellbeing. Prior to starting the programme, caregivers participated in a baseline survey assessing past war trauma exposure, current daily stressors, mental health symptoms, parenting behaviour, and child psychosocial problems. The field team consisted of 16 female and two male interviewers from the IRC's children's and women's protection programs in the survey sites. Surveys were administered in Arabic

at the IRC office or the participant's home using the application Open Data Kit (ODK) on electronic tablets. Survey data were used for the quantitative analyses reported in DPhil Papers 2 and 3 of this thesis.

**Figure 6. Survey Participant Flow Chart**




[a] Did not consent (n=10); did not have child in the eligible age range (n=120).

[b] Already participated in parenting programme (n=14); could not locate or staff did not have sufficient time to interview (n= 77).

[c] Only 1 male caregiver in the sample so data not included in analysis.

Figure 6 depicts the flow of participants through the study. IRC field staff assessed a total of 714 caregivers for eligibility based on the following inclusion criteria: at least 18 years old; of Syrian origin and currently displaced to Lebanon as a result of the war; and parent or primary caregiver to a child aged 2 to 12 years (the target population for IRC's parenting programme). Of the 584 caregivers who were

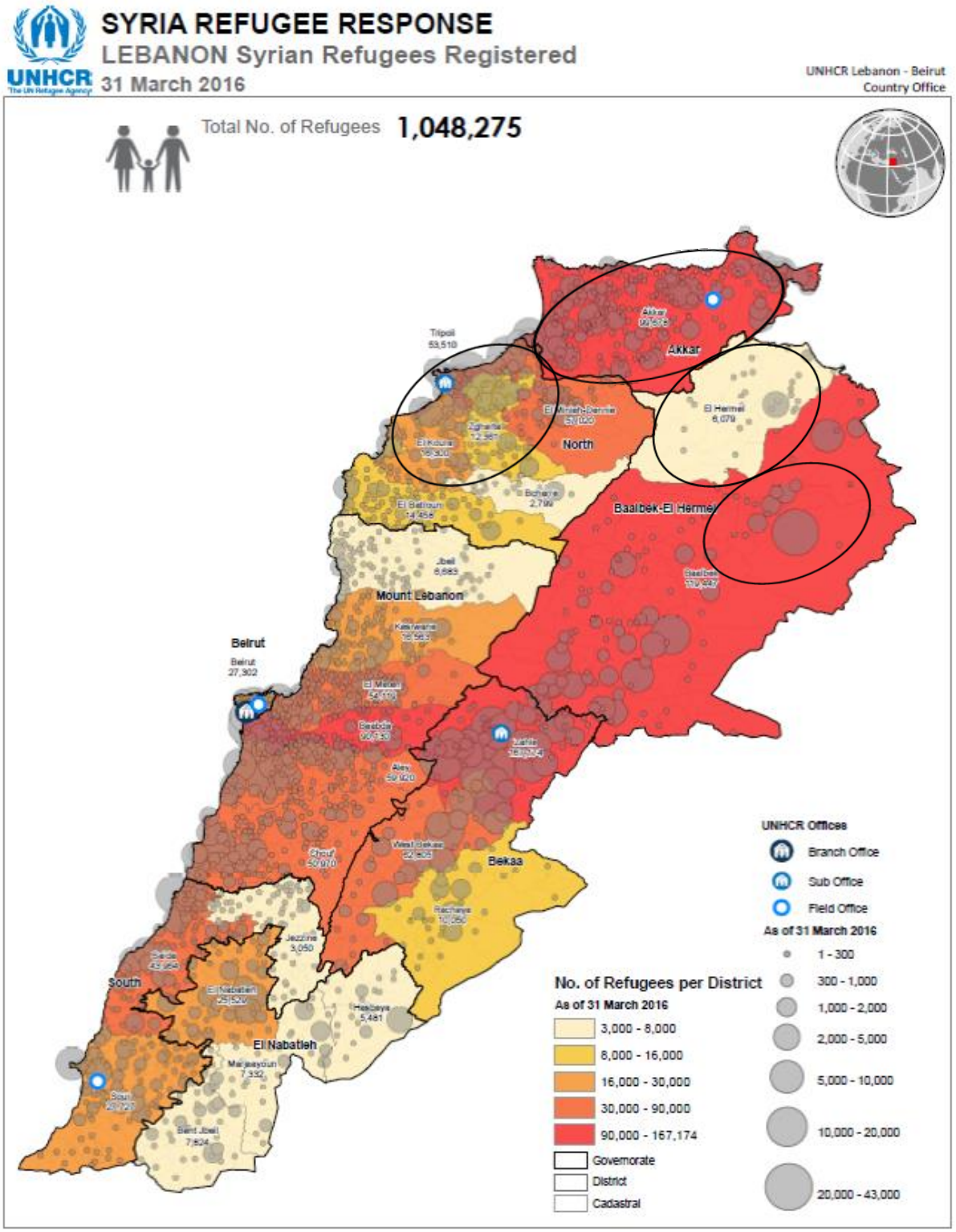
eligible for inclusion, I randomly selected 383 caregivers to participate in the survey. It was necessary to select only a subsample of eligible caregivers due to field staff having limited time to devote to data collection. Of the 383 caregivers who were randomly selected, a total of 292 were surveyed. The remaining 91 caregivers were not surveyed either because they had previously participated in the parenting programme, could not be located, or staff did not have sufficient time to contact and interview them. Based on feedback from field staff, there did not appear to be any systematic bias influencing which caregivers were ultimately surveyed (e.g. caregivers who were not surveyed were particularly vulnerable, resistant, or hard-to-reach). It is possible, however, that those who were not located and interviewed had particular characteristics that differentiated them from the survey sample. Further discussion of the limitations of the sample can be found in section 2.12.

In total, 291 mothers and one father participated in the survey. Since there was only one male participant, his data were not included in the analysis in order to make it clear that results pertain to Syrian refuge mothers only. The original design of the quantitative component had also included surveys with children aged 8 to 12 years, who could then provide an additional source of data on their mothers' parenting behaviour and their own emotional and behavioural symptoms. Hence, if the caregiver had more than one child aged 8 to 12 years, I used an online random number generator to randomly select one child to be the index child (i.e. the child about whom the caregiver reported their own parenting behaviour and the child's psychosocial adjustment), *and* to participate in the survey. If the caregiver participant did not have a child aged 8 to 12 years, I randomly selected a child aged 2 to 7 years to serve as the index child only. However, the subsample of children aged 8 to 12 years (n=88) proved too small to

conduct any meaningful analysis. Thus, only data reported by mothers were used in the analysis.

The survey was conducted in four regions of Lebanon with a large Syrian refugee presence: Arsal, Akkar, Hermel, and Tripoli (see Figure 7 for a map of survey sites). At the time of data collection, mothers had been displaced in Lebanon an average of 2 to 3 years. The mean age of mothers was 31.83 years (SD = 8.18) and 53% had completed secondary school. On average, participants had three children under the age of 18. The mean age of the index child was 7.4 years, and almost half were female (46.4%). The majority of participants (69.1%) lived in substandard housing defined as improvised shelters in informal tented settlements, one-room structures, and converted or commercial spaces, and 73% lived in overcrowded conditions (i.e. more than 3 persons residing in a room). Only 12% of participants had worked for income in the last 30 days, and almost half (47.1%) did not have a working member of the household. Participants reported lacking food or money to buy food an average of 13.73 days (SD = 7.87) days in the previous month. War-related trauma exposure averaged 7.21 events (SD = 3.48), with witnessing bombardment or explosion most commonly reported.

**Figure 7. Map of registered Syrian refugees in Lebanon with quantitative data collection sites circled** (UNHCR, 2016)



*2.6 Cross-cultural measurement*

There is a longstanding debate between proponents of a universalistic view of mental health, which posits that concepts, categories, and criteria for psychiatric disorders can be universally applied across cultures, and those who advocate a relativistic view emphasising the importance of social and cultural factors in shaping the experience and expression of distress (Canino & Alegria, 2008; Kirmayer, 1989). Scholars of transcultural psychiatry and medical anthropology, in particular, have critiqued the "global mental health" movement for the application of essentially Western biomedical models of mental illness to non-Western settings without adequate attention to the socially and culturally determined nature of mental health (Kirmayer & Pedersen, 2014). The extent to which PTSD is a universal and cross-culturally valid psychiatric response to trauma, versus a political and social invention of the West, is one particularly virulent example of this debate (Summerfield, 2001; Kienzler, 2008).

This debate is essential to methodological considerations around cross-cultural measurement of mental health and parenting, particularly when conducting research with populations for which validated measures and established norms do not yet exist. While standardised measures are useful in aiding comparability across studies, uncritical use of measures that have not been validated with a particular social or cultural group may fail to capture local idioms of distress (Bass, Bolton & Murray, 2007). For example, most Arabic and Syrian idioms of distress do not separate somatic experience and psychological symptoms, because body and soul are interlinked in explanatory models of illness (Hassan et al., 2015). Cross-cultural measurement is particularly challenging when attempting to assess such culturally-specific constructs as parenting and resilience (Panter-Brick, 2015). Recognition of the importance and challenge of culturally-informed mental health assessment has spawned a whole

subarea of research devoted to local validation of existing instruments, or the development of new instruments for specific contexts or populations (Betancourt et al., 2012; Hall et al., 2014; Panter-Brick et al., 2018). For example, Bolton and colleagues from the Applied Mental Health Research Group at Johns Hopkins University have developed a methodology for local validation of standard mental health instruments, which consists of qualitative research to identify local syndromes and symptoms of distress, selecting and adapting the most relevant standard instrument, and testing its local validity through a community-based survey (Bolton, Wilk & Ndogoni, 2004).

While the validation, or where necessary, creation of new measures for the Syrian refugee population would have been ideal, it was not possible to do so within the constraints of this DPhil project. Instead, an extensive review of existing measures was conducted to identify and select instruments that have been validated in similar contexts (e.g. refugee populations in other countries; Arabic-speaking immigrants), or successfully administered in multi-country studies representing different social and cultural groups. For example, the Parental Acceptance and Rejection Questionnaire (PARQ), which was selected for use in this research, had been used in an eight-country study of parenting behaviour and child adjustment problems, including in Jordan, Kenya, China, and Thailand (Lansford et al., 2014). In order to avoid ad-hoc translations of the measures, Arabic versions were obtained either from the original developers of the instrument, or from researchers and practitioners who had previously validated or administered the Arabic version in the field. The entire battery of measures underwent an extensive process of field-testing with interviewers and members of the study population, with minor clarifications made to the translations until the field team reached consensus on accuracy and comprehensibility of all the items. In order to help respondents understand and respond to questionnaire items, interviewers used a

pictorial aid (circles of increasing size to depict Likert scale response options) that has been successfully used in previous studies among low-income, conflict-affected populations (Puffer et al., 2015; Annan, Sim, Puffer, Salhi & Betancourt, 2016).

The strategies described above were employed to maximise the local relevance and applicability of selected measures. However, in the absence of local validity testing, it is not possible to know if the measures have adequate psychometric properties beyond internal consistency (e.g. test-retest reliability, criterion validity) when applied to this population, or if there are culturally-specific parenting practices or local idioms of distress that are not captured by these measures. This limitation of the study is further described in Section 2.12.

### *2.7 Overview of measures*

Below is a summary of the measures used in the quantitative component of the study, specifically the survey of Syrian refugee mothers.

#### *Socio-demographic information*

Items to obtain socio-demographic information about the participant and her household (e.g. age, number of household members, legal status, employment status, type of shelter) were drawn from the Vulnerability Assessment of Syrian Refugees in Lebanon, a representative survey of Syrian refugee households conducted annually by the UN (UNHCR et al., 2017).

#### *War trauma exposure*

The Traumatic Events Checklist, adapted from the Harvard Trauma Questionnaire and Gaza Traumatic Event Checklist for use in conflict settings, was

used to measure exposure to war-related trauma. The measure contains 17 yes/no items such as “Been forcibly separated from your family” and “Been severely beaten.” The Arabic translation was obtained from the principal investigator of a randomised controlled trial for a psychosocial intervention for Syrian refugee youth in Jordan (Panter-Brick et al., 2018).

*Displacement-related daily stressors*

The Humanitarian Emergency Settings Perceived Needs Scale (HESPER) was used to measure displacement-related stressors (World Health Organization & King's College London, 2011). HESPER consists of 26 items assessing the perceived physical, social, and psychological needs of the general adult population in humanitarian settings. Examples of need items include: “Do you have a serious problem because you do not have an adequate place to live in?” and “Do you have a serious problem because your children are not in school or are not getting a good enough education?” In the original measure, ratings are made for each need item according to unmet need (or serious problem; ‘1’ rating) and no need (or no serious problem; ‘0’ rating). For this study, a 3-point scale was used to increase sensitivity. The Arabic version of HESPER was validated with Iraqi refugees in Jordan and demonstrated excellent interrater reliability (ICC for total number of unmet needs was 0.998), test–retest reliability (ICC, absolute agreement, for total number of unmet needs was 0.961), and internal consistency (Cronbach’s alpha was 0.89) (Jordans et al., 2012). In this study, the Cronbach’s alpha was 0.89.

For this study, one item (‘Do you have a serious problem because you have been displaced from your home country, city or village?’) was omitted as all participants have been displaced. An additional item related to legal status, also included in the

Jordans et al. (2012) study with Iraqi refugees in Jordan, was included based on initial qualitative findings suggesting lack of legal documentation as a significant source of stress among Syrian refugees in Lebanon. The Arabic version of HESPER was obtained from the World Health Organization for use in this study.

*Maternal mental health*

The Post Traumatic Stress Disorder (PTSD) Checklist – Civilian Version (Weathers et al., 1993) was used to assess symptoms of post-traumatic stress among Syrian mothers. It comprises 17 items corresponding to the key symptoms of PTSD and asks respondents to indicate how much they have been bothered by a symptom using a 5-point Likert scale ranging from 1 "Not at all" to 5 "Extremely." In this study, the Cronbach's alpha was 0.89. The Arabic translation of this measure was obtained from the International Medical Corps (IMC), a medical organisation currently using this measure in Lebanon.

The Depression Anxiety and Stress Scale (DASS-21) Short Form was used to assess mothers' general psychological distress (Lovibond & Lovibond, 1995). This 21-item version of the DASS uses 7 items for each subscale of depression, anxiety and stress, which are scored by summing and doubling the score for each subscale. Respondents use a 4-point severity/frequency scale to report the extent to which they experienced each state in the past week. The Arabic language version of the original 42-item measure was previously validated with Arabic-speaking immigrants to Australia (Moussa, Lovibond, Laube, & Megahead, 2016). Moussa and colleagues provided the Arabic translation for use in this study. Cronbach's alpha for DASS-21 was 0.91.

*Negative parenting behaviour*

The Parental Acceptance Rejection Questionnaire (PARQ) examines four areas of parental behaviour: warmth/affection, hostility/aggression, indifference/neglect, and undifferentiated rejection (Rohner & Khaleque, 2008). The study used the short version of PARQ which contains 24 items. Positive items were reverse-coded to achieve an overall measure of parental rejection, with Cronbach's alpha of 0.79. In a nine-country study (including Jordan) by Putnick et al. (2015), internal consistency reliabilities across all countries ranged from .75 to .81 for mother and father reports. An Arabic version of PARQ has also been used in a study of Arab Israeli parents with Cronbach's alpha coefficients of .69–.90 for the subscales (Lavi & Slone 2012). The author of PARQ provided an Arabic translation for use in this study.

The Discipline Module of UNICEF's Multiple Indicator Cluster Survey was used to assess discipline practices (UNICEF, 2016). The MICS has been implemented in over 100 countries, and the Discipline Module was recently administered as part of a representative household survey of Syrian refugees in Lebanon (UNHCR et al., 2017). It consists of 11 items relating to caregivers' behaviours in three domains: non-violent discipline, harsh verbal punishment, and physical punishment. An additional item asks if the respondent believes it is necessary to use physical punishment to raise the child properly. This study used a Likert scale assessing frequency of each behaviour in the past 30 days. Only the 8 items on verbal and physical punishment were used to assess mother's use of harsh punishment in the analyses for this thesis, with Cronbach's alpha of 0.78. The Arabic version of the Discipline Module was obtained from UNICEF.

*Social support*

The modified Medical Outcomes Study Social Support Survey (mMOS-SS) was used to assess mothers' perceived social support (Sherbourne & Stewart, 1991). The original 19 item-version covers four domains (emotional/informational support, tangible or instrumental support, positive social interaction, and affection). This study used the 8-item modified version which has two subscales covering the domains of emotional and instrumental social support. Cronbach's alpha in this study was 0.88 for the 8-item measure, and 0.83 and 0.85 for the emotional and instrumental support subscales respectively.

A validity study conducted with data from patients in the United States found that the psychometric properties of the 8-item mMOS-SS were excellent and similar to those of the original measure (Moser, Stuck, Silliman, Ganz, & Clough-Gorr, 2012). As there was no Arabic version of the measure, bilingual staff at the IRC in Lebanon performed a translation and back-translation of the items.

*Child psychosocial difficulties*

The Strengths and Difficulties Questionnaire (SDQ) was used to assess maternal report of child psychosocial difficulties (Goodman, 1997). The SDQ consists of 25 items and 5 subscales: emotional symptoms, conduct problems, hyperactivity-inattention, peer problems, and prosocial behaviour. Each item is scored on a 3-point scale (0 = not true, 1 = somewhat true, and 2 = certainly true). The Arabic version of the SDQ has been validated for use in epidemiological and clinical studies (Alyahri & Goodman, 2006). In this study, the Cronbach's alpha for the 20 items assessing emotional and behavioural problems was 0.68.

*2.8 Sample size calculation*

In order to ensure that the sample for the quantitative component of the study would be sufficient for conducting SEM, a sample size calculation was performed *a priori* using an online sample size calculator for structural equation models (http://www.danielsoper.com/statcalc/calculator.aspx?id=89). The following parameter values were used in the calculation: anticipated effect size: 0.20; desired statistical power level: 0.80; number of latent variables: 5; number of observed variables: 13; probability level: 0.05. The anticipated effect size of 0.20 was based on Huang et al.'s (2016) structural equation model of the association among parental depression, parenting and child functioning, which reported coefficients of 0.16 and 0.30 for the effect of depression on corporal punishment and harsh/inconsistent discipline respectively. Calculations indicated a minimum sample size of 268 for assessing the model structure and fit.

In order to estimate the sample size required for detecting specific mediated effects within the overall model, estimates for the bias-corrected bootstrap test by Fritz & MacKinnon (2007) were used as reference. The bias-corrected bootstrap test involves repeated random sampling from the original data and estimating the indirect effect to form a bootstrap distribution, while correcting for any skew in the data (Efron & Tibshirani, 1993). Based on estimates for achieving 0.8 power in the bias-corrected bootstrap test, a sample of 148 participants is required to detect a mediated effect where the *a* and *b* paths both equal 0.26 (Fritz & MacKinnon, 2007). While there is limited research on which to base estimates of mediated effects, studies examining the role of displacement stressors in mediating the association between trauma exposure and distress (e.g. Jordans et al., 2012) have found that the size of the *a* and *b* paths were

0.52 and 0.60 respectively. The final sample size of 291 caregivers in the quantitative phase would thus be adequate for fitting the structural model and conducting mediation analysis.

### *2.9 Partnership*

Data collection for this thesis was conducted in partnership with the IRC, an international humanitarian organisation founded in 1933 to respond to the needs of communities affected by conflict and natural disaster. The IRC has been operational in Lebanon since 2012 and delivers a wide range of services to Syrian refugees, including cash assistance, vocational and life skills training, case management for survivors of gender-based violence, and psychosocial support for caregivers, children, and youth. Prior to starting the DPhil programme, I worked with the IRC in multiple humanitarian settings including Afghanistan, Liberia, and Ethiopia, and thus had an in-depth understanding of the challenges of fieldwork and a well-established relationship with IRC leadership and field staff.

A team of 18 field staff from the IRC's Child Protection and Women's Protection and Empowerment programmes in Lebanon conducted participant recruitment and data collection. All field staff were fluent in Arabic and had prior experience recruiting Syrian refugee caregivers into the IRC's parenting intervention, and collecting pre/post survey data using mobile devices. As staff were already actively engaged in psychosocial and protection activities with Syrian refugees, they had previously received extensive training on child protection and case management, and had experience working in a volatile security context. Prior to beginning fieldwork, I conducted several in-person trainings with field staff covering topics including research ethics, confidentiality, informed consent, interview techniques, data collection

procedures, and reporting and management of adverse events. I also maintained a close working relationship with IRC leadership and technical staff within the Lebanon country office as well as at headquarters in London and New York to ensure organisational support of the project. Feedback from IRC staff at all levels was instrumental to the development of research questions and data collection tools, as well as dissemination of results within Lebanon and internationally to maximise relevance to policy and programmatic issues.

*2.10 Data management and security*

In order to ensure high quality data and minimise the risk of adverse events, I worked with IRC field staff to develop comprehensive data collection, management, and security protocols. The IRC Monitoring & Evaluation (M&E) Officer based in Beirut acted as the primary liaison for monitoring adherence to the protocols, and to identify and help resolve questions or issues that arose during the course of data collection. The M&E Officer was also the focal point for field staff to report any adverse events such as disclosures of abuse, participant distress, or breaches in study protocol. During the course of the project, I conducted daily debriefings with the M&E Officer to monitor the progress of data collection and to quickly identify any concerns with staff or participant welfare.

The application Open Data Kit (ODK) was used to conduct electronic data collection for the quantitative component of the study. ODK is a free and open-source set of tools that enables users to build a survey, collect the data on a mobile device and send it to a server, and aggregate the collected data on a server and extract it for analysis (Hartung et al., 2010). The IRC in Lebanon has been using ODK to collect participant data since 2015. ODK is also the platform of choice for the annual refugee household

survey conducted by UN agencies (UNHCR et al., 2017). The use of electronic devices for data collection in humanitarian settings has become increasingly popular due to advantages such as elimination of manual data entry and related errors (Falb et al., 2016). Mobile data collection also facilitates real-time data verification as data can be uploaded to the online server on a daily basis, ensuring that problems are quickly identified and resolved.

Data were sent to an online server hosted by Zoho Corporation, a technology company in California that provides a suite of online productivity tools and software for businesses. Zoho was already being used by the IRC to manage and store participant data. Zoho servers and infrastructure are located in secure data centres that have multiple levels of restrictions for access. Zoho also employs state of the art firewall protection on multiple levels eliminating the possibility of intrusion from outside attacks, and anti-virus software that scans for suspicious traffic and viruses. Zoho performs regular vulnerability testing and all data is backed up on multiple servers in multiple locations on a daily basis.

In order to closely monitor data quality and adherence to data collection protocols, I conducted a daily review of the data sent to the online server to identify systematic errors (e.g. non-functioning skip patterns, illogical responses) and make corrections to the data collection forms if necessary. I also maintained daily telephone or email contact with the IRC M&E Officer throughout the study to provide specific feedback on data quality, discuss action points to improve data quality (e.g. refresher trainings for specific enumerators), and receive reports of any adverse events.

In addition, the following procedures were implemented to ensure data security. Electronic tablets used for data collection were password-protected. When not in use,

tablets were securely stored at the IRC offices in the various data colletion sites with access only by designated IRC staff. Field staff uploaded data to the online server at the end of each day of data collection when they returned to the IRC office in their field site and connected to the secure IRC wireless network. Once the data were uploaded to the online server, they were automatically deleted from the tablet, thereby ensuring limited participant data on the tablet in the event that it was lost or stolen. Access to data on the online server was password-protected and limited to designated personnel only (myself, the IRC M&E Officer, and the IRC Technology & Innovation Officer). I exported data from the online server to a password-protected folder on a daily basis. Backups were made on a weekly basis to the University of Oxford HFS backup and archive service.

### *2.11 Ethical and safety considerations*

Given the vulnerability of the participants and the volatile security conditions in the study setting, ethical and safety considerations were paramount in designing and implementing the research. A review of guidelines and resources informed the development of procedures for informed consent, confidentiality, and data collection and management, paying particular attention to ethical concerns related to conducting research in conflict settings (Child Protection Monitoring and Evaluation Reference Group, 2012; Ford, Mills, Zachariah, & Upshur, 2009; International Society for the Prevention of Child Abuse and Neglect, 2016; Morrow, 2013). The following section provides an overview of the main ethical and safety issues considered in designing and completing the research for this thesis, and the strategies used to address those issues.

*Informed consent*

Given the vulnerable status of the study population, particular attention was paid to informed consent procedures and training. Field staff read aloud from a script explaining in detail the purpose and procedures of the study, emphasising that participation was voluntary and not linked in any way to receiving assistance from the IRC or any other humanitarian organisation. For the qualitative phase of the research, staff obtained written consent from adult participants. If the participant had a child aged 8 to 12 years, staff also obtained written parental consent before meeting with the child separately to obtain verbal assent. For the quantitative phase, participants were given the option of participating in the parenting programme but not the survey, and vice versa. Participants who agreed to be surveyed gave verbal consent to staff, who noted their consent in writing. Interviewers were trained to remind participants before and during the interview that they could stop at any time or choose not to answer any question without repercussions. Interviewers were also trained to look for non-verbal cues of participant discomfort and to ask if the participant would like to pause, skip a question, or stop the interview.

*Breach of confidentiality*

There is often a risk that confidential participant information may be exposed due to loss or theft of documents or devices containing data, or lack of privacy at the interview site. In order to minimise such risks, identifying information such as names and phone numbers were recorded and stored separately so that individual participants could not be linked to survey data. Data were linked to individuals using a unique participant code, which I assigned. Audio recordings from the focus groups and interviews were saved onto the password-protected computer of the IRC M&E Officer,

then immediately deleted from the digital recorders. Transcription and translation of the focus group and interview data were performed by a professional contractor in Beirut who signed a confidentiality agreement detailing data management and security protocols as part of their business contract.

In order to minimise breach of confidentiality due to lack of privacy at the interview location, interviews were conducted at the IRC office where possible. If interviews were conducted in the community, such as at the participant's home, field staff went to the interview in pairs so that one person could be devoted to ensuring privacy, for example, by engaging family members or neighbours in the vicinity. Staff were trained to halt or reschedule the interview if the location was not conducive to confidentiality. As IRC employees, all staff were bound by organisational policies around data confidentiality. I also provided staff with additional training on research ethics and confidentiality.

*Participant distress*

There was a risk that participants may experience distress when asked certain sensitive questions, for example, about traumatic experiences during the war. In particular, there was concern that children may feel distressed if discussing experience of harsh punishment or maltreatment from parents or caregivers. In order to assess the actual risk of harm, some researchers have begun reporting the number of children who report feeling upset or distressed due to participation in a research study. Radford and colleagues (2013) found that 7.9% of children in a national study in the UK reported some distress compared to 7.4% of parents who participated, while 95% indicated their participation was worthwhile. Finkelhor and colleagues (2014) found 4.6% of child participants in a study of child and youth exposure to violence in the United States

reported being upset, and 95.3% of those indicated they would participate in the study again. Of note, the researchers also compared responses of younger (10 to 11 year olds) and older (12 to 16 year olds) children and found no association between age and reports of distress. The authors conclude that concerns around survey related upset are based more on anecdotal than empirical evidence, but acknowledge that there is a small minority of upset child participants who should be of concern.

To minimise the risk of children experiencing distress during the interview, I worked with the field staff to implement several strategies to maximise the safety and comfort of child participants in the focus group discussions. Staff began the focus groups with an activity such as drawing or singing to create a welcoming and warm environment. Prior to beginning the discussion, staff reiterated that participation was voluntary and that children could withdraw or decide not to answer any question at any time with no consequences. There were scheduled breaks during the focus group to ensure children did not become too distressed or fatigued. At the end of the focus group, staff played a short game or asked the children about a positive subject or experience in order to end on a positive note. As interviewers were IRC child protection staff with extensive experience conducting educational, recreational and psychosocial support activities with Syrian refugee children, many of these strategies were already familiar.

In addition, I collaborated with IRC staff to develop a protocol for responding to risk of harm, which provided detailed guidance on how to proceed based on the level of participant distress (see Appendix D). The protocol detailed simple steps for staff to follow if the adult or child participant exhibited signs of distress, for example, pausing the interview and offering a beverage, or engaging in light conversation about a positive topic to help the participant calm down. If the participant recovered within 5-10 minutes and was willing to continue, staff resumed the interview and debriefed with the

participant at the end to see if he or she required additional support. Staff carried information about availability of counselling and health services in the area, which they provided to participants when appropriate. All instances of participant distress were logged and reported to me and the IRC M&E Officer to monitor follow up. In total, interviewers reported that 29 out of 291 survey participants (10%) experienced some distress during the interview. There were no instances of severe participant distress resulting in termination of the interview.

*Disclosure of harm*

Given the nature of research topic, it was possible that adult or child participants may reveal instances of domestic violence, abuse, or intention to self-harm during the course of data collection. I collaborated closely with IRC staff to develop and implement a risk of harm protocol which provided detailed guidance on the steps to follow if disclosures occurred. For example, if there was concern about the participant's immediate safety, staff were to stay with the participant and seek advice from their supervisor. Risk of harm cases were referred to the IRC child protection or gender-based violence case management team for further action, such as developing a safety plan. The IRC has an established case management programme in Lebanon with local staff experienced in responding to cases of abuse and providing case management and psychosocial support.

In addition, to safeguard the children participating in the study, interviewers received an automated alert if the caregiver participant endorsed the survey item, "Hit child over and over again as hard as you could." Out of 291 survey participants, 44 (15.1%) endorsed this item. In addition, interviewers reported that 19 out of 291 survey respondents (6.5%) disclosed experiencing abuse or intention to self-harm.

Interviewers referred all such cases to the IRC's protection programme. Cases were also logged with me and the IRC M&E Officer to ensure appropriate and timely follow up. To my knowledge, all instances of participant distress and potential abuse that arose during the course of data collection were appropriately referred to and managed by IRC case management staff.

*Secondary traumatisation*

Given the research topic and fieldwork conditions, there was a risk of interviewers experiencing secondary trauma through hearing the first-hand accounts of traumatic experiences of participants. Symptoms of secondary traumatisation may include "burnout" characterised by emotional and physical exhaustion, or arousal and avoidance reactions related to post-traumatic stress disorder (National Child Traumatic Stress Network, 2011). Recognising the stressful nature of humanitarian work, the IRC had already established measures to prevent or alleviate staff distress and burnout. These included regular staff meetings in which staff welfare was a standard agenda item, trainings on self-care, and access to a psychologist through medical insurance. These resources were available to all IRC staff, including those who participated in data collection for this study. In addition, I conducted a brief training on the symptoms of burnout and secondary trauma, simple strategies for prevention, and resources available at the IRC and elsewhere.

For the most part, I did not participate directly in data collection and thus had a reduced risk of experiencing secondary traumatisation. It was, however, at times distressing to feel helpless in the face of such overwhelming human misery. I drew on the support of family, friends, and colleagues, as well as my extensive prior experience working in conflict settings, to cope with these feelings of distress. Ensuring that the

results of my research would accurately represent the lived experiences of parents and children, as well as make an impact on policy and practice, also helped to channel my distress in a productive and meaningful way.

*Security*

Finally, there was a risk that security conditions in the study sites could deteriorate during the course of data collection. The IRC has staff dedicated to monitoring security conditions throughout the country, and has communication systems in place to provide daily security updates and issue emergency warnings when necessary. Prior to leaving the office for data collection in the field, staff obtained security clearance from the IRC security team. Staff were experienced in following communication protocols regarding field movements and only travelled to field locations in IRC vehicles with IRC drivers who were trained in security procedures. When staff conducted interviews in the community (e.g. at the participant's home), they did so in pairs as a safety precaution.

I adhered to IRC security procedures during field trips to Lebanon, including obtaining a security briefing upon arrival, communicating with IRC security personnel regarding field movements, and travelling in IRC vehicles with IRC drivers. No security-related incidents affected data collection during the course of the study.

*Potential benefits*

While there are considerable risks when conducting research in a conflict setting, there may also be potential benefits to study participants who may appreciate the opportunity to share their experiences with a neutral outsider. El-Khani and colleagues (2013), for example, reported that Syrian refugee parents in Turkey were keen to discuss their parenting experiences and coping strategies. Similarly, at the end of one

of the focus groups during the qualitative research phase, several female participants volunteered that they enjoyed the discussion and would agree to come again if asked (personal field notes, April 2016). Potential benefits of participating in the study may be particularly marked for women who experience a high degree of social isolation due to sociocultural norms and concerns about personal safety in a foreign country (Boswall & Al Akash, 2015).

*Ethical approvals*

The study protocols for the qualitative and quantitative components of the study were submitted separately to the Central University Research Ethics Committee (CUREC) at the University of Oxford for ethical review. Approval for the qualitative component of the study was obtained from CUREC on 30 March 2016 (Ref No: R44582/RE001). Approval for the quantitative component of the study was obtained from CUREC on 7 July 2016 (Ref No: R46541/RE001). Study protocols were also reviewed by senior staff at the IRC.

*2.12 Strengths and limitations*

This research benefits from several strengths. First, it examines a timely and relevant issue in an ongoing displacement crisis of unprecedented proportions, with a hard-to-reach and highly vulnerable population. The issue of mental health and parenting among Syrian refugees is significant not only because of the scale and severity of the crisis, but also because of the current policy and programmatic focus on family-based approaches to child protection and psychosocial resilience (Murphy et al., 2017). Second, the use of mixed methods is an advantage when examining a complex phenomenon among a population for which little evidence currently exists. Using both qualitative and quantitative methods in a strategic, complementary, and sequenced

manner enables "multiple ways of seeing" (Greene, 2007, p. 20), thus helping to deepen interpretation and application of results to policy and practice. Third, the explicit focus on modelling *processes* instead of simple bivariate associations allows for a more substantial contribution to the literature on parenting in war, and directly informs the development of a theory of change for parenting interventions. In modelling the mechanisms underlying the intergenerational impacts of war and displacement, the thesis also expands understanding of the effects of different types of risk exposure on different dimensions of mental health and parenting behaviour, as well as investigates social support as a potentially modifiable promotive factor for parental resilience. As discussed in the Introduction, the factors and processes contributing to resilience among parents has been long neglected in the literature. This thesis addresses this gap by investigating parental resilience across two specific domains, mental health and parenting behaviour, using a theoretically compelling analytic strategy, with a highly vulnerable refugee population. Finally, the close partnership with the IRC, one of the leading humanitarian organisations in the Syrian refugee response in Lebanon as well as the Middle East region, helps to ensure that study results are disseminated widely and have direct influence on policy and practice.

While this research would not have been possible without the access and assistance provided by the IRC, partnership with an implementing agency in an ongoing crisis also involved certain constraints that affected the design and implementation of the research. For example, funding and programmatic timelines necessitated that data collection for the quantitative component of the thesis started before transcription, translation, and analysis of the qualitative data were complete. Thus, in order to accommodate the partner organisation's timelines, a "pre-analysis" was conducted with field interviewers to generate research questions and hypotheses for further

investigation in the quantitative phase, pending a more thorough analysis of the interview transcripts. The challenges of implementing the selected mixed methods design as originally intended exemplify the constraints of conducting research in humanitarian settings, where access is often dependent on a partner organisation with its own agendas, priorities, and timelines. Flexibility and creativity were essential to finding workable solutions in the field that maintained the integrity and rigour of the research design to the extent possible.

Another limitation of the qualitative study is the relatively modest sample size and relatedly, the constraints on performing theoretical sampling. Unlike quantitative research, the goal of qualitative research is usually not to produce generalisable results but to examine and illuminate complex human phenomena through the collection and analysis of rich narrative data (Green & Thorogood, 2009). Hence, there are no stringent guidelines for sampling in qualitative research, and the number of individuals or groups interviewed and the sampling strategy differ based on the objectives of the study. One strategy for sampling in qualitative research, referred to as *theoretical sampling* in the grounded theory approach, consists of purposefully sampling cases that can help to elaborate, refine, and test the categories that are emerging from the data (Charmaz, 2006). The intention is to continue sampling to develop properties of the categories until no new properties emerge, a point called "saturation." While the methodological rationale for theoretical sampling is compelling in principle, in practice it involves considerable time and funding, both of which are often in short supply when conducting research in conflict settings. As interviews were to be conducted by IRC field staff, it was necessary to balance time spent on data collection with their other tasks, namely programme implementation. As a result, although several categories, such as social support as a source of parental resilience, emerged from the data, resource

limitations meant that it was not possible to conduct theoretical sampling to reach saturation.

In general, the use of local IRC staff for participant recruitment and data collection in both the qualitative and quantitative phases of the research had its advantages and disadvantages. On the one hand, having had previous programme implementation experience, staff were already well-versed in the protection and psychosocial issues that arise when working with refugee communities. On the other hand, participant recruitment and data collection by staff of an implementing organisation may have contributed to recruitment and response bias. Although there was no indication of this during the course of the project, it is possible that staff prioritised recruitment from certain communities where they already had an established relationship or rapport, for example. It is also possible that participants agreed to participate in the study, or tailored their responses in a certain way, in the hope of receiving assistance from IRC staff. In an effort to mitigate this particular risk, informed consent procedures emphasised that participation was voluntary and not linked to receiving assistance from the IRC or any other humanitarian organisation. Participants were also reminded that they could stop at any time and refuse to answer any question with no negative repercussions. Finally, all interviewers underwent training on interview skills and, in particular, the importance of avoiding leading questions and verbal and non-verbal cues so as to minimise response bias. While the use of IRC staff to recruit and interview participants entailed the risk of bias, it is important to note the challenges of hiring skilled interviewers in this context. There were attempts to hire and train external (i.e. non-IRC) enumerators for the survey, but the poor calibre of the candidates resulted in the decision to use IRC field staff for data collection so as to maintain data quality.

Data collection for the quantitative phase of this research "piggybacked" on the baseline assessment of the IRC's parenting intervention in Lebanon. This had several implications for the quantitative sample. First, the sample was derived from refugees who were recruited to participate in the IRC's parenting intervention. Thus, the sample was not representative and results cannot be generalised to the Syrian refugee population in Lebanon. Second, because the vast majority of the participants in the IRC's parenting intervention are biological mothers, the quantitative sample did not include fathers or other types of caregivers. This feature of the sample precludes any analysis of whether or not the pathways linking war and displacement to parental and child outcomes may differ by caregiver gender or type, and whether social support may function differently for fathers versus mothers. This is a significant limitation of the quantitative component of this thesis given evidence suggesting that social, economic, and cultural factors may have differential influences on fathering (Panter-Brick et al., 2014; Taraban & Shaw, 2018). For example, in a study with Palestinian parents and their children, fathers' war trauma was positively associated with child mental health problems via increased psychological maltreatment, while mothers' war trauma had a negative association with the child's depression and anxiety via decreased psychological maltreatment (Palosaari, Punamäki, Qouta & Diab, 2013). Other research has found support for a "father vulnerability hypothesis," for instance showing that fathers' parenting is more affected by the quality of the marital relationship than mothers' parenting (Cummings, Goeke-Morey & Raymond, 2004).

Another important limitation of the quantitative component of the thesis is the cross-sectional nature of the data, which precludes causal inferences regarding the directionality of effects. This has particular implications for the structural equation model tested in DPhil Paper 2, which proposes a specific sequence of cascading effects

from war trauma to daily stressors, maternal mental health, negative parenting, and finally child psychosocial adjustment. While the antecedent to displacement-related daily stressors is obviously exposure to the war in Syria, other pathways in the model may operate in the opposite direction or have bidirectional effects that are undetectable with cross-sectional data. For example, Neuner (2010) has argued that poor mental health can negatively influence the perception of daily stressors or even generate stress, a potential pathway that is not examined in this thesis. Similarly, while the central hypothesis in DPhil Paper 3 is that more social support can lead to fewer mental health problems, some research has shown that depression and anxiety can actually lead to less support seeking (Hammen, 2006; Monroe, 1983). While the hypothesised direction of pathways and effects in DPhil Papers 2 and 3 was informed by existing theoretical and empirical literature, it is possible that there are alternative pathways or bidirectional effects which would only be detected with longitudinal data.

All measures were maternal self-report only, which increases the risk of bias associated with shared method variance, or variance that is attributable to the measurement method rather than to the constructs the measures represent (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003). For example, studies have shown that mothers with depressive symptoms tend to report higher levels of behaviour problems in their children, although direct observations show no difference between those children's behaviour and the behaviour of children of asymptomatic mothers (Webster-Stratton & Hammond, 1988). Therefore, it is possible for example that the association between poor maternal mental health and increased child psychosocial problems reported in DPhil Paper 2 is partly or wholly attributable to this bias. Cognisant of the issue of shared method variance, the original design of the quantitative component included surveys with children, who would then provide an additional source of data on their

mothers' parenting behaviour and their own emotional and behavioural symptoms. However, because only parents of children aged 2 to 12 years were included in the IRC's parenting intervention and therefore the survey, we could only interview a subsample of children aged 8 to 12 years who would be developmentally mature enough to participate. This subsample proved too small (n=88) to conduct any meaningful analysis. Without children's own reports, it was also not possible to account for potential confounds in the structural equation model reported in DPhil Paper 2, such as children's own exposure to war trauma and daily stressors, which likely had a direct effect on their psychosocial adjustment. Futhermore, there were ethical concerns about asking children about potentially traumatic experiences.

While efforts were made to use existing Arabic translations of standardised measures, these measures were primarily developed in Western contexts and have not been validated with the Syrian refugee population. As such, it is not known whether the translated measures have adequate psychometric properties (e.g. test-retest reliability; criterion validity) when applied to this population, or if there are culturally-specific parenting practices or local idioms of distress that are not captured by these measures (Kirmayer, 2001). For example, a review of the Strengths and Difficulties Questionnaire (SDQ) when translated into languages spoken by major refugee groups found structural inequivalence with the original 5-factor model, suggesting that the translated SDQ subscales may measure different constructs (Stolk, Kaplan & Szwarc, 2017).

Finally, the quantitative component of the thesis examined only one of the pathways found in the qualitative results, namely the relationship between parental mental health problems and increased negative parenting. It is possible and likely, however, that other pathways exist: for example, a cognitive-behavioural pathway

whereby refugee parents perceive and experience their environment as more dangerous and risky, and thus increase control and discipline of their children. As the survey did not assess parental cognitions, beliefs, or other dimensions of parenting behaviour such as monitoring, it was not possible to use quantitative methods to examine other potential pathways.

This discussion of the strengths and limitations of the research highlights the challenges of conducting research in conflict-affected settings, and the tradeoffs involved in partnering with an implementing organisation. The following chapters of the thesis present the three papers resulting from the research, each with its unique yet complementary contribution to the study of parenting in times of war.

*2.13 References*

Alyahri, A., & Goodman, R. (2006). Validation of the Arabic strengths and difficulties questionnaire and the development and well-being assessment.

Annan, J., Sim, A., Puffer, E. S., Salhi, C., & Betancourt, T. S. (2016). Improving Mental Health Outcomes of Burmese Migrant and Displaced Children in Thailand: a Community-Based Randomized Controlled Trial of a Parenting and Family Skills Intervention. *Prevention Science*, *18*, 793–803.

Aoun, A., Joundi, J., & El Gerges, N. (2018). Post-Traumatic Stress Disorder Symptoms and Associated Risk Factors: A cross-sectional study among Syrian refugees. *British Journal of Medical Practitioners*, *11*(1).

Bass, J. K., Bolton, P. A., & Murray, L. K. (2007). Do not forget culture when studying mental health. *The Lancet*, *370*(9591), 918–919.

Betancourt, T. S., Rubin-Smith, J. E., Beardslee, W. R., Stulac, S. N., Fayida, I., & Safren, S. (2011). Understanding locally, culturally, and contextually relevant mental health problems among Rwandan children and adolescents affected by HIV/AIDS. *AIDS Care*, *23*(4), 401–412.

Betancourt, T., Scorza, P., Meyers-Ohki, S., Mushashi, C., Kayiteshonga, Y., Binagwaho, A., … Beardslee, W. R. (2012). Validating the center for epidemiological studies depression scale for children in Rwanda. *Journal of the American Academy of Child & Adolescent Psychiatry*, *51*(12), 1284–1292.

Bolton P, Wilk CM, Ndogoni L. (2004). Assessment of depression prevalence in rural Uganda using symptom and function criteria. *Social Psychiatry and Psychiatric Epidemiology*, *39*, 442–47.

Boswall, K., & Al Akash, R. (2015). Personal perspectives of protracted displacement: an ethnographic insight into the isolation and coping mechanisms of Syrian women and girls living as urban refugees in northern Jordan. *Intervention, 13*(3), 203–215.

Bowes, L., Maughan, B., Caspi, A., Moffitt, T. E., & Arseneault, L. (2010). Families promote emotional and behavioural resilience to bullying: evidence of an environmental effect: Families promote resilience to bullying. *Journal of Child Psychology and Psychiatry*, *51*(7), 809–817.

Bridgett, D. J., Laake, L. M., Gartstein, M. A., & Dorn, D. (2013). Development of Infant Positive Emotionality: The Contribution of Maternal Characteristics and Effects on Subsequent Parenting: Infant Positive Emotion and Subsequent Parenting. *Infant and Child Development*, *22*(4), 362–382.

Canino, G., & Alegría, M. (2008). Psychiatric diagnosis – is it universal or relative to culture? *Journal of Child Psychology and Psychiatry*, *49*(3), 237–250.

Card, N. A., & Barnett, M. A. (2015). Methodological Considerations in Studying Individual and Family Resilience: Methodological Considerations. *Family Relations*, *64*(1), 120–133.

Charmaz, K. (2006). *Constructing Grounded Theory*. Sage.

Child Protection Monitoring and Evaluation Reference Group. (2012). *Ethical principles, dilemmas and risks in collecting data on violence against children: A review of available literature*. New York: UNICEF.

Cicchetti, D., & Garmezy, N. (1993). Prospects and promises in the study of resilience. *Development and Psychopathology*, *5*(4), 497–502.

Creswell, J. W., & Clark, V. L. P. (2007). *Designing and Conducting Mixed Methods Research*. Sage.

Creswell, J. W., Plano Clark, V. L., Gutmann, M., & Hanson, W. (2003). Advanced mixed methods research designs. In *Handbook of mixed methods in social & behavioral research* (pp. 209–240). Thousand Oaks, CA: Sage.

Cummings, E. M., Goeke-Morey, M. C., & Raymond, J. (2004). Fathers in Family Context: Effects of Marital Quality and Marital Conflict. In *The role of the father in child development* (4th ed.). Hoboken, New Jersey: John Wiley & Sons, Inc.

Efron, B., & Tibshirani, R. J. (1993). *An Introduction to the Bootstrap*. Chapman & Hall/CRC.

El-Khani, A., Ulph, F., & Calam, R. (2009). Ethical issues in research into conflict and displacement. *Conflict Health, 3*, 7.

Eruyar, S., Maltby, J., & Vostanis, P. (2018). Mental health problems of Syrian refugee children: the role of parental factors. *European Child & Adolescent Psychiatry*.

Falb, K., Tanner, S., Asghar, K., Souidi, S., Mierzwa, S., Assazenew, A., … Stark, L. (2016). Implementation of Audio-Computer Assisted Self-Interview (ACASI) among adolescent girls in humanitarian settings: feasibility, acceptability, and lessons learned. *Conflict and Health, 10*(1).

Finkelhor, D., Vanderminden, J., Turner, H., Hamby, S., & Shattuck, A. (2014). Upset among youth in response to questions about exposure to violence, sexual assault and family maltreatment. *Child Abuse & Neglect, 38*(2), 217–223.

Ford, N., Mills, E. J., Zachariah, R., & Upshur, R. (2009). Ethics of conducting research in conflict settings. *Conflict and Health*, *3*(1), 7. https://doi.org/10.1186/1752-1505-3-7

Fritz, M. S., & MacKinnon, D. P. (2007). Required Sample Size to Detect the Mediated Effect. *Psychological Science*, *18*(3), 233–239.

Glantz, M. D., & Johnson, J. L. (2002). *Resilience and Development: Positive Life Adaptations*. Boston, MA: Springer US. Retrieved from http://public.eblib.com/choice/publicfullrecord.aspx?p=3035427.

Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry*, *38*, 581–586.

Green, J., & Thorogood, N. (2004). *Qualitative methods for health research*. London: SAGE Publications.

Greene, J. C. (2007). *Mixed methods in social inquiry*. San Francisco: Jossey-Bass.

Hall, B. J., Puffer, E., Murray, L. K., Ismael, A., Bass, J. K., Sim, A., & Bolton, P. A. (2014). The Importance of Establishing Reliability and Validity of Assessment Instruments for Mental Health Problems: an Example from Somali Children and Adolescents Living in Three Refugee Camps in Ethiopia. *Psychological Injury and Law*, *7*(2), 153–164.

Hammen, C. (2006). Stress generation in depression: Reflections on origins, research, and future directions. *Journal of Clinical Psychology*, *62*(9), 1065–1082.

Hartung, C., Lerer, A., Anokwa, Y., Tseng, C., Brunette, W., & Borriello, G. (2010). Open data kit: tools to build information services for developing regions. In *Proceedings of the 4th ACM/IEEE International Conference on Information and*

*Communication Technologies and Development* (p. 18). ACM. Retrieved from http://dl.acm.org/citation.cfm?id=2369236.

Hassan, G, Kirmayer, LJ, Mekki-Berrada A., Quosh, C., el Chammay, R., Deville-Stoetzel, J.B., Youssef, A., Jefee-Bahloul, H., Barkeel-Oteo, A., Coutts, A., Song, S. & Ventevogel, P. (2015). *Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians: A Review for Mental Health and Psychosocial Support staff working with Syrians Affected by Armed Conflict.* Geneva: UNHCR.

Huang, K.-Y., Abura, G., Theise, R., & Nakigudde, J. (2016). Parental Depression and Associations with Parenting and Children's Physical and Mental Health in a Sub-Saharan African Setting. *Child Psychiatry & Human Development*.

Human Rights Watch. (2016). *"I Just Wanted to be Treated Like a Person." How Lebanon's Residency Rules Facilitate Abuse of Syrian Refugees*. New York: Human Rights Watch.

International Crisis Group. (2015). *Lebanon's Self-Defeating Survival Strategies* (Middle East Report No. 160). Brussels: International Crisis Group.

International Society for the Prevention of Child Abuse and Neglect. (2016). *Ethical Considerations for the Collection, Analysis & Publication of Child Maltreatment Data*.

Jaffee, S. R., Caspi, A., Moffitt, T. E., Polo-Tomas, M., & Taylor, A. (2007). Individual, family, and neighborhood factors distinguish resilient from non-resilient maltreated children: A cumulative stressors model. *Child Abuse & Neglect*, *31*(3), 231–253.

Jordans, M. J. D., Semrau, M., Thornicroft, G., & van Ommeren, M. (2012). Role of current perceived needs in explaining the association between past trauma exposure and

distress in humanitarian settings in Jordan and Nepal. *The British Journal of Psychiatry*, *201*(4), 276–281.

Kandemir, H., Karataş, H., Çeri, V., Solmaz, F., Kandemir, S. B., & Solmaz, A. (2018). Prevalence of war-related adverse events, depression and anxiety among Syrian refugee children settled in Turkey. *European Child & Adolescent Psychiatry*.

Kienzler, H. (2008). Debating war-trauma and post-traumatic stress disorder (PTSD) in an interdisciplinary arena. *Social Science & Medicine*, *67*(2), 218–227.

Kim-Cohen, J., Moffitt, T. E., Caspi, A., & Taylor, A. (2004). Genetic and environmental processes in young children's resilience and vulnerability to socioeconomic deprivation. *Child Development*, *75*(3), 651–668.

Kirmayer, L. J. (1989). Cultural Variations in the Response to Psychiatric Disorders and Emotional Distress. *Social Science & Medicine*, *29*(3), 327–339.

Kirmayer, L. J. (2001). Cultural variations in the clinical presentation of depression and anxiety: implications for diagnosis and treatment. *Journal of Clinical Psychiatry*, *62*, 22–30.

Kirmayer, L. J., & Pedersen, D. (2014). Toward a new architecture for global mental health. *Transcultural Psychiatry*, *51*(6), 759–776.

Lansford, J. E., Sharma, C., Malone, P. S., Woodlief, D., Dodge, K. A., Oburu, P., … Di Giunta, L. (2014). Corporal Punishment, Maternal Warmth, and Child Adjustment: A Longitudinal Study in Eight Countries. *Journal of Clinical Child & Adolescent Psychology*, *43*(4), 670–685.

Lavi, I., & Slone, M. (2012). Parental practices and political violence: The protective role of parental warmth and authority-control in Jewish and Arab Israeli children. *American Journal of Orthopsychiatry*, *82*(4), 550–561.

Lovibond, P. F., & Lovibond, S. H. (1995). The Structure of Negative Emotional States: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy*, *33*(3), 335–343.

Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, *71*(3), 543–562.

Luthar, S. S., Sawyer, J. A., & Brown, P. J. (2006). Conceptual Issues in Studies of Resilience: Past, Present, and Future Research. *Annals of the New York Academy of Sciences*, *1094*(1), 105–115.

Masten, A. S. (1994). Resilience in individual development: Successful adaptation despite risk and adversity. In *Educational resilience in inner-city America: Challenges and prospects* (pp. 45–72). Hillsdale, NJ: Erlbaum.

Meyer, S., Murray, L. K., Puffer, E. S., Larsen, J., & Bolton, P. (2013). The nature and impact of chronic stressors on refugee children in Ban Mai Nai Soi camp, Thailand. *Global Public Health*, *8*(9), 1027–1047.

Monroe, S. M. (1983). Social support and disorder: Toward an untangling of cause and effect. *American Journal of Community Psychology*, *11*(1), 81–97.

Morrow, V. (2013). Practical Ethics in Social Research with Children and Families in Young Lives: A Longitudinal Study of Childhood Poverty in Ethiopia, Andhra Pradesh (India), Peru and Vietnam. *Methodological Innovations Online*, *8*(2), 21–35.

Moser, A., Stuck, A. E., Silliman, R. A., Ganz, P. A., & Clough-Gorr, K. M. (2012). The eight-item modified Medical Outcomes Study Social Support Survey: psychometric evaluation showed excellent performance. *Journal of Clinical Epidemiology*, *65*(10), 1107–1116.

Moussa, M. T., Lovibond, P., Laube, R., & Megahead, H. A. (2016). Psychometric Properties of an Arabic Version of the Depression Anxiety Stress Scales (DASS). *Research on Social Work Practice*.

Murphy, K. M., Rodrigues, K., Costigan, J., & Annan, J. (2017). Raising children in conflict: An integrative model of parenting in war. *Peace and Conflict: Journal of Peace Psychology*, *23*(1), 46–57.

National Child Traumatic Stress Network. (2011). Secondary traumatic stress: A fact sheet for child-serving professionals. National Center for Child Traumatic Stress.

Palosaari, E., Punamäki, R.-L., Qouta, S., & Diab, M. (2013). Intergenerational effects of war trauma among Palestinian families mediated via psychological maltreatment. *Child Abuse & Neglect*, *37*(11), 955–968.

Panter-Brick, C. (2015). Culture and Resilience: Next Steps for Theory and Practice. In L. C. Theron, L. Liebenberg, & M. Ungar (Eds.), *Youth Resilience and Culture* (Vol. 11, pp. 233–244). Dordrecht: Springer Netherlands.

Panter-Brick, C., Burgess, A., Eggerman, M., McAllister, F., Pruett, K., & Leckman, J. F. (2014). Practitioner Review: Engaging fathers - recommendations for a game change in parenting interventions based on a systematic review of the global evidence. *Journal of Child Psychology and Psychiatry*, *55*(11), 1187–1212.

Panter-Brick, C., Dajani, R., Eggerman, M., Hermosilla, S., Sancilio, A., & Ager, A. (2018). Insecurity, distress and mental health: experimental and randomized controlled trials of a psychosocial intervention for youth affected by the Syrian crisis. *Journal of Child Psychology and Psychiatry*, *59*(5), 523-541.

Panter-Brick, C., Hadfield, K., Dajani, R., Eggerman, M., Ager, A., & Ungar, M. (2018). Resilience in Context: A Brief and Culturally Grounded Measure for Syrian Refugee and Jordanian Host-Community Adolescents. *Child Development*, *89*(5), 1803-1820.

Podsakoff, P. M., MacKenzie, S. B., Lee, J.-Y., & Podsakoff, N. P. (2003). Common method biases in behavioral research: A critical review of the literature and recommended remedies. *Journal of Applied Psychology*, *88*(5), 879–903.

Puffer, E. S., Green, E. P., Chase, R. M., Sim, A. L., Zayzay, J., Friis, E., … Boone, L. (2015). Parents make the difference: a randomized-controlled trial of a parenting intervention in Liberia. *Global Mental Health*, *2*.

Putnick, D. L., Bornstein, M. H., Lansford, J. E., Malone, P. S., Pastorelli, C., Skinner, A. T., … Oburu, P. (2015). Perceived mother and father acceptance-rejection predict four unique aspects of child adjustment across nine countries. *Journal of Child Psychology and Psychiatry*, *56*(8), 923–932.

Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N., & Collishaw, S. (2011). Child abuse and neglect in the UK today. Retrieved from http://clok.uclan.ac.uk/6022/

Rohner, R. P., & Khaleque, A. (2008). *Handbook for the study of parental acceptance and rejection*. Storrs, Connecticut: Rohner Research.

Sherbourne, C. D., & Stewart, A. L. (1991). The MOS social support survey. *Social Science & Medicine*, *32*(6), 705–714.

Sirin, S. R., & Rogers-Sirin, L. (2015). *Educational and Mental Health Needs of Syrian Refugee Children*. Washington, DC: Migration Policy Institute.

Stolk, Y., Kaplan, I., & Szwarc, J. (2017). Review of the strengths and difficulties questionnaire translated into languages spoken by children and adolescents of refugee background. *International Journal of Methods in Psychiatric Research*, *26*(4), e1568.

Taraban, L., & Shaw, D. S. (2018). Parenting in context: Revisiting Belsky's classic process of parenting model in early childhood. *Developmental Review*, *48*, 55–81.

Tekeli-Yesil, S., Isik, E., Unal, Y., Aljomaa Almossa, F., Konsuk Unlu, H., & Aker, A. T. (2018). Determinants of Mental Disorders in Syrian Refugees in Turkey Versus Internally Displaced Persons in Syria. *American Journal of Public Health*, *108*(7), 938–945.

UNICEF. (2016). Multiple Indicator Cluster Surveys. Retrieved May 5, 2016, from http://mics.unicef.org

United Nations High Commissioner for Refugees. (2016). UNHCR - Registration - Lebanon - Map of Registered Syrian Refugees by District in Lebanon. Beirut, Lebanon: UNHCR. Retrieved from https://data2.unhcr.org/en/documents/details/43733

United Nations High Commissioner for Refugees. (2018a). *Global Trends: Forced Displacement in 2017*. Geneva: UNHCR.

United Nations High Commissioner for Refugees. (2018b). Syria Regional Refugee Response. Retrieved July 10, 2018, from http://

data.unhcr.org/syrianrefugees/regional.php#_ga=2.
87672475.2089617872.1497030295–2087191681. 1489940027

United Nations High Commissioner for Refugees, United Nations Children's Fund, & World Food Programme. (2017). *Vulnerability Assessment of Syrian Refugees in Lebanon 2017*. Beirut, Lebanon.

United Nations Office for the Coordination of Humanitarian Affairs. (2011). Lebanon. UNOCHA. Retrieved from http://www.unocha.org/cerf/category/country/middle-east/lebanon

United Nations Office for the Coordination of Humanitarian Affairs. (2018, February). Syrian Arab Republic. Retrieved February 13, 2018, from http://www.unocha.org/syria

Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., & Keane, T. M. (1993). The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility. Paper presented at the annual convention of the International Society for Traumatic Stress Studies. San Antonio, TX.

Webster-Stratton, C., & Hammond, M. (1988). Maternal Depression and Its Relationship to Life Stress, Perceptions of Child Behavior Problems, Parenting Behaviors, and Child Conduct Problems. *Journal of Abnormal Child Psychology*, *16*(3), 299–315.

World Health Organization, & King's College London. (2011). *The humanitarian emergency settings perceived needs scale (HESPER): manual with scale.*

# CHAPTER III. *DPhil Paper 1*: Pathways linking war and displacement to parenting and child adjustment: A qualitative study with Syrian refugees in Lebanon

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This is the first paper produced as part of this DPhil thesis. Using qualitative data from Syrian refugee parents (n=39) and children (n=15), the paper examines the pathways linking war and displacement to parenting and child psychosocial adjustment. The qualitative component of the thesis, on which this paper is based, constitutes the first phase of the exploratory sequential design. Results from the qualitative phase informed the development of the research questions, hypotheses, and outcome measures used in the second, quantitative phase, which are reported in DPhil Papers 2 and 3.

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## Abstract

Forcibly displaced children are at risk of a range of negative outcomes, yet little is known about how to support war-affected caregivers in promoting children's psychosocial resilience. The current study uses qualitative methods to examine the mechanisms underlying the effects of war and displacement on parenting and child adjustment in order to inform intervention development. In April and November 2016, group and individual interviews were conducted with 39 Syrian parents and 15 children in partnership with a humanitarian organisation in Lebanon. Interviews were transcribed and analysed using a grounded theory approach. Results show three interrelated pathways linking daily displacement stressors to various dimensions of parenting: (1) economic hardship prevents parents from meeting their children's basic needs and forces adaptation strategies that impair positive parent-child interactions; (2) parental psychological distress contributes to harsh parenting; and (3) perceptions and experiences of insecurity in the community results in increased parental control. Greater economic resources and social support emerged as potential protective factors for maintaining positive parenting despite exposure to war and displacement-related adversity. Our findings suggest that implementation of policies and programmes to remove structural barriers to refugees' physical and economic security can have tangible impacts on parental mental health, parenting quality, and child psychosocial outcomes. Future research priorities include a stronger focus on the effects of war and displacement on family processes, taking into account interactions with the broader social, economic and political context.



**Keywords:** Lebanon; Syrian refugees; war; displacement; daily stressors; mental health; parenting; child adjustment.

## Introduction

Forced displacement affects an estimated 28 million children across the world, yet research is limited on how to support war-affected caregivers in promoting children's psychosocial resilience (UNICEF, 2016). The importance of stable, nurturing parenting for positive child developmental outcomes has been established across diverse social, economic, and cultural contexts (Putnick et al., 2015). For refugee children, who have likely been exposed to potentially traumatic events and whose extended support structures have been disrupted, strong family relationships may be even more crucial as a source of protection and resilience (Masten & Narayan, 2012; Qouta et al., 2008; Betancourt et al., 2010; Sriskandarajah et al., 2015). Prospective, longitudinal studies in Sierra Leone, Afghanistan, and Pakistan demonstrate the "intergenerational impact of war," in which caregiver and family variables such as parental mental health, family acceptance, and domestic violence have cascading effects on the next generation, predicting child mental health outcomes over and above individual predictors including trauma exposure (Betancourt et al., 2015, p. 1101; Panter-Brick et al., 2015). These studies reflect a recent shift away from the historical emphasis on the individual child's direct exposure to war events, towards a more integrated family perspective in which parenting and other family variables mediate the effects of armed conflict on child psychosocial outcomes (Timshel et al., 2017).

Qualitative studies in conflict-affected areas have found that the problems induced or exacerbated by war and persistent social and economic inequality have knock-on effects on parenting and family relationships. In Afghanistan, poverty and overcrowded housing led to frustration and anger among men and women, which in turn contributed to intimate partner violence and child maltreatment (Eggerman & Panter-Brick, 2010). The same study also found, however, that family unity and

harmony were sources of strength and perseverance amidst unrelenting economic and social suffering. Similarly, in post-conflict Rwanda, family unity and good parenting were protective constructs described by HIV/AIDS-affected families as crucial to surviving difficult times (Betancourt et al., 2011). Other studies have shown how the effects of war on parenting and family dynamics are complex and multidimensional. Song et al. (2014) found that war trauma experienced by Burundian former child combatants was transmitted to the next generation via effects on parenting behaviour and norms, parental psychological distress, and community stigma. In East Timor, qualitative findings suggest a "post-conflict cycle of violence" in which patriarchal values, combined with war-related psychological distress, contributed to male perpetration of intimate partner violence, which in turn increased mothers' use of violence against children (Rees et al., 2015, p. 285).

In this study, we aim to further elucidate the mechanisms through which parenting is impacted by exposure to mass conflict. Using qualitative interviews with Syrian refugee parents and children in Lebanon, we examine the perceived effects of war and displacement on parenting and family functioning. The United Nations has called the war and resulting exodus from Syria "the biggest humanitarian and refugee crisis of our time" (UN, 2016). More than half of Syria's 22 million pre-war population has been displaced and over half of the refugee population is comprised of children, with nearly 75 percent under the age of 12 (UNOCHA, 2017). At the time of data collection in April 2016, there were 1,048,275 Syrian refugees registered with the UNHCR, almost one-fifth of the total Lebanese population (UNHCR et al., 2015). Onerous and costly residency renewal regulations issued by the Lebanese government in 2015 have resulted in many Syrian refugees losing their legal status, which in turn contributes to restrictions on movement, work, and access to basic services (Human Rights Watch,

2016). As refugees are officially prohibited from working in Lebanon, many resort to working in the informal sector where there is a high risk of exploitation and abuse (Verme et al., 2015).

Given the still nascent evidence base on the effects of war and displacement on parenting behaviour, this study uses an emic approach to develop a conceptual model of parenting in war that is rooted in the lived experiences of Syrian refugees themselves. Our ultimate aim is to inform the development of parenting and family interventions that increase caregivers' capacity to protect and promote children's psychosocial wellbeing.

*Theoretical frameworks*

We used two theoretical frameworks, each with its unique but complementary perspective on transgenerational effects of adversity, to inform the interpretation and discussion of the conceptual model resulting from this study. First, the intergenerational transmission of trauma model posits that the experience of trauma in one generation influences the developmental outcomes of successive generations, mainly via the effects of post-traumatic stress disorder (PTSD) on parenting and family dynamics (Danieli, 1998). First investigated with survivors of the Holocaust and their families, the model has since been extended to other war-affected populations (Dekel & Goldblatt, 2008; Van Ee et al., 2012; Catani, 2010). For example, in northern Uganda, male caregivers' PTSD symptom severity and female caregivers' war trauma exposure increased both parental and child reports of maltreatment (Saile et al., 2014).

A second theoretical framework used in this study is the family stress model, which theorises that economic stress is linked to child emotional and behavioural problems via parental mental health, marital conflict, and parental rejection and

hostility (Conger et al., 1994). In contrast to the previous model, which is centred on the psychosocial fallout from the dramatic events of war, the family stress model emphasises the more mundane but no less corrosive daily struggle to "get by." This emphasis on daily stressors is particularly relevant to refugee settings characterised by multiple environmental stressors (Miller & Rasmussen, 2010). Despite differences in aetiology and emphasis, both theoretical models present parenting and family dynamics as the main mechanism through which exposure to adversity results in negative life trajectories for subsequent generations. Together they capture how past exposure to traumatic events, combined with current economic and social stress, can impair parenting quality and ultimately result in negative child psychosocial outcomes.

## Methodology

### *Participant recruitment and sample characteristics*

The study was conducted in partnership with the International Rescue Committee (IRC), a non-governmental organisation (NGO) implementing economic, psychosocial, and educational programs for refugees and host communities in Lebanon. Data collection took place in April and November 2016 in the northern district of Hermel, where the partner NGO has an established child protection program, including a parenting skills intervention. Approximately 60 percent of refugee households in Hermel rely on food vouchers and over 80 percent live in rented apartments, with the remainder in informal tented settlements and other substandard shelters (UN, 2016).

Participant recruitment was conducted by local partner organisation staff who were implementing child protection and psychosocial activities with refugee communities in the area. Staff conducted individual and group outreach meetings with refugees to introduce the study and its objectives, and recorded the names and contact

information of those who were interested in participating. Staff purposively sampled on a rolling basis refugees living in rented apartments and informal tented settlements (a proxy indicator for vulnerability), as well as participants of different ages and employment status. As one of the objectives of the study was to inform recommendations for the partner NGO's parenting intervention, which targeted caregivers of children aged 2 to 9 years, we used the same criteria for inclusion in the study. We decided to include children aged 8 to 12 years based on previous field experience indicating that children younger than eight would find it difficult to participate productively in the focus group discussions. None of the adult or child participants had previously attended the partner NGO's programs. In total, four focus groups were conducted with parents (n=29) and two focus groups with children (n=15). All focus groups were gender-segregated. Upon conclusion of the focus groups, local staff used the same method and criteria described above to recruit an additional 10 parents to participate in individual interviews. Three of the 10 interview respondents had a follow-up interview to probe more deeply into areas of interest that emerged during their initial meeting.

Adult participants ranged in age from 18 to 60, with a mean age of 31.3 years. Half of the participants were female (53.8%). All were married and the number of children per household ranged from one to five. The majority of adult participants had some primary school education (74.4%) and were engaged in paid work (69.2%), almost all as day labourers. Nine of the 27 participants who were working were female. Approximately 72 percent of participants were living in rented apartments with the remainder in informal tented settlements, roughly mirroring the proportions reported in a representative survey of Syrian refugee households (UN, 2015). The mean age of child participants was 9.2 years and half were female. All child participants, with one

exception, were reported by parents to be their biological children. At the time of recruitment, parents reported that all child participants were enrolled in school and none were engaged in paid work. However, subsequent interviews revealed that several children were not currently attending school or were attending irregularly, and were intermittently engaged in work alongside their parent. At the time of data collection, the length of displacement in Lebanon ranged from six to 59 months, with an average of 42.2 months.

*Data collection procedures*

The lead author trained local partner organisation staff on research ethics, informed consent, and interview skills prior to data collection. The training included review and practice of interview questions to check the accuracy and comprehensibility of the Arabic translation, and to encourage open-ended probing techniques. Trained staff obtained written informed consent from adult participants. If the participant had a child aged 8 to 12 years, staff also obtained written parental consent before meeting with the child separately to obtain verbal assent. All focus group discussions and individual interviews were conducted in Arabic at the IRC office by two female and two male local staff, with the exception of three follow-up interviews which were conducted by the lead author with the assistance of an interpreter. All 6 focus groups and 10 out of 13 individual interviews were conducted by interviewers of the same gender as the participant. Interviewers did not have any prior relationship to participants apart from being generally familiar with the Syrian refugee communities in the area from previous or ongoing child protection programming. Participants received transportation to and from the IRC office, and childcare and light refreshments were provided onsite. There were no financial or material incentives for participation.

Interviews were audio-recorded with consent from participants, transcribed into Arabic and translated into English.

Data collection took place in two stages. First, focus groups were conducted with parents and children to allow themes as well as divergent experiences and viewpoints to emerge. Topics discussed in the focus groups were purposefully broad and included: *What is your experience as a parent here in Lebanon? How has the way you parent your child changed or stayed the same since coming to Lebanon?* Focus groups with children began with an introductory game and a drawing activity to help children feel at ease, followed by questions including: *How do you and your parents spend time together here in Lebanon? What do your parents do or say when you do something wrong? What do you do when you feel upset or angry?* Interviewers concluded the child focus groups with a game and debrief to ensure children were not distressed by the discussion.

The lead author observed all focus groups, recorded field notes, and facilitated debriefing sessions with interviewers to provide feedback and identify emerging themes, points of contradiction or confusion, and areas for further clarification or exploration. In the second stage of data collection, individual interviews were conducted with 10 parents to probe their experiences of displacement to Lebanon, the effects of these experiences on parenting behaviour and parental and child psychosocial wellbeing, as well as other questions emerging from the focus groups. Upon reviewing the transcripts of the individual interviews, the lead author and an interpreter conducted follow-up interviews with three of the respondents to probe more deeply into areas of interest that had emerged during their initial meeting (e.g. social support as a potential protective resource).

*Data analysis*

The qualitative data analysis software QSR International NVivo 11 was used to store, organise, and code transcripts. Analysis followed a grounded theory approach with the aim of developing a conceptual model of the impacts of war and displacement on parenting (Charmaz, 2006). First, the lead author and a second researcher who was not involved in data collection familiarised themselves with the data by reading and annotating the transcripts. The second step involved "fracturing" the data through intensive, line-by-line open coding of the transcripts, including using *in vivo* codes taken from the respondents' own words. These initial codes were subsequently grouped together to form emerging conceptual categories (Charmaz, 2006). For example, the initial codes "barely making ends meet" and "facing difficulty providing for family" were grouped together to form the category "economic hardship." An initial coding framework was developed using these emerging conceptual categories and refined iteratively following discussions among the researchers. Data were re-coded using the coding framework and the resulting conceptual model emerged from linking together categories in the form of pathways. For example, focused coding revealed a link between economic hardship and parents' inability to provide for their children's basic needs, a pathway that was subsequently called "economic hardship and adaptation." Quotes that most clearly and vividly illustrated the category or pathway were then selected for inclusion in the paper.

In order to check reliability and validity of the analysis, simple frequency counts of the initial and focused codes were conducted to provide some indication of the typicality of the observation or account (Green & Thorogood, 2004). Particular attention was paid to "deviant cases" or data that did not fit within the resulting model, with results clearly stating when a certain experience or perspective was reported by

only a minority of participants. All analytic and coding procedures were documented in memos, thus providing a transparent and potentially replicable account of the analysis. Memo-ing was also employed as an analytic tool in its own right to note initial impressions and reflections about the data, relationships between codes, and how codes and conceptual categories developed. To check the accuracy and credibility of results, preliminary findings were presented to refugee parents and study interviewers in Hermel, and to humanitarian agencies in Lebanon. Feedback was consistent with the overall conclusions of the study as determined by the research team.

*Ethical and safety considerations*

Given the vulnerable status of refugees, informed consent procedures emphasised that participation was voluntary and not linked to receiving assistance from the IRC or any other organisation. Trained staff read aloud from a study information and consent script to adult and child participants to ensure comprehension and provide the opportunity for questions. As part of the consent process, staff explained to both parents and children that their responses were confidential, except in the instance of a child protection concern, in which case staff may have to report to the research team and NGO supervisor.

In order to safeguard the wellbeing of child participants, interviewer training included practice of child-friendly techniques to explain assent and confidentiality, and the use of games and creative activities to put children at ease and minimise emotional strain. Interviewers were also trained to ask open-ended questions about parent-child interactions and to avoid soliciting detailed accounts of maltreatment, if any. The lead author observed the child focus groups and debriefed with the facilitators to ascertain that none of the children were distressed during their participation. In a few instances

when adult participants appeared distressed during the interview, staff followed a risk of harm protocol developed for this study and paused the interview, offering the participant the opportunity to stop or reschedule. In all cases, participants chose to resume the interview after a few minutes and were given a list of local health and psychosocial support services should they wish to request further support.

Participants were assigned a unique code at the point of transcription and identifying information was replaced with pseudonyms. The study protocol was reviewed by senior staff from the partner organisation and approved by the University of Oxford Social Sciences and Humanities Inter-divisional Research Ethics Committee (Ref No: R44582/RE001).

**Results**

Results show three pathways linking war-induced displacement stressors to various dimensions of parenting behaviour including parental supervision and parent-child interaction, harsh parenting, and parental control. Diminished parenting quality, combined with exposure to war and displacement, contributed to a range of emotional and behavioural difficulties in children. Results suggest that greater economic resources and social support may be important protective factors for maintaining positive, non-violent parenting despite exposure to war and displacement-related adversity. Each pathway is presented in depth below, followed by a conceptual model linking war and displacement to parenting behaviour and child psychosocial adjustment. Although the depiction of the model implies that each pathway is distinct, results indicate that interactions exist between pathways with subsequent cascading effects on parent and child outcomes.

*Economic hardship and adaptation pathway*

When asked if war and displacement have changed the way they parent, all adult participants emphasised their diminished ability to provide for children's basic survival needs including food, safe shelter, and health care. Parents described how the higher cost of living, lack of income, inadequate humanitarian assistance, and increasing indebtedness in Lebanon have resulted in a drastically lower quality of life for their children. Once commonplace items were now luxuries, creating economic quandaries as this mother explains:

> In Syria, we always ate fruits, now the kids tell me, "Mom, why don't you get us bananas or apples?" … The price of a kilo of bananas is 2,500 or 1,500 pounds (US$1-1.65), so how many kilos can I get if we are 10 persons in the house, and how can I distribute the bananas!

Children were keenly aware of the economic pressures faced by their family. Below, a 10-year-old girl describes her reaction to her teacher asking her to bring school supplies:

> I come to school upset with everything. Then the teacher comes to ask, “Where is your pen? Where is your notebook? And where is the eraser? Bring a pencil and an eraser.” Sometimes she says, “Bring the whole world with you." Where would my mother get money for all this? Our rent is 300,000 or 400,000 pounds (US$200-265). Second, my father does not work and my brothers drink milk…

A few parents described adopting creative strategies to meet their children's needs in spite of limited resources. For example, one mother described attaching a “price tag” to second-hand clothing so that her children would think they were new. Some hardship adaptation strategies, however, involved making painful choices between competing needs, such as delaying medical treatment for a sick child in order to use the money for

rent or food. In some households, the steep decline in financial circumstances has necessitated a shift in gender, household and economic roles. Seven of the 20 women who participated in the study worked outside the home in contrast to their homemaker role in Syria. For these women, work entailed a trade-off between meeting their children's material needs and providing appropriate care and supervision. Working mothers cited the health and safety implications of leaving their children, for example, not being able to breastfeed infants and leaving young children unsupervised. The effects of working outside the home on parental monitoring and the parent-child relationship was also of significant concern to adult participants, many of whom attributed increased behaviour problems to their absence from home to discipline children. The overall deterioration in the parent-child relationship as a result of work-induced separation and fatigue was summed up by this mother of three, a former housewife in Syria now living with her family in a tent and working as an agricultural labourer:

> We used to live in peace; my kids and I used to understand each other more than we do now. Now, I leave them all morning, so there is a gap between us. I live with them like a ghost. They are raising themselves…There is no time to spend with the kids. When I come back home in the evening, I just sleep right away because I come back too tired to do anything else.

*Psychological difficulties pathway*

All parents described significant mental and emotional distress as a result of the change in their family's circumstances and the struggle for everyday survival. Fathers, in particular, expressed deep anguish and shame at not being able to fulfil their role as

provider, framing their family's unmet needs as a form of "dereliction" and deprivation of their children's rights. A 45-year-old father of five said:

> For a man whose main concern is his home, wife, and children, I used to care for everything and not neglect anything. Now if my wife asked me to buy a veil and I couldn't buy it, these things kill me and drive me to desperation, such as not being able to buy a pair of shoes for my son, or dresses for my wife.

Other sources of parental psychological distress related to the insecurity and injustice of life as a refugee. The majority of adult participants described feelings of anger, shame and helplessness at the perceived widespread discrimination and abuse from Lebanese neighbours, employers, health care providers, and authorities. The requirement for Syrians to hold a Lebanese residency permit provoked particular anxiety, as most participants were unable to afford the application fee or secure a Lebanese sponsor. Without a residency permit, parents lived with the constant fear of arrest and were restricted in their mobility, which in turn hampered their ability to pursue work. Another common source of frustration, particularly among fathers, was the lack of humanitarian assistance to help with basic living expenses, and the perception of corruption and favouritism among aid agencies. Parents expressed anger at not being deemed "needy" enough to receive aid, and felt humiliated by the treatment of aid agencies and the lack of transparency in how aid was distributed. Parental distress was compounded by a sense of powerlessness and diminishing hope for the future. While all participants clung to the hope of returning to Syria, for some "hope has completely died." Children's "lost future" caused particular anguish for those who could not see a way out of their current circumstances. The psychological toll of the daily stressors of displacement was especially pronounced for parents coping with the burden

of their own or their children's ill health, particularly given the high cost of healthcare in Lebanon. A 30-year-old mother of three said:

> Because of my son’s sickness, I became forgetful, I can't gather my thoughts, I walk and don't know where I'm walking, I can't concentrate, I'm confused, I don't know how to deal with my children and feel like I'm losing them, I can't feel them.

Her 8-year-old daughter offered her own perspective on her brother’s illness, highlighting the cascading effects of ill health and unaffordable health care on parental mental health and harsh parenting:

> My mother didn’t shout at me in Syria. Now, she is always shouting…My brother is very sick and we do not have enough money to treat him. My mother cries and the doctor says that he has a broken rib and his stomach swells a lot like a balloon.

Daily stressors associated with displacement contributed to significant psychological difficulties, with adult participants reporting feeling "psychologically exhausted," "stressed out," "depressed," "nervous," and “under pressure." Many parents described being overwhelmed and struggling to get through each day; a 42-year-old father of five said: "I sometimes prefer to die instead of living this way." The mental health effects of displacement were exacerbated by the lack of social support among the majority of parents. While a few men and women described seeking emotional support from their spouse or other family members, most engaged in solitary activities such as going for a walk, smoking cigarettes, crying, and ruminating when feeling stressed or upset. Men, in particular, believed that family problems should be kept private; as a 45-year-old father of five said: "House matters stay in the house, I don't

tell anyone about it." Separation from extended family, mistrust of others in the community, and the perception that everyone was suffering from similar problems and thus unable to help others, were other reasons contributing to lack of support and social isolation among adult participants.

Almost all parents made explicit links between their psychological state and parenting behaviour. A 36-year-old father of four explained how anxiety, depression and fatigue led to fewer positive interactions with his children: “We used to have a good relationship with each other, and with the kids. But we don't play with them anymore. You just don't have the urge to do so because of the circumstances, and you're always worried.” High levels of stress and frustration, primarily from economic pressures, contributed to reduced emotional regulation, greater propensity for losing one’s temper, and venting negative emotions on children. A 30-year-old mother of three stated:

> I became so unfair with my children, nothing is suitable for us here because we're not in our country and so I vent my anger on my children, I hit them, I suffer so much. When I send them to school, I feel more relieved and relaxed, but I feel angry when they return.

Some children also made the link between their parents’ psychological state and the use of violence. A 9-year-old girl said of her mother: "When she is upset at anything, she beats us and beats all of my brothers and sisters." Marital conflict stemming from economic pressure and disagreement over household responsibilities was also reported by several men and women, who noted the negative effect that such conflict had on their children's emotional wellbeing. A female focus group participant, whose husband was disabled and unable to find work, said: “I tell him to go and find work until the

argument between us reaches the degree of yelling and the kids cry, and in order to end the controversy and problems they say, please shut up, we don't want anything."

*Lack of safety pathway*

Children's lack of safety at school and in the neighbourhood was a significant concern for parents and children. Most safety fears were related to bullying and abuse from Lebanese teachers and schoolmates:

> They don't like going to the school anymore because of the many things that happen to them there. They are beaten all the time by the teachers or the Lebanese students… My 9-year old son came home yesterday crying. He told me, "The teacher hit me on my eye"
>
> – 30-year-old mother of three

> If one of us forgets a pen or a notebook at home, Miss Fatimah either beats her with the stick or she will be sent to the headmaster.
>
> – 9-year-old girl in focus group

Fears for children's safety also stemmed from being an unwelcome "guest" in another country. Parents described receiving complaints from Lebanese neighbours when their children played outside and expressed concern that altercations between Syrian and Lebanese children might jeopardise their presence in the community. The risk of children being exposed to negative influences was also a source of anxiety for some parents, such as this father of four who said: "I don't like them going out, knowing other kids. You know, it's really risky. They might get into trouble, or know the wrong kids. I don't want them getting into trouble, we're here as guests. We shouldn't cause any problems whatsoever."

In response to the multiple safety concerns, many parents described ramping up parental monitoring and control. Children were confined to the home and discouraged from interacting with their peers. As one mother said: "They have been under lock and key for four years now." Parents themselves left the house only to look for work, in large part due to the security risks related to not holding a residency permit. Participants noted the effects of confinement on their children, describing them as socially isolated and unable to expend their energy through play and other outdoor activities. Parental fatigue and stress were also exacerbated by being cooped up together in cramped living conditions, which in turn contributed to harsh verbal and physical outbursts towards children. A 33-year-old woman said of her husband: “He sometimes lost his temper because of the difficult situation, all of us cramped in one place. You know…he used to shout at the children, he couldn't bear their noise.” Lack of safety, and its ripple effects on parental mental health and harsh parenting, link back to the previous pathway on psychological difficulties, demonstrating how these pathways interact with one another to heighten risks to children’s psychosocial adjustment.

*Effects on child psychosocial adjustment*

Parents and children described a range of child emotional and behavioural problems related to negative parenting as well as child exposure to war and displacement stressors. Parents described their children as more "difficult," "stubborn," "aggressive," and "irritable," as well as "sad," "nervous," "agitated," and "lonely." Children themselves described having high levels of anxiety, which manifested in nightmares and bedwetting, as well as fears about the dark, leaving the house, and being separated from parents.

Parents attributed children's behaviour problems to feeling neglected or unloved because parents were no longer able to meet their material needs, and to feeling bored and "imprisoned" at home. Working mothers, in particular, attributed their children's increasing disobedience to not being home to discipline them. Some parents expressed concern about pre-adolescent and adolescent children engaging in negative social comparisons with Lebanese peers, and the risk of their sons dropping out of school to work or engaging in delinquent behaviours such as stealing. As a mother explains below, children's unmet needs and desires were a constant source of distress and parent-child conflict:

> My son has become aggressive all the time because of the beating. When he cries over something I didn't buy, I beat him. As a result, he becomes angry, and breaks whatever he sees in front of him, even if it is a chair.

Although some parents viewed corporal punishment as a necessary form of discipline, extreme or excessive violence against children was seen as a potential cause of emotional problems. A mother in a focus group stated: "The boy who is beaten too much becomes afraid," while an 8-year-old girl said: "When my mother beats me, I feel that no one cares about me." Children's accounts suggest that physical punishment is a common feature of interactions with their parents. The following excerpt from a focus group with boys illustrates how parents' modelling of violence may contribute to an intergenerational cycle resulting in children themselves perpetrating violent acts as a means of coping with difficult emotions:

Boy 5: Sometimes when I feel angry with someone, I feel that I want to hit him.

Interviewer: What does your father do?

Boy 6: Mister, he hits us both.

Interviewer: He hits you together?

Boy 4: Mister, my father slaps so hard that it makes me stay all day crying.

Interviewer: Well, at times you may feel angry. What do you do when you feel angry?

Boy 2: When I get mad, I hit my brother.

Boy 3: I do the same.

Boy 4: When I get angry, I break my brothers

Interviewer: Ah break them, you mean beat them?

Boy 4: Yes.

Boy 6: Mister, when I'm angry at school, I break things.

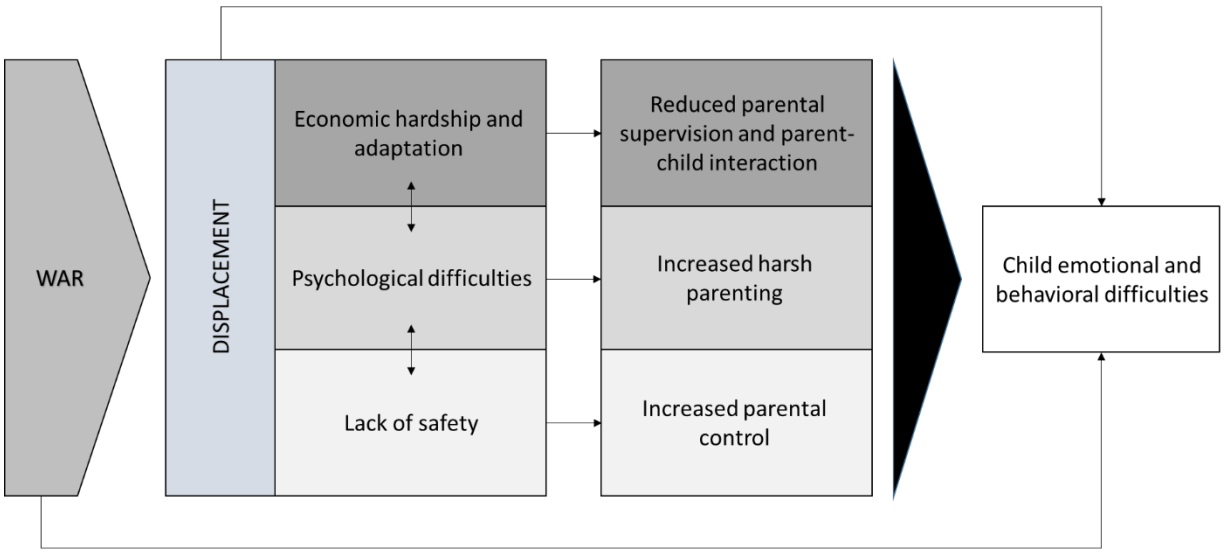
Boy 7: When I'm angry…

Interviewer: What do you do?

Boy 7: I beat him to death.

Boy 8: I slap him many times, and it becomes ok.

**Figure 8. Conceptual model of pathways linking war and displacement to parenting behaviour and child psychosocial adjustment**




*Potential protective resources for positive parenting*

Despite diminished ability to provide and care for their children, parents' love and devotion to their family were evident in all the interviews. Parents described trying to keep things "normal" for their children and shielding them from the many stressors of refugee existence. Several spoke of putting up a brave front for their children and not showing the extent of their worry and distress, often foregoing their own needs in order to ensure their children did not feel "deprived." As a 33-year-old mother said: "We try to make it like home, as much as we can." Most parents described using positive parenting strategies such as praise, rewards, and play to encourage positive behaviour or to distract and soothe children when they were upset.

While all parents described the negative effects of displacement on their quality of life and psychological wellbeing, some were better able to maintain a positive relationship with their children, respond sensitively to their desires or distress, and

refrain from harsh or violent treatment. Greater access to economic resources and social support emerged as potential protective factors contributing to positive parenting during displacement. However, more in-depth investigation of sources of parenting resilience is required given the small number of respondents in our sample who reported no or minimal adverse effects on their parenting behaviour.

In households with more economic resources, mothers were able to stay at home with their children, thus maintaining the role they had in Syria and allowing for a sense of normalcy and consistency. Greater access to economic resources also appeared to be associated with a sense of agency or trajectory, as these parents were more equipped to make plans for a better future either in or outside Lebanon. Social support, particularly a supportive relationship with one's spouse, may be another protective resource for positive parenting. Although several parents reported receiving emotional or financial support from family members or neighbours, only one of the participants explicitly linked her ability to "adapt to the current situation" and maintain a positive relationship with her children to emotional and instrumental support from her husband and his social network. This 28-year-old mother of four explained:

Respondent: My husband's family has been in Lebanon for more than 12 years…We don't feel that we are refugees here.

Interviewer: What about the relationship with your husband? Has it changed or is it still the same since you left Syria?

Respondent: Thank God, it improved. I am far away from my family and he understands that and doesn't upset me because I don't have my relatives here…Some women are arguing with their spouses and pour their anger on their children. Because my relationship with

> my husband is solid, I feel no need to pour my anger on children…Everything was difficult in the beginning, the living and the expenses. We were very tired but my husband asked me to live life normally and not think much…I now have friends among the neighbours and we go out together. We are like one family.

## Discussion

This study aimed to understand the pathways through which war and displacement affect parenting and ultimately child psychosocial adjustment. To our knowledge, it is among only a few studies to trace the linkages between war and parenting in an ongoing humanitarian crisis. With this study, we aim to address the need for empirical evidence to inform the development of parenting interventions for conflict-affected populations (Murphy et al., 2017). Results show three interrelated pathways that link the daily stressors of displacement to various dimensions of parenting: (1) economic hardship preventing parents from meeting their children's basic needs and forcing adaptation strategies that impair positive parent-child interactions; (2) parental psychological distress contributing to harsh and violent parenting; and (3) increased parental control due to perceptions and experiences of insecurity in the community. These findings corroborate previously reported parenting experiences of Syrian refugee and internally displaced families (El-Khani et al., 2016).

Our results suggest a common set of themes that characterise the experience of displacement despite differences in culture, geography, and socio-political context. First, the economic, social, and institutional stressors that define the experience of

ongoing displacement, rather than past exposure to war trauma, were viewed by parents as the main drivers of shifts in parenting behaviour. This finding is consistent with other research highlighting daily stressors as the primary mechanism through which war exposure affects mental health (Miller & Rasmussen, 2010; Jordans et al., 2012). Studies conducted in the Occupied Palestinian Territories have reported feelings of being "broken" and "destroyed" similar to the mental suffering described in this paper (Barber et al., 2016). Like the participants in this study, Palestinians attributed their distress to the political and economic constraints on their basic rights and dignity, and drew connections between political conflict, economic consequences, mobility constraints, household stress, and family dysfunction and violence (Clark et al., 2010). Similarly, in Afghanistan, the everyday grind of poverty and social inequality, rather than the dramatic events of war, was the main driver of social suffering with attendant effects on family relationships (Eggerman & Panter-Brick, 2010). In our study, gender differences in parents' experience of and response to social suffering manifested in fathers' frustration, shame, and anger due to their inability to fulfil the role of provider. This gendered family dynamic has been found in other conflict-affected populations (Wachter et al., 2017; Horn, 2010; Eggerman & Panter-Brick, 2010).

Results showing a pathway from daily stressors to harsh parenting via parental psychological distress support the family stress model, which emphasises parental mental health as the key mediator between economic pressure and disruptions to parenting and other family processes (Conger et al., 1994). However, the other pathways in the model also point to structural barriers that directly impinge on parents' ability to provide children with opportunities for physical, social and emotional development. For example, constraints on refugees' freedom of movement reduce opportunities for children's play and interaction with peers, while also having cascading

negative effects on economic self-sufficiency, parental mental health, positive parenting, and family functioning. These results echo other work highlighting the negative impacts of structural violence on developmental outcomes via unequal access to services and support, and reduced quality of caregiving (Dawes & van der Merwe, 2014). Our study also illustrates the effects of structural violence on family and child-to-child violence. Thus, not only do we see evidence of the transmission of violence across generations, but also across the social ecology from the macro and structural to the most intimate relationships within the child's ecological sphere.

Second, changes in parenting behaviour can be framed as adaptations to local conditions where parents are rational actors who adjust their behaviour based on assessments of environmental risks and benefits (Levine, 1988; Ryan et al., 2008). We use the term "adaptation" in the context of evolutionary biology, acknowledging that adaptations can serve different functions and involve trade-off and compromise, which may result in maladaptive outcomes (Frankenhuis & Del Giudice, 2012). In our study, parents' attempts to perform fundamental parenting tasks such as providing safety, sustenance, and support were often thwarted by economic pressures and other environmental constraints (Bradley, 2007). Strategies employed to adapt to their resource-constrained environment usually involved trade-offs such as mothers working outside the home to help meet the survival needs of their children at the expense of parental care and supervision. Some adaptation strategies, while seeking to minimise certain types of risk to children, increased the risk of other negative outcomes. For instance, controlling parenting, while a rational response to the security context in which refugees are living, also has potentially negative consequences for children's physical, social, and emotional development.

Finally, although the dominant narrative was on the burden of displacement stressors, results suggest that participants varied in their capacity to mitigate negative impacts on parenting. Social support, particularly from one's spouse, was a potentially important protective resource for promoting positive parenting and reducing the risk of maltreatment. This finding is consistent with research highlighting the importance of social support for parental mental health and parenting behaviour in situations of chronic adversity (McConnell et al., 2011; Morris et al., 2017). Social support as a buffer for risks to parental mental health and parenting behaviour is likely to be particularly crucial in refugee contexts given the disruption of extended support networks during war and displacement (Betancourt et al., 2013).

*Study limitations*

The study has several limitations. Purposive selection of participants, the small sample, and the unique characteristics of the study site (e.g. remoteness, paucity of social services) preclude generalizability of findings to refugees in other parts of Lebanon where access to basic services and humanitarian assistance, religious and cultural makeup, and density of refugee populations vary widely. The majority of participants fled Syria in 2012, one year into the war, limiting our ability to compare the experiences of refugees who have been more recently displaced and for whom prolonged exposure to war trauma may be more influential in changing parenting behaviour. Finally, interviews were mostly conducted by local staff of a well-known NGO. Although interviewers stressed that study participation was not linked to receiving aid, it is possible that participants placed greater emphasis on their current needs in the hope of receiving assistance.

*Implications for policy, programming and research*

With increasing investments in parenting interventions for humanitarian settings, it is important to recognise that parenting is nested within the macro system in which families are displaced, and that structural features of this system have direct and indirect effects on parenting behaviour. Efforts to remove these structural barriers or mitigate their effects may have tangible impacts on various aspects of child and parental wellbeing. For instance, easing the requirement for Syrian refugees to hold residency permits could reduce parental anxiety and increase their sense of safety, which in turn could increase positive parent-child and community interactions, ultimately reducing the risk of familial violence and improving child psychosocial outcomes.

Policies and programs that help to restore dignity and hope are also crucial to promoting positive parenting and child adjustment. Bradley & Corwyn (2013, p. 2) proposed that there are three conditions necessary for parents to make positive investments in their children: "a sense of future, a sense of purpose, and a sense of connection." For many study participants who had no viable option for return or resettlement and few prospects for integration into Lebanese society, there was little incentive to invest scarce resources today in the hope of an elusive better future. Panter-Brick & Eggerman (2017, p. 385) argue that restoring a "sense of trajectory – a sense of coherence and hope – is fundamental to the struggle to be well." Humanitarian assistance that promotes a sense of agency and self-efficacy, in addition to helping households meet basic needs, can be critical to fostering a more positive family environment in which parents see tangible value in investing in their children's future. Cash assistance is one example of aid that fosters dignity and choice, with one study finding a positive impact on reducing child labour (International Rescue Committee, 2014).

Overall, results suggest the need for a multi-layered framework of psychosocial support, from safe community spaces for social and recreational activities, to parenting or mental health interventions for families in need of more focused support (Inter-Agency Standing Committee (IASC), 2007; Jordans et al., 2016; Panter-Brick, 2010). Adaptations to common parenting intervention components such as communication, attachment, and discipline, may be necessary to address the specific ways in which displacement impairs parenting and parent-child relationships. Promoting positive emotional regulation and coping strategies, including increasing social networks and support, may need to play a bigger part in interventions for war-affected families given the enormous strain on parental mental health and spill-over effects on parenting behaviour.

Replication of this study with a larger sample of Syrian refugees in other parts of Lebanon is necessary to validate results and better inform subsequent recommendations for policy and practice. Other directions for future research include greater attention to the impact of war and displacement on family processes in addition to individual-level outcomes. In order to advance our understanding of the nature of parenting in wartime, future studies will need to incorporate linkages between different levels of analysis, including individual, family, and macro-environmental factors, in order to investigate how parenting behaviour changes through interactions with the broader social, economic, and political context. Results from this study showing multiple, interrelated pathways call for future quantitative research to go beyond simple bivariate associations to examine and test mediational pathways between war and child adjustment outcomes. Interventions based on a systemic, interactional perspective on the complex mechanisms underlying the intergenerational impact of war will likely be more

effective at disrupting cycles of violence and promoting the psychosocial wellbeing of refugee children and families.

## References

Barber, B. K., McNeely, C. A., El Sarraj, E., Daher, M., Giacaman, R., Arafat, C., … Abu Mallouh, M. (2016). Mental Suffering in Protracted Political Conflict: Feeling Broken or Destroyed. *PLOS ONE*, *11*(5), e0156216.

Betancourt, T. S., Borisova, I. I., Williams, T. P., Brennan, R. T., Whitfield, T. H., De La Soudiere, M., … Gilman, S. E. (2010). Sierra Leone's Former Child Soldiers: A Follow-Up Study of Psychosocial Adjustment and Community Reintegration: Sierra Leone's Former Child Soldiers. *Child Development*, *81*(4), 1077–1095.

Betancourt, T. S., Meyers-Ohki, S., Stulac, S. N., Elizabeth Barrera, A., Mushashi, C., & Beardslee, W. R. (2011). Nothing can defeat combined hands (Abashize hamwe ntakibananira): Protective processes and resilience in Rwandan children and families affected by HIV/AIDS. *Social Science & Medicine*, *73*(5), 693–701.

Betancourt, T. S., McBain, R. K., Newnham, E. A., & Brennan, R. T. (2015). The intergenerational impact of war: longitudinal relationships between caregiver and child mental health in postconflict Sierra Leone. *Journal of Child Psychology and Psychiatry*, *56*(10), 1101–1107.

Betancourt, T. S., Meyers-Ohki, S. E., Charrow, A. P., & Tol, W. A. (2013). Interventions for Children Affected by War: An Ecological Perspective on Psychosocial Support and Mental Health Care. *Harvard Review of Psychiatry*, *21*(2), 70–91.

Bradley, R. H. (2007). Parenting in the breach: How parents help children cope with developmentally challenging circumstances. *Parenting: Science and Practice*, *7*(2), 99–148.

Bradley, R. H., & Corwyn, R. F. (2013). “Family Process” Investments That Matter for Child Well-Being. In *Family Investments in Children’s Potential*. New York: Psychology Press.

Catani, C. (2010). War at Home – a Review of the Relationship between War Trauma and Family Violence. *Verhaltenstherapie*, *20*(1), 1–1.

Charmaz, K. (2006). *Constructing Grounded Theory*. SAGE Publications.

Clark, C. J., Everson-Rose, S. A., Suglia, S. F., Btoush, R., Alonso, A., & Haj-Yahia, M. M. (2010). Association between exposure to political violence and intimate-partner violence in the occupied Palestinian territory: a cross-sectional study. *The Lancet*, *375*(9711), 310–316.

Conger, R. D., Ge, X., Elder, G. H., Lorenz, F. O., & Simons, R. L. (1994). Economic Stress, Coercive Family Process, and Developmental Problems of Adolescents. *Child Development*, *65*(2), 541.

Danieli, Y. (1998). *International handbook of multigenerational legacies of trauma*. New York: Plenum Press.

Dawes, A., & van der Merwe, A. (2014). Structural violence and child development. In *Pathways to Peace: The Transformative Power of Children and Families*. Cambridge, MA: MIT Press.

Dekel, R., & Goldblatt, H. (2008). Is there intergenerational transmission of trauma? The case of combat veterans’ children. *American Journal of Orthopsychiatry*, *78*(3), 281–289.

Eggerman, M., & Panter-Brick, C. (2010). Suffering, hope, and entrapment: Resilience and cultural values in Afghanistan. *Social Science & Medicine*, *71*(1), 71–83.

El-Khani, A., Ulph, F., Peters, S., & Calam, R. (2016). Syria: the challenges of parenting in refugee situations of immediate displacement. *Intervention*, *14*(2), 99–113.

Frankenhuis, W. E., & Del Giudice, M. (2012). When do adaptive developmental mechanisms yield maladaptive outcomes? *Developmental Psychology*, *48*(3), 628–642.

Green, J., & Thorogood, N. (2004). *Qualitative methods for health research*. London: SAGE Publications.

Horn, R. (2010). Exploring the Impact of Displacement and Encampment on Domestic Violence in Kakuma Refugee Camp. *Journal of Refugee Studies*, *23*(3), 356–376.

Human Rights Watch. (2016). *"I Just Wanted to be Treated Like a Person." How Lebanon's Residency Rules Facilitate Abuse of Syrian Refugees*. New York.

Inter-Agency Standing Committee (IASC). (2007). *IASC guidelines on mental health and psychosocial support in emergency settings*. Geneva.

International Rescue Committee. (2014). *Emergency Economies: The Impact of Cash Assistance in Lebanon*.

Jordans, M. J. D., Pigott, H., & Tol, W. A. (2016). Interventions for Children Affected by Armed Conflict: a Systematic Review of Mental Health and Psychosocial Support in Low- and Middle-Income Countries. *Current Psychiatry Reports*, *18*(1).

Jordans, M. J. D., Semrau, M., Thornicroft, G., & van Ommeren, M. (2012). Role of current perceived needs in explaining the association between past trauma exposure and distress in humanitarian settings in Jordan and Nepal. *The British Journal of Psychiatry*, *201*(4), 276–281.

Levine, R. A. (1988). Human Parental Care: Universal Goals, Cultural Strategies, Individual Behavior. *New Directions for Child and Adolescent Development, 1988*(40), 3-12.

Masten, A. S., & Narayan, A. J. (2012). Child Development in the Context of Disaster, War, and Terrorism: Pathways of Risk and Resilience. *Annual Review of Psychology*, *63*(1), 227–257.

McConnell, D., Breitkreuz, R., & Savage, A. (2011). From financial hardship to child difficulties: main and moderating effects of perceived social support: Main and moderating effects of perceived social support. *Child: Care, Health and Development*, *37*(5), 679–691.

Miller, K. E., & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. *Social Science & Medicine*, *70*(1), 7–16.

Morris, A. S., Robinson, L. R., Hays-Grudo, J., Claussen, A. H., Hartwig, S. A., & Treat, A. E. (2017). Targeting Parenting in Early Childhood: A Public Health Approach to Improve Outcomes for Children Living in Poverty. *Child Development*, *88*(2), 388–397.

Murphy, K. M., Rodrigues, K., Costigan, J., & Annan, J. (2017). Raising children in conflict: An integrative model of parenting in war. *Peace and Conflict: Journal of Peace Psychology*, *23*(1), 46–57.

Panter-Brick, C. (2010). Conflict, violence, and health: Setting a new interdisciplinary agenda. *Social Science & Medicine, 70*(1), 1–6.

Panter-Brick, C., & Eggerman, M. (2017). Anthropology and Global Mental Health: Depth, Breadth, and Relevance. In *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health*. London: Springer.

Panter-Brick, C., Grimon, M.-P., & Eggerman, M. (2014). Caregiver-child mental health: a prospective study in conflict and refugee settings. *Journal of Child Psychology and Psychiatry*, *55*(4), 313–327.

Putnick, D. L., Bornstein, M. H., Lansford, J. E., Malone, P. S., Pastorelli, C., Skinner, A. T., … Oburu, P. (2015). Perceived mother and father acceptance-rejection predict four unique aspects of child adjustment across nine countries. *Journal of Child Psychology and Psychiatry*, *56*(8), 923–932.

Qouta, S., Punamaki, R.-L., & El Sarraj, E. (2008). Child development and family mental health in war and military violence: The Palestinian experience. *International Journal of Behavioral Development*, *32*(4), 310–321.

Rees, S., Thorpe, R., Tol, W., Fonseca, M., & Silove, D. (2015). Testing a cycle of family violence model in conflict-affected, low-income countries: A qualitative study from Timor-Leste. *Social Science & Medicine*, *130*, 284–291.

Ryan, D., Dooley, B., & Benson, C. (2008). Theoretical Perspectives on Post-Migration Adaptation and Psychological Well-Being among Refugees: Towards a Resource-Based Model. *Journal of Refugee Studies*, *21*(1), 1–18.

Saile, R., Ertl, V., Neuner, F., & Catani, C. (2014). Does war contribute to family violence against children? Findings from a two-generational multi-informant study in Northern Uganda. *Child Abuse & Neglect*, *38*(1), 135–146.

Song, S. J., Tol, W., & de Jong, J. (2014). Indero: Intergenerational Trauma and Resilience between Burundian Former Child Soldiers and Their Children. *Family Process*, *53*(2), 239–251.

Sriskandarajah, V., Neuner, F., & Catani, C. (2015). Parental care protects traumatized Sri Lankan children from internalizing behaviour problems. *BMC Psychiatry*, *15*(1).

Timshel, I., Montgomery, E., & Dalgaard, N. T. (2017). A systematic review of risk and protective factors associated with family related violence in refugee families. *Child Abuse & Neglect*, *70*, 315–330.

UNHCR, WFP, & UNICEF. (2015). *Vulnerability Assessment of Syrian Refugees in Lebanon 2015 Report*. Beirut, Lebanon.

United Nations. (2016, March 15). Syria conflict at 5 years: the biggest refugee and displacement crisis of our time demands a huge surge in solidarity. http://www.unhcr.org/afr/news/press/2016/3/56e6e3249/syria-conflict-5-years-biggest-refugee-displacement-crisis-time-demands.html (accessed May 17, 2017).

United Nations Children's Fund (UNICEF). (2016). *Uprooted: The Growing Crisis for Refugee and Migrant Children*. New York.

UNOCHA. (2017, October). Syrian Arab Republic. Retrieved October 10, 2017.

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

Verme, P., Gigliarano, C., Wieser, C., Hedlund, K., Petzoldt, M., & Santacroce, M. (2015). *The Welfare of Syrian Refugees: Evidence from Jordan and Lebanon*. The World Bank.

Wachter, K., Horn, R., Friis, E., Falb, K., Ward, L., Apio, C., … Puffer, E. (2017). Drivers of Intimate Partner Violence Against Women in Three Refugee Camps. *Violence Against Women*.

# CHAPTER IV. *DPhil Paper 2*: Modelling the effects of war exposure and daily stressors on maternal mental health, parenting, and child psychosocial adjustment: a cross-sectional study with Syrian refugees in Lebanon

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This is the second paper of the DPhil thesis. Using cross-sectional data from Syrian refugee mothers (n=291), the paper employs structural equation modelling to test a conceptual model linking war trauma, daily stressors, mothers' general psychological distress and PTS, negative parenting, and child psychosocial problems. Results from the qualitative research reported in DPhil Paper 1, combined with extant literature, informed the conceptual model examined in this paper, including specific research questions and hypotheses around pathways and outcomes. For example, the salience of displacement-related daily stressors and maternal psychological distress (as opposed to past war trauma and PTS symptoms) in the qualitative results informed the decision to model general psychological distress as a separate construct from PTS. As described in the Methodology chapter, quantitative methods are used here as another "way of seeing" (Green, 2007), thus complementing the findings from the qualitative phase.

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## Abstract

*Background:* The psychological effects of war trauma are well-documented, but comparatively little research has focused on the mechanisms underlying intergenerational impacts of war and displacement. Specifically, the effects of armed conflict on family processes such as parenting behaviour, and subsequent impacts on child psychosocial outcomes, are less understood.

*Methods:* This study tests a conceptual model linking past war trauma and current displacement-related stressors to maternal mental health, parenting behaviour, and child psychosocial problems. Cross-sectional data were collected in 2016-2017 from a sample of 291 Syrian refugee mothers in Lebanon. We used structural equation modelling to examine associations between war trauma, daily stressors, mothers' general psychological distress and post-traumatic stress (PTS), negative parenting, and child psychosocial problems.

*Results:* Exposure to war-related events was directly associated with maternal PTS and general psychological distress, as well as indirectly via daily stressors. Mothers' general psychological distress, but not PTS, was directly associated with negative parenting and child psychosocial difficulties. Negative parenting mediated the association between maternal general psychological distress and child psychosocial problems. Model fit statistics indicate that the measurement and structural models provided a good fit to the data.

*Conclusions:* Results suggest that the adverse effects of past war trauma and ongoing displacement on refugee mothers' general mental health can increase the risk of negative parenting behaviour, and in turn contribute to poorer psychosocial outcomes for children. Interventions should focus on psychosocial and parenting support for war-

affected caregivers, as well as address structural challenges that debilitate caregiver and child mental health.

*Keywords:* War; displacement; mental health; parenting; structural equation modelling

## Introduction

A growing body of research suggests that contextual factors, particularly caregiver mental health, are crucial in predicting the psychosocial outcomes of war-affected children (Betancourt & Khan, 2008; Tol et al., 2013; Meyer et al., 2017). For instance, a systematic review examining the effects of armed conflict and terrorism on children aged 0 to 6 years found that maternal depression and post-traumatic stress (PTS) predicted children's PTS symptoms, behavioural problems, and somatic complaints (Slone & Mann, 2016). Prospective studies with war-affected families in Afghanistan, Pakistan, and Sierra Leone have also demonstrated intergenerational mental health impacts over a one to four-year period (Panter-Brick et al., 2014; Betancourt et al., 2014).

While these studies suggest a robust and consistent relationship between caregiver and child mental health in conflict settings, the mechanisms underlying this association are less understood. Hypotheses around causal pathways have focused on the mediating role of parenting quality, largely drawing on evidence of the effects of caregiver mental health on parenting behaviour in non-war settings. For example, meta-analytic reviews have found effects of maternal and paternal depression on negative parenting behaviours such as hostility and unresponsiveness (Lovejoy et al., 2000; Wilson & Durbin, 2010).

In theoretical and empirical work with war-exposed populations, there has been a strong emphasis on the effects of parental traumatisation on parenting behaviour. This is likely due in part to the historical predominance of the trauma-focused model of mental health in research on conflict settings, which is centred on exposure to war-related trauma and resulting PTS symptoms (Miller & Rasmussen, 2010). For instance,

PTSD as an explanatory model for family violence focuses on symptoms such as anger, hyperarousal, and irritability heightening the risk for harsh parenting (Timshel et al., 2017). Avoidance-related PTSD symptoms such as emotional numbing and withdrawal may result in lack of emotional attunement and availability. Traumatic experiences may also impair parent-child relationships by disrupting internal attachment representations of the self as caregiver, thereby debilitating parents' ability to respond sensitively to children's cues (De Haene et al., 2010). The association between parental traumatisation and harsh parenting has been demonstrated in multiple war-affected contexts including Sri Lanka (Catani et al., 2008), northern Uganda (Saile et al., 2012), Israel (Halevi et al., 2016), and resettled refugees in The Netherlands (Van Ee et al., 2013).

By comparison, there is less evidence on how other forms of psychological distress (e.g. depression, anxiety) stemming from post- as well as pre-migration stressors may affect parenting behaviour. This gap in the literature is striking given evidence of the direct and indirect associations between stressful material and social conditions post-migration, and refugee mental health (Jordans et al., 2012; Chen et al., 2017). Research with disadvantaged communities in non-war settings suggests that daily stressors such as poverty and discrimination, also ubiquitous in refugee contexts, increase the risk of negative parenting via effects on caregiver mental health (Conger et al., 1994; Leventhal & Brooks-Gunn, 2000). In order for interventions to disrupt the intergenerational effects of war-related trauma and adversity, it is vital to analyse the various pathways contributing to harsh parenting and child psychosocial outcomes in conflict settings.

*The present study*

This study aims to expand our understanding of how war and displacement-related daily stressors influence child psychosocial wellbeing via effects on maternal mental health and parenting behaviour, with the view of informing psychosocial and parenting interventions for Syrian refugee families. The war in Syria has resulted in a displacement crisis of unprecedented scale, with over half of the country's 22 million pre-war population displaced since 2011 (UNOCHA, 2018). In Lebanon alone, there are almost one million Syrian refugees registered with the United Nations, approximately one-sixth of the entire Lebanese population (UNHCR, 2018). Using cross-sectional data from 291 Syrian refugee mothers in Lebanon, we test a multiple linkages model in which greater maternal exposure to war trauma and daily stressors such as poverty and inadequate healthcare are hypothesised to be associated with increased maternal PTS and general psychological distress, which in turn have cascading and deleterious effects on parenting and child psychosocial outcomes. The hypothesised model builds on previous conceptual and empirical work that includes past exposure to war trauma as well as post-migration daily stressors as predictors of refugee mental health (Miller & Rasmussen, 2010; Jordans et al., 2012; Chen et al., 2017). Furthermore, we investigate the unique effects of maternal PTS and general psychological distress on harsh parenting and child psychosocial difficulties, in view of the scarce research on the associations between various forms of caregiver distress and parenting and child outcomes among war-affected populations.

Study hypotheses were as follows:

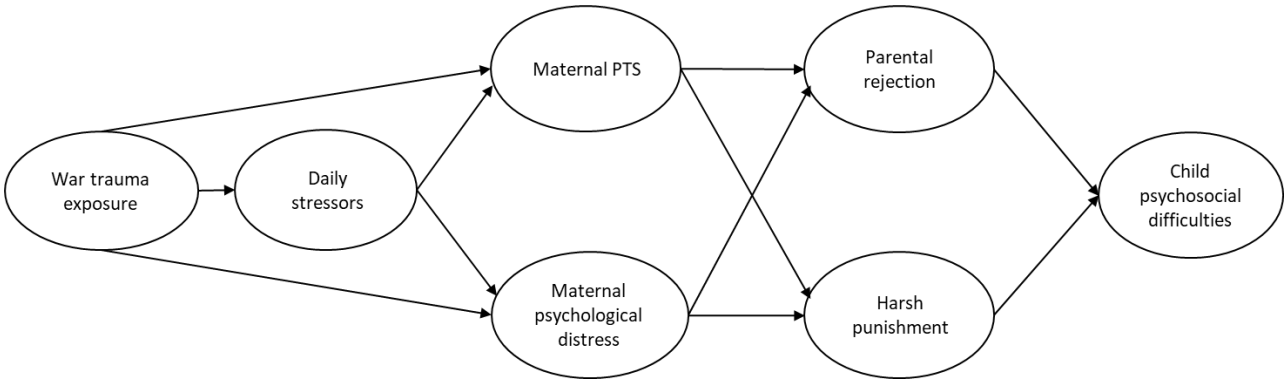
1. Mothers' past exposure to war trauma would be directly associated with increased maternal PTS and general psychological distress.

2. The relationship between past war trauma exposure and maternal mental health would be mediated by current experience of daily stressors.

3. Maternal PTS and general psychological distress would be uniquely associated with greater parental rejection and harsh punishment, as well as greater child psychosocial difficulties.

4. The relationship between maternal and child mental health would be mediated by parental rejection and harsh punishment.

**Figure 9. Conceptual model linking war trauma and daily stressors to maternal mental health, parenting, and child psychosocial difficulties**




## Methods

Data for this study were collected in collaboration with the International Rescue Committee (IRC), a non-governmental organisation providing economic, educational, and psychosocial services for Syrian refugees and vulnerable host communities in Lebanon. We used baseline data from an evaluation of the IRC's parenting intervention to conduct the analyses reported in this paper. Local IRC staff used community outreach

meetings, home visits, and referrals to recruit Syrian caregivers of children aged 2 to 12 years (the target population for IRC's parenting program) in Akkar, Arsal, Hermel and Tripoli districts where the IRC had ongoing protection and psychosocial programming. Field staff first described the structure and content of the parenting program and invited caregivers to register their interest. If the individual had a child within the appropriate age range, staff then explained the purpose and procedures of the study by reading aloud from a script. Caregivers were given the option of participating in the parenting program but not the study, and vice versa. Staff obtained verbal consent from caregivers who agreed to participate in the study. Given the vulnerable status of refugees, informed consent procedures emphasised that participation was voluntary and not linked to receiving assistance from the IRC or any other humanitarian organisation.

Data collection took place from August 2016 to March 2017. The field team consisted of 16 female and two male staff from the IRC's children's and women's protection programs in the study sites. All interviewers completed training on research ethics, informed consent, and interview skills prior to commencing survey administration using the application Open Data Kit (ODK) on electronic tablets. Pictorial response ratings (e.g. circles of increasing size to depict Likert scales) were used during the interviews to aid participant comprehension. Individual interviews were conducted in Arabic at the participants' home or the IRC office. In response to adverse events such as participant distress or disclosure of abuse, interviewers followed a safety protocol that included procedures for referral to additional services. In addition, participant endorsement of the item "Beat him/her up, that is hit him/her over and over as hard as one could" were immediately flagged to the IRC child protection staff for follow up. The study protocol was reviewed by senior IRC staff and approved by the

University of Oxford Social Sciences and Humanities Inter-divisional Research Ethics Committee (Ref No: R46541/RE001).

*Measures*

Arabic translations of the measures were obtained either from the original developers of the instrument, or from researchers and practitioners who had previously validated or administered the Arabic version in the field. The entire battery of measures underwent an extensive process of field-testing with interviewers and members of the study population, with minor clarifications made to the translations until the field team reached consensus on accuracy and comprehensibility of all the items.

*Sociodemographic information*

Sociodemographic data such as maternal age and education, length of displacement, shelter type, and income were collected using items from the United Nations Vulnerability Assessment of Syrian Refugees in Lebanon, an annual household survey conducted with Syrian refugees (UNHCR et al., 2015).

*Past war trauma*

The Traumatic Events Checklist, adapted from the Harvard Trauma Questionnaire and Gaza Traumatic Event Checklist for use in conflict settings, contains 17 yes/no items assessing experience of war events such as “Been forcibly separated from your family” (Panter-Brick et al., 2009). Item scores were summed to obtain an overall measure of mothers’ war trauma exposure.

*Current daily stressors*

Mothers’ current experience of daily stressors was assessed with the Humanitarian Emergency Settings Perceived Needs Scale (HESPER) (World Health

Organization & King's College London, 2011). HESPER consists of 21 items assessing perceived physical, social, and psychological needs in humanitarian settings (e.g. “Do you have a serious problem because you do not have an adequate place to live in?”). The Arabic language version was validated with Iraqi refugees in Jordan and demonstrated excellent, test–retest reliability, and internal consistency (Jordans et al., 2012). In this study, one item from the original measure (“Do you have a serious problem because you have been displaced from your home country, city or village?”) was omitted as all participants were refugees. One item related to legal status was added based on qualitative research suggesting that lack of legal documentation was a source of stress among refugees in Lebanon (Sim et al., 2018). Item responses ranged from 0 (*No serious problem*) to 2 (*Very serious problem*) ($\alpha = 0.89$).

*Maternal post-traumatic stress*

The Post Traumatic Stress Disorder Checklist – Civilian Version (PCL-C) (Weathers et al., 1993) consists of 17 items assessing symptoms of post-traumatic stress in the last 30 days (e.g. “How much were you bothered by repeated, disturbing memories, thoughts, or images of the stressful experience?”). The Arabic translation of this measure was obtained from the International Medical Corps, a humanitarian organisation providing mental health services to Syrian refugees in Lebanon. Item responses ranged from 1 (*Not at all*) to 5 (*Extremely*) ($\alpha = 0.89$).

*Maternal general psychological distress*

The 21-item Depression Anxiety and Stress Scale (DASS) Short Form was used to evaluate symptoms of psychological distress in the last 30 days (e.g. “I couldn't seem to experience any positive feeling at all”) (Lovibond & Lovibond, 1995). The Arabic language version of the original 42-item measure was previously validated with Arabic-

speaking immigrants to Australia (Moussa et al., 2016.) Item responses ranged from 0 (*Did not apply to me at all*) to 3 (*Applied to me very much, or most of the time*) (α = 0.91).

*Negative parenting*

The Parental Acceptance Rejection Questionnaire (PARQ) Short Form consists of 24 items assessing parental warmth, hostility, and indifference or neglect (e.g. "I see my child as a big nuisance") (Rohner, 2008). A meta-analysis of the reliability of the PARQ using data from 51 studies in 8 countries found that Cronbach's *alpha* coefficients exceeded .70 in all groups, effect sizes were homogenous across groups, and convergent and discriminant validity were demonstrated (Khaleque & Rohner, 2002). Positive items were reverse-coded to achieve an overall measure of parental rejection. Item responses ranged from 0 (*Almost never true*) to 3 (*Almost always true*) in the last 30 days (α = 0.79).

We used 8 items from the Discipline Module of UNICEF's Multiple Indicator Cluster Survey (MICS) to assess mothers' use of harsh verbal and physical punishment in the last 30 days. The MICS has been implemented in over 100 countries, and was recently administered as part of a representative household survey of Syrian refugees in Lebanon (UNHCR et al., 2015). Items include "Shouted, yelled, or screamed at him/her" and "Hit or slapped him/her on the face, head or ears" (UNICEF, 2016). Responses ranged from 0 (*Never*) to 4 (*Almost all the time*) (α = 0.78).

*Child psychosocial difficulties*

We used the Strengths and Difficulties Questionnaire (SDQ) to obtain mothers' report of child psychosocial difficulties (e.g. "Often loses temper") (Goodman, 1997). The Arabic version of the SDQ has been validated for use in epidemiological and

clinical studies (Alyahri & Goodman, 2006). Item responses ranged from 0 (*Not true*) to 2 *(Certainly true*) of the child in the last 30 days ($\alpha = 0.68$).

*Data analysis*

We used IBM SPSS Statistics 24 to conduct descriptive and exploratory factor analyses. To examine direct and indirect effects of war trauma exposure and daily stressors on maternal mental health, parenting behaviour, and child psychosocial outcomes, we performed structural equation modelling using Mplus 8 (Muthen & Muthen, 1998). We used parcelling to create latent variables for all constructs in the model, with the exception of war trauma exposure which was represented by a total sum score. Parcelling refers to the technique of creating aggregate-level indicators consisting of the sum or mean of a subset of items (Little et al., 2002). Parcelling can have psychometric and modelling advantages over the use of individual items or scale scores in structural equation modelling, such as higher reliability, lower likelihood of distributional violations, and fewer parameter estimates (Little et al., 2002; 2013; Coffman & MacCallum, 2005). Critics, however, argue that improved fit produced by item parcelling may be the result of masking rather than correcting the source of model misfit, and that the "use of parcels can obscure rather than clarify the factor structure of the data and result in biased parameter estimates and fit index values" (Bandalos, 2008, p. 212; Marsh, Lüdtke, Nagengast, Morin, & von Davier, 2013). While not without controversy, reviews of the use of parcelling strategies have generally been positive about parcelling when the focus is on examining relations among different constructs, rather than scale development or measurement invariance (Little et al. 2013; Bandalos & Finney, 2001).

As the measures used in this study have not been previously validated with the Syrian refugee population, the dimensionality and factor structure of the items when used in this particular context were unknown. Hence, we first performed exploratory factor analysis with oblique rotation to assess the dimensionality of the items as per guidance by Little et al. (2002; 2013). We examined Eigenvalues, scree plots, and theoretical cohesiveness of the resulting item groupings to assess the factor structure for each measure. Results from the exploratory factor analyses suggested that all item sets were multidimensional, and that in general factor structures did not correspond with established subscales that had been validated with other populations. Given the multidimensional nature of the items, parcels were created using the domain representative approach (Little et al., 2002; 2012). With this method, parcels are created by randomly combining items from different dimensions into item sets, thereby ensuring that each parcel is equally representative of all the facets present within the construct (Kishton & Widaman, 1994). The parcels are then used to create the latent variables in the structural equation model.

Models were estimated using full information maximum likelihood (FIML), which uses all available information from the observed data in the analyses. The percentage of participants with missing data was 14%. All parameters were estimated using the bootstrapping procedure with 5,000 bootstrapped samples to deal with non-normally distributed variables. We used the following goodness-of-fit indices to evaluate model fit: Comparative Fit Index (CFI, CFI $\geq$ 0.95); Root Mean Square Error of Approximation (RMSEA, RMSEA < 0.06); and, Standardised Root Mean Square Residual (SRMR, SRMR < 0.08) (Hu & Bentler, 1999). The MODEL INDIRECT command within Mplus was used to calculate direct and indirect effects. Maternal education, and child sex and age, were included as covariates in the structural equation

model based on prior research suggesting that mothers with less education tend to exhibit more negative parenting behaviours, and boys and younger children tend to experience more harsh discipline (Lansford et al., 2015; UNICEF, 2010).

## Results

### *Sample characteristics*

Characteristics of the sampled mothers and the index child on which they reported are summarised in Table 1. At the time of data collection, participants had been displaced in Lebanon an average of 2 to 3 years. The mean age of mothers was 31.83 years (*SD* = 8.18) and 53% had completed secondary school. Approximately half of the sample (56%) lived in an informal tented settlement and one third (31%) in a rented apartment (both individual and shared families), with the remainder in one-room structures. Only 12 percent of mothers had worked for income in the last 30 days. Participants reported lacking food or money to buy food an average of 13.73 days (*SD* = 7.87) days in the previous month. On average, mothers reported experiencing 7.2 war-related traumatic events, and the mean PCL-C score was 50.4. Applying a conventional cut score of 44 would result in approximately 70% of the sample having a positive screen for PTSD.

**Table 1. Sample characteristics**

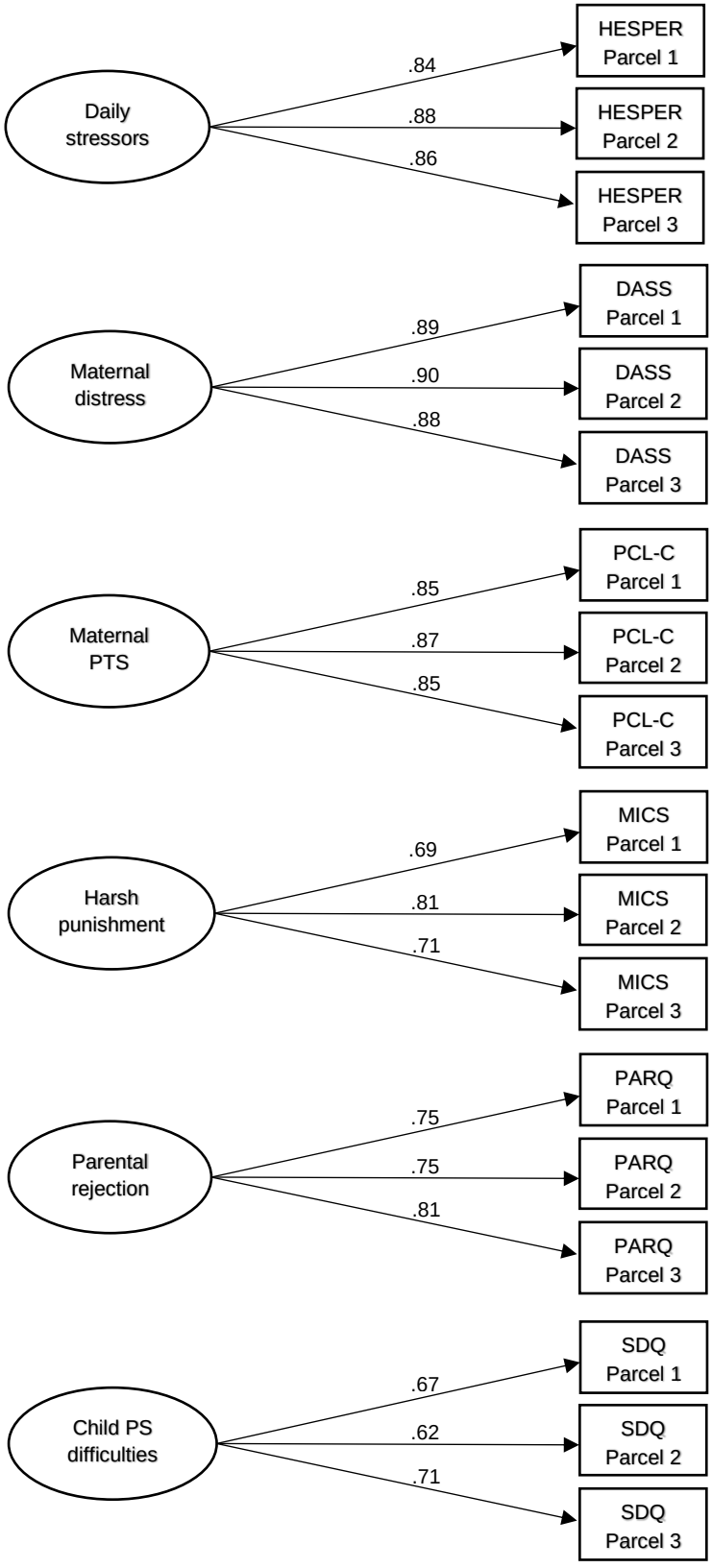
| | Mothers (n = 291) M (SD) | Scale score range |
|---|---|---|
| *Demographics* | | |
| Age (year) | 31.83 (8.18) | - |
| Children under 18 | 3.36 (1.50) | - |
| Age of index child | 7.44 (3.23) | - |
| Sex of index child, female *n* (%) | 135 (46.4) | - |
| War trauma (*N* lifetime events) | 7.21 (3.48) | 0-17 |
| Daily stressors | 25.72 (9.02) | 0-63 |
| *Maternal psychological distress* | | |
| Depression Anxiety Stress (DASS) | 32.16 (13.18) | 0-63 |
| *Maternal traumatic stress* | | |
| Post-traumatic stress (PCL) | 50.41 (12.64) | 17-85 |
| *Parenting behaviour* | | |
| Parental rejection (PARQ) | 20.78 (9.00) | 0-72 |
| Harsh punishment | 9.47 (5.80) | 0-32 |
| *Child psychosocial difficulties* | | |
| SDQ total difficulties | 16.59 (5.48) | 0-40 |

Data are Mean (*SD*), unless otherwise indicated.

*Measurement model testing*

We first examined the measurement model with confirmatory factor analysis to establish the latent constructs of daily stressors, maternal psychological distress, maternal PTS, harsh punishment, parental rejection, and child psychosocial difficulties. Model fit indices showed that the baseline measurement model was a good fit with the data: $\chi^2$ [120] = 183.87, $p < 0.001$; CFI = 0.98; RMSEA = 0.04 (90 percent C.I. 0.03-0.06); SRMR = 0.04. All factor loadings were above 0.6 and statistically significant ($p < 0.001$). Correlations between latent variables were all statistically significant ($p < 0.001$) except for daily stressors with parental rejection (see Table 2). There was high collinearity between maternal general psychological distress and PTS ($r = 0.70$).

**Figure 10. Baseline measurement model with standardised factor loadings**




All factor loadings significant at $p < 0.001$. Model fit statistics: $\chi^2$ [120] = 183.87, $p < 0.001$; CFI = 0.98; RMSEA = 0.04 (90 percent C.I. 0.03-0.06); SRMR = 0.04.

**Table 2. Correlations between war trauma exposure and latent variables for daily stressors, maternal mental health, parenting behaviour, and child psychosocial difficulties**

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| War trauma exposure | | 0.33*** | 0.44*** | 0.54*** | 0.16** | -0.03$^{ns}$ | 0.35*** |
| Daily stressors | | | 0.45*** | 0.42*** | 0.16** | 0.08$^{ns}$ | 0.35*** |
| Maternal psychological distress | | | | 0.70*** | 0.31*** | 0.28*** | 0.56*** |
| Maternal post-traumatic stress | | | | | 0.16** | 0.13* | 0.35*** |
| Harsh punishment | | | | | | 0.66*** | 0.50*** |
| Parental rejection | | | | | | | 0.48*** |
| Child psychosocial difficulties | | | | | | | |

*** $p < 0.001$, ** $p < 0.05$, *$p < 0.1$, $^{ns}$ $p \geq 0.1$.

*Structural model testing*

We used structural equation modelling to test the hypothesised pathways between constructs. War trauma exposure was associated with greater maternal psychological distress (β = 0.36, $p < 0.001$) and maternal PTS β = 0.45 ($p < 0.001$). Daily stressors was also associated with greater maternal psychological distress (β = 0.30, $p < 0.001$) and maternal PTS β = 0.25 ($p < 0.001$). In addition, daily stressors mediated the association between war trauma and maternal mental health (β = 0.10, $p < 0.001$ for psychological distress; β = 0.08, $p = 0.002$ for maternal PTS).

Maternal psychological distress was associated with greater use of harsh punishment (β = 0.34, $p = 0.002$) and more rejecting parenting behaviour (β = 0.36, $p < 0.001$). Maternal PTS, however, did not have an effect on either of these forms of negative parenting (β = -0.03, $p = 0.832$ for harsh punishment; β = -0.14, $p = 0.205$ for rejection). Similarly, maternal psychological distress (β = 0.45, $p < 0.001$), but not PTS (β = -0.004, $p = 0.973$), was associated with greater child psychosocial difficulties. While the direct effects of parental rejection (β = 0.201, $p = 0.09$) and harsh punishment (β = 0.205, $p = 0.13$) on child psychosocial outcomes were nonsignificant, there was a total indirect effect of maternal psychological distress on child psychosocial difficulties via parenting behaviour (β = 0.14, $p = 0.004$). There was no indirect effect of maternal PTS on child psychosocial difficulties via parenting behaviour.

The baseline structural model was a good fit with the data: $\chi^2$ [186] = 275.70, $p < 0.001$; CFI = 0.97; RMSEA = 0.05 (90 percent C.I. 0.04-0.06); SRMR = 0.04. All analyses controlled for maternal education, and age and sex of the index child.

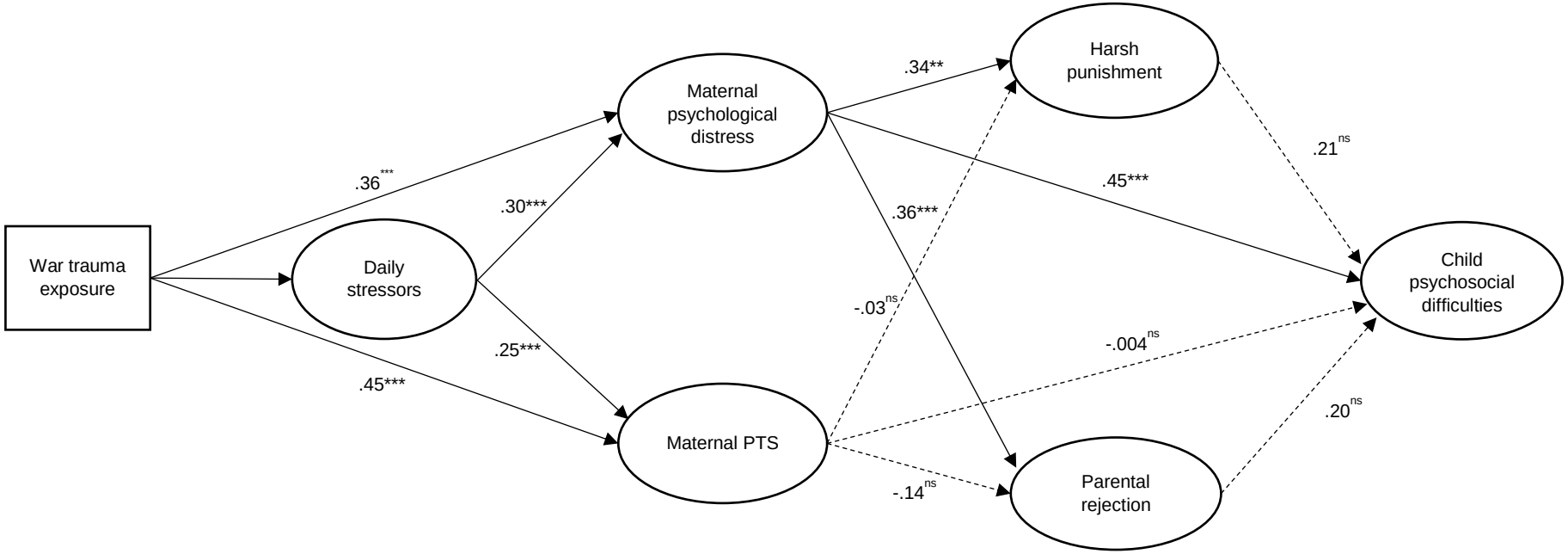
**Table 3. Direct, total indirect, and specific indirect effects (standardised regression coefficients and 95% CIs)**

| | n=291<br>Std. β (95% CI) |
|---|---|
| Direct effect of war trauma exposure on maternal psychological distress | 0.355*** (0.282, 0.570) |
| Indirect effect of war trauma exposure on maternal psychological distress via daily stressors | 0.097*** (0.045, 0.149) |
| Direct effect of war trauma exposure on maternal PTS | 0.448*** (0.386, 0.694) |
| Indirect effect of war trauma exposure on maternal PTS via daily stressors | 0.081** (0.029, 0.134) |
| Direct effect of maternal psychological distress on child psychosocial difficulties | 0.445*** (0.237, 0.654) |
| Sum of indirect effect of maternal psychological distress on child psychosocial difficulties via harsh punishment and parental rejection | 0.140** (0.044, 0.236) |
| Specific indirect effect of maternal psychological distress on child psychosocial difficulties via harsh punishment | $0.069^{ns}$ (-0.035, 0.173) |
| Specific indirect effect of maternal psychological distress on child psychosocial difficulties via parental rejection | $0.071^{ns}$ (-0.026, 0.168) |
| Direct effect of maternal PTS on child psychosocial difficulties | $-0.004^{ns}$ (-0.207, 0.200) |
| Sum of indirect effect of maternal PTS on child psychosocial difficulties via harsh punishment and parental rejection | $-0.033^{ns}$ (-0.121, 0.055) |
| Specific indirect effect of maternal PTS on child psychosocial difficulties via harsh punishment | $-0.005^{ns}$ (-0.080, 0.052) |
| Specific indirect effect of maternal PTS on child psychosocial difficulties via parental rejection | $-0.028^{ns}$ (-0.089, 0.034) |

Analyses adjusted for maternal education, and child sex and age.

*** $p < 0.001$, ** $p < 0.05$, *$p < 0.1$, $^{ns}$ $p \geq 0.1$.

**Figure 11. Structural model representing pathways from war trauma and daily stressors to maternal general psychological distress and post-traumatic stress, and to harsh punishment, parental rejection, and child psychosocial difficulties**




Maternal education, and child age and sex, were included as control variables (not shown in figure). All estimates are standardised. Solid lines indicate significant effects and dashed lines indicate nonsignificant effects. The baseline structural model was a good fit with the data: $\chi^2$ [186] = 275.70, $p < 0.001$; CFI = 0.97; RMSEA = 0.05 (90 percent C.I. 0.04-0.06); SRMR = 0.04. ***$p < .001$, **$p < .05$, *$p < .1$, $^{ns}$ $p \geq .1$.

*Sensitivity analysis*

Given the high collinearity between maternal general psychological distress and PTS in the current study ($r = 0.70$), sensitivity analyses were conducted by running two additional models: one including maternal general psychological distress only, and the other including maternal PTS only. Results from these two models are presented in Figures 12 and 13 respectively (***$p < .001$, **$p < .05$, *$p < .1$, $^{ns}$ $p \geq .1$).

**Figure 12. Structural model including maternal general psychological distress only**

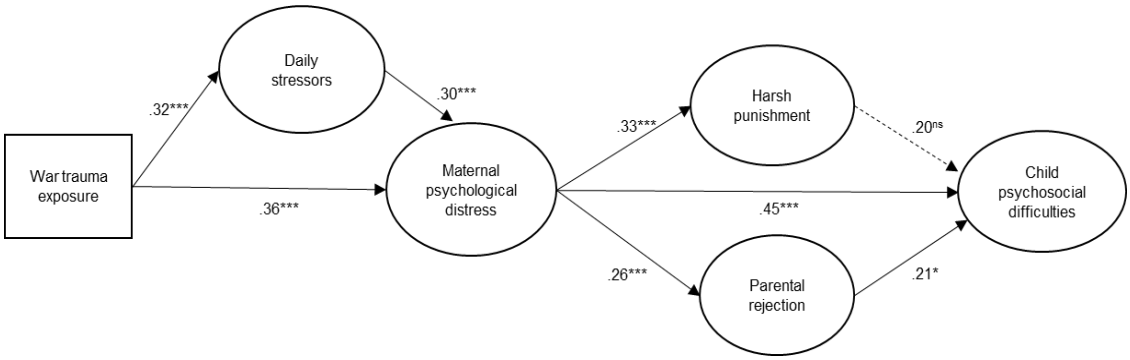
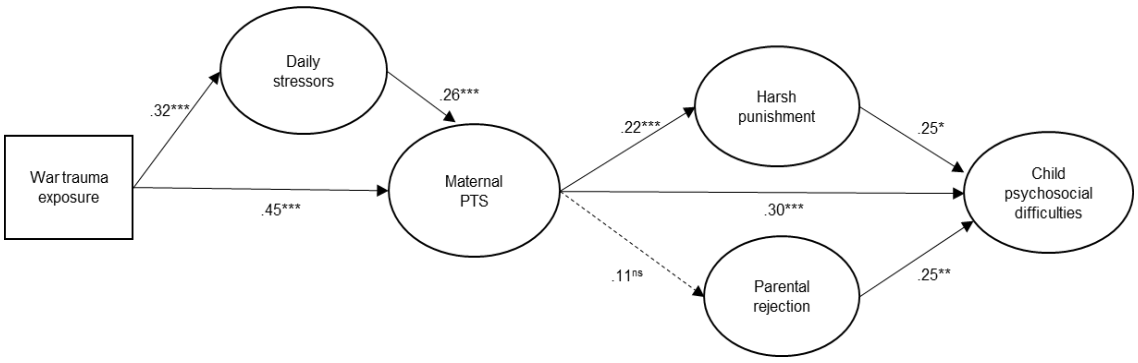



**Figure 13. Structural model including maternal PTS only**




Overall, Figures 12 and 13 show similar results. In both models, general psychological distress only and maternal PTS only had a significant direct effect on child psychosocial difficulties, with the former exhibiting a larger effect. This is in contrast to the full

model depicted in Figure 11, in which general psychological distress, but not PTS, had a significant direct effect on child psychosocial difficulties. Results from modelling maternal PTS alone suggest that the null association between maternal PTS and child psychosocial difficulties in the full model may be due to the high collinearity between mothers' general psychological distress and PTS. Furthermore, Figure 13 shows that in the model with maternal PTS alone, there was a significant effect of maternal PTS on harsh punishment, although the effect on parental rejection remained non-significant. Calculation of indirect effects showed that the indirect effect of maternal PTS on child psychosocial difficulties via negative parenting was significant.

**Discussion**

This study aimed to represent the processes contributing to the psychosocial outcomes of Syrian refugee mothers and their children. We tested a multiple linkages model in which past war trauma and current daily stressors were hypothesised to be associated with poorer maternal mental health, which in turn would be linked to more negative parenting behaviour and child psychosocial difficulties. Consistent with prior research on the mental health consequences of direct trauma exposure, our results showed that past exposure to war-related events was associated with greater maternal PTS and general psychological distress. Furthermore, current daily stressors contributed directly to greater maternal PTS and general psychological distress, as well as mediated the relationship between war trauma exposure and maternal mental health. Our findings are consistent with the conceptual model elaborated by Miller & Rasmussen (2010), which posits that stressful material and social conditions caused or exacerbated by armed conflict and displacement are a primary pathway through which war exposure impacts mental health. Qualitative research with Syrian refugees in Lebanon has also found that displacement-related daily stressors such as poverty and

lack of legal documentation were perceived by refugees as the primary drivers of parental distress and impaired parenting (Sim et al., 2018).

Study results also showed a direct link between mothers' general psychological distress and child psychosocial difficulties, thus contributing to a growing body of evidence on the impact of caregiver mental health on child and youth mental health in conflict settings. A recent study with Syrian parent-child dyads in Turkey, for instance, found that parental psychopathology was associated with child psychosocial problems, even after accounting for children's war trauma exposure (Eruyar et al., 2018). Furthermore, our results support extant theory and research positing impaired parenting as one of the primary mechanisms underlying such intergenerational mental health impacts (Fazel & Betancourt, 2017). In our study, mothers' general psychological distress was associated with increased parental rejection and harsh punishment, and the combined effect of both forms of negative parenting partially mediated the association between maternal and child mental health. These findings are consistent with a robust body of research from diverse socioeconomic and cultural groups on the negative impact of poor parental mental health on parenting behaviour, and subsequent effects of harsh parenting on child psychosocial outcomes (Lee et al., 2012; Lansford et al., 2014).

Surprisingly, our study did not find a direct association between maternal PTS and child psychosocial problems, or maternal PTS and negative parenting. For this sample, the mean score on the PCL, the measure used to assess PTS symptoms, was 50.4. Conventionally, a cut score of 44 has been used for the civilian version of the PCL, although a review of the PCL's diagnostic accuracy found significant variation in operating characteristics across populations, settings, and research methods (McDonald & Calhoun, 2010). With that caveat in mind, applying a cut score of 44 to this study

sample would result in 69.8% of participants having a positive screen for PTSD. Given the high prevalence of likely PTSD among this sample, the null association between maternal PTS, negative parenting, and child psychosocial difficulties contradicts the bulk of evidence on the negative effects of PTSD on parenting and child outcomes. Most notably, a longitudinal cohort study of refugees resettled in Australia found direct and indirect associations between caregiver PTSD and child psychosocial problems via increased harsh parenting (Bryant et al., 2018). However, it should be noted that the authors of this study cite as a limitation the lack of assessment of other parental mental health problems such as depression, which might differentially affect parenting and child outcomes. Given the modest sample size and the high correlation between maternal general psychological distress and PTS in the current study ($r$ = 0.70), results showing a null association between maternal PTS, negative parenting, and child psychosocial difficulties should be interpreted with caution. Sensitivity analyses modelling the effects of maternal PTS alone found significant associations between maternal PTS, harsh punishment, and child psychosocial difficulties, suggesting that the null effects of PTS in the full model may be due to the high collinearity between mothers' general psychological distress and PTS. A synthesis of the psychometric properties of the PTSD Checklist demonstrated high correlation with measures of depression and general anxiety, suggesting that it may pick up general negative affect rather than symptoms specific to PTSD (Wilkins, Lang & Norman, 2011). The null effect of maternal PTS in our study may therefore be due to lack of statistical power given the modest sample size, overlap between measures, and high comorbidity between PTS and depression, anxiety, and stress (Conybeare et al., 2012).

*Study limitations*

Study results and conclusions should be viewed in light of several limitations. Our sample, while recruited from four districts in Lebanon with a large refugee presence, was not representative and thus results cannot be generalised to the Syrian refugee population as a whole. As the sample only included biological mothers, it was not possible to analyse differential outcomes for fathers or other types of caregivers. The relatively modest sample size also limits statistical power to detect potentially small effects. While findings suggest an important relationship between maternal mental health parenting on child psychosocial problems, the use of cross-sectional data precludes causal inferences. It is possible, for example, that poor parental mental health may actually cause or exacerbate daily stressors, thus operating in the opposite direction than hypothesised. Determinants of parenting are complex and multidimensional, with intersecting drivers such as parents' own childhood experience of maltreatment and sociocultural norms (Fulu et al., 2017; Lansford et al., 2015). While this study goes beyond simple bivariate associations to represent a more nuanced explanation of the processes contributing to child psychosocial outcomes, the model does not account for potential confounding factors including child-driven effects such as child temperament and children's own exposure to trauma and daily stressors. The measures used in this study have not been validated with the Syrian refugee population. Due to the small sample size, we were not able to split the sample into two subsamples, one for exploratory factor analysis and one for confirmatory factor analysis, which would have provided a more stringent test of factorial structure (Wang, Watts, Anderson, & Little, 2013). Finally, data were maternal self-reports only, which increases the risk of bias associated with shared method variance, particularly as parental distress has been found to affect ratings of offspring symptomatology (Smith et al., 2001).

The use of prospective, longitudinal designs with a multi-informant assessment strategy will be important for inferring causality and capturing the mental health trajectories of war-affected children and caregivers in future research. Further work on measurement development and validation for the Syrian refugee population is also necessary to be able to discriminate between different dimensions of mental health, specifically to disentangle the potential effects of trauma-specific symptoms such as re-experiencing from those of general distress. Specific outreach to male caregivers is also important to determine if the pathways in the model investigated in this paper operate differently for male and female caregivers, as suggested by evidence from other studies of war-affected families (Palosaari et al., 2013; Panter-Brick et al., 2014).

*Conclusion*

While the direct effects of war on adult and child mental health have been well-documented, research on the pathways through which child psychosocial outcomes are shaped by impaired parental mental health and parenting behaviour is lacking. Our study contributes to the growing literature on parenting in war by testing a comprehensive model linking war trauma and daily stressors to maternal mental health, parenting, and child psychosocial adjustment, and by modelling the effects of maternal PTS and general psychological distress on parenting and child outcomes.

Our results have several implications for policy and practice. Given the strong influence of caregiver-related variables, interventions to improve the mental health and psychosocial resilience of war-affected children also need to address caregiver mental health and its impacts on parenting behaviour. An ongoing debate among mental health scholars and practitioners concerns the prioritisation and sequencing of specialised clinical treatment for PTSD versus interventions for other manifestations of distress,

including depression and impaired social functioning (Miller & Rasmussen, 2010; Neuner, 2010). Results highlighting the importance of general psychological distress stemming from multiple pre-and post-migration factors, while preliminary and should be interpreted with caution, suggest that addressing general mental health problems among war-affected caregivers may have wide-ranging, beneficial impacts on overall functioning, and parenting in particular. For example, adopting a common elements treatment approach, in which cognitive behavioural and parenting components can be flexibly combined and delivered by trained paraprofessionals to treat a range of emotional and behavioural problems, may be a feasible and effective intervention strategy for improving caregiver mental health and parenting in conflict settings (Murray et al., 2018).

Refugee policies and programs must also address the structural challenges that debilitate caregiver and child mental health, such as inadequate support for basic survival needs, lack of access to quality health and education services, and restrictions on movement and employment (Sim et al., 2018; Fazel & Betancourt, 2017). Adopting a multi-level, cross-sectoral intervention approach to reduce or mitigate the impacts of structural and family-related stressors will be instrumental to protecting the psychosocial wellbeing of subsequent generations of Syrian children.

## References

Alyahri, A. & Goodman, R. (2006). Validation of the Arabic strengths and difficulties questionnaire and the development and well-being assessment. *Eastern Mediterranean Health Journal*, 12, S138–S146.

Bandalos, D.L. (2008). Is parceling really necessary? A comparison of results from item parceling and categorical variable methodology. *Structural Equation Modeling*, 15, 211–240.

Bandalos, D.L. & Finney, S.J. (2001). Item parceling issues in structural equation modeling. In G.A. Marcoulides & R.E. Schumacker (Eds.), *New developments and techniques in structural equation modeling* (pp. 269–296). Mahwah, NJ: Erlbaum.

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

Betancourt, T.S., McBain, R.K., Newnham, E.A. & Brennan, R.T. (2015). The intergenerational impact of war: longitudinal relationships between caregiver and child mental health in postconflict Sierra Leone. *Journal of Child Psychology and Psychiatry* 56, 1101–1107.

Bryant, R.A., Edwards, B., Creamer, M., O'Donnell, M., Forbes, D., Felmingham, K.L., Silove, D., Steel, Z., Nickerson, A. & McFarlane, A.C. (2018). The effect of post-traumatic stress disorder on refugees' parenting and their children's mental health: a cohort study. *The Lancet Public Health* 3, e249–e258.

Catani, C., Jacob, N., Schauer, E., Kohila, M. & Neuner, F. (2008). Family violence, war, and natural disasters: A study of the effect of extreme stress on children's mental health in Sri Lanka. *BMC Psychiatry* 8.

Chen, W., Hall, B.J., Ling, L. & Renzaho, A.M. (2017). Pre-migration and post-migration factors associated with mental health in humanitarian migrants in Australia and the moderation effect of post-migration stressors: findings from the first wave data of the BNLA cohort study. *The Lancet Psychiatry* 4, 218–229.

Coffman, D.L. & MacCallum, R.C. (2005). Using parcels to convert path analysis models into latent variable models. *Multivariate Behavioral Research* 40, 235–259.

Conger, R.D., Ge, X., Elder, G.H., Lorenz, F.O. & Simons, R.L. (1994). Economic Stress, Coercive Family Process, and Developmental Problems of Adolescents. *Child Development* 65, 541.

De Haene, L., Grietens, H. & Verschueren, K. (2010). Adult attachment in the context of refugee traumatisation: the impact of organized violence and forced separation on parental states of mind regarding attachment. *Attachment & Human Development* 12, 249–264.

Eruyar, S., Maltby, J. & Vostanis, P. (2018). Mental health problems of Syrian refugee children: the role of parental factors. *European Child & Adolescent Psychiatry*.

Fazel, M. & Betancourt, T.S. (2017). Preventive mental health interventions for refugee children and adolescents in high-income settings. *The Lancet Child & Adolescent Health* 2, 121-132.

Fulu, E., Miedema, S., Roselli, T., McCook, S., Chan, K.L., Haardörfer, R. & Jewkes, R., on behalf of the UN Multi-country study on Men and Violence study team (2017).

Pathways between childhood trauma, intimate partner violence, and harsh parenting: findings from the UN Multi-country Study on Men and Violence in Asia and the Pacific. *The Lancet Global Health* 5, e512–e522.

Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry* 38, 581–586.

Halevi, G., Djalovski, A., Vengrober, A. & Feldman, R. (2016). Risk and resilience trajectories in war-exposed children across the first decade of life. *Journal of Child Psychology and Psychiatry* 57, 1183–1193.

Hu, L. & Bentler, P.M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling: A Multidisciplinary Journal* 6, 1–55.

Jordans, M.J.D. & Semrau, M., Thornicroft, G. & van Ommeren, M. (2012). Role of current perceived needs in explaining the association between past trauma exposure and distress in humanitarian settings in Jordan and Nepal. *The British Journal of Psychiatry* 201, 276–281.

Khaleque, A. & Rohner, R.P. (2002). Reliability of measures assessing the pancultural association between perceived parental acceptance-rejection and psychological adjustment: A meta-analysis of cross-cultural and intracultural studies. *Journal of Cross-Cultural Psychology* 33, 87-99.

Kishton, J.M. & Widaman, K.F. (1994). Unidimensional versus domain representative parceling of questionnaire items: an empirical example. *Educational and Psychological Measurement* 54, 757–765.

Lansford, J. E., Sharma, C., Malone, P. S., Woodlief, D., Dodge, K. A., Oburu, P., Pastorelli, C., Skinner, A.T., Sorbring, E., Tapanya, S., Uribe Tirado, L.M., Zelli, A., Al-Hassan, S.M., Alampay, L.P., Bacchini, D., Bombi, A.S., Bornstein, M.H., Chang, L., Deater-Deckard, K., Di Giunta, L. (2014). Corporal Punishment, Maternal Warmth, and Child Adjustment: A Longitudinal Study in Eight Countries. *Journal of Clinical Child & Adolescent Psychology*, 43(4), 670–685.

Lansford, J. E., Godwin, J., Uribe Tirado, L. M., Zelli, A., Al-Hassan, S. M., Bacchini, D., Bombi, A.S., Bornstein, M.H., Chang, L., Deater-Deckard, K., Di Giunta, L., Dodge, K.A., Malone, P.S., Oburu, P., Pastorelli, C., Skinner, A.T., Sorbring, E., Tapanya, S. & Alampay, L. P. (2015). Individual, family, and culture level contributions to child physical abuse and neglect: A longitudinal study in nine countries. *Development and Psychopathology*, 27(4pt2), 1417–1428.

Lee, S.J., Taylor, C.A. & Bellamy, J.L. (2012). Paternal depression and risk for child neglect in father-involved families of young children. *Child Abuse & Neglect* 36, 461–469.

Leventhal, T. & Brooks-Gunn, J. (2000). The neighborhoods they live in: The effects of neighborhood residence on child and adolescent outcomes. *Psychological Bulletin* 126, 309–337.

Little, T.D., Cunningham, W.A., Shahar, G. & Widaman, K.F. (2002). To Parcel or Not to Parcel: Exploring the Question, Weighing the Merits. *Structural Equation Modeling: A Multidisciplinary Journal* 9, 151–173.

Little, T.D., Rhemtulla, M., Gibson, K. & Schoemann, A.M. (2013). Why the items versus parcels controversy needn't be one. *Psychological Methods* 18, 285–300.

Lovejoy, M.C., Graczyk, P.A., O'Hare, E. & Neuman, G. (2000). Maternal depression and parenting behavior: A meta-analytic review. *Clinical Psychology Review* 20, 561–592.

Lovibond, P.F. & Lovibond, S.H. (1995). The Structure of Negative Emotional States: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy* 33, 335–343.

Marsh, H. W., Lüdtke, O., Nagengast, B., Morin, A. J. S., & von Davier, M. (2013). Why item parcels are (almost) never appropriate: Two wrongs do not make a right—Camouflaging misspecification with item parcels in CFA models. *Psychological Methods*, 18(3), 257–284.

McDonald, S.D. & Calhoun, P.S. (2010). The diagnostic accuracy of the PTSD checklist: A critical review. *Clinical Psychology Review* 30(8), 976-987.

Meyer, S.R., Steinhaus, M., Bangirana, C., Onyango-Mangen, P. & Stark, L. (2017). The influence of caregiver depression on adolescent mental health outcomes: findings from refugee settlements in Uganda. *BMC Psychiatry* 17.

Miller, K.E. & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. *Social Science & Medicine* 70, 7–16.

Moussa, M.T., Lovibond, P., Laube, R. & Megahead, H.A. (2016). Psychometric Properties of an Arabic Version of the Depression Anxiety Stress Scales (DASS). *Research on Social Work Practice* 27, 375-386.

Murray, L.K., Hall, B.J., Dorsey, S., Ugueto, A.M., Puffer, E.S., Sim, A., Ismael, A., Bass, J., Akiba, C., Lucid, L., Harrison, J., Erikson, A. & Bolton, P.A. (2018). An

evaluation of a common elements treatment approach for youth in Somali refugee camps. *Global Mental Health* 5.

Neuner, F. (2010). Assisting war-torn populations – Should we prioritize reducing daily stressors to improve mental health? Comment on Miller and Rasmussen (2010). *Social Science & Medicine* 71, 1381–1384.

Palosaari, E., Punamäki, R.L., Qouta, S. & Diab, M. (2013). Intergenerational effects of war trauma among Palestinian families mediated via psychological maltreatment. *Child Abuse & Neglect* 37, 955–968.

Panter-Brick, C., Burgess, A., Eggerman, M., McAllister, F., Pruett, K., Leckman, J.F. (2014). Practitioner Review: Engaging fathers - recommendations for a game change in parenting interventions based on a systematic review of the global evidence. *Journal of Child Psychology and Psychiatry* 55, 1187–1212.

Panter-Brick, C., Grimon, M.P. & Eggerman, M. (2014). Caregiver-child mental health: a prospective study in conflict and refugee settings. *Journal of Child Psychology and Psychiatry* 55, 313–327.

Panter-Brick, C., Eggerman, M., Gonzalez, V. & Safdar, S. (2009). Violence, suffering, and mental health in Afghanistan: A school-based survey. *Lancet* 374, 807–886.

Rohner, R.P. & Khaleque, A. (2008). *Handbook for the study of parental acceptance and rejection*. Storrs, Connecticut: Rohner Research.

Saile, R., Ertl, V., Neuner, F. & Catani, C. (2014). Does war contribute to family violence against children? Findings from a two-generational multi-informant study in Northern Uganda. *Child Abuse & Neglect* 38, 135–146.

Sim, A., Fazel, M., Bowes, L. & Gardner, F. (2018). Pathways linking war and displacement to parenting and child adjustment: A qualitative study with Syrian refugees in Lebanon. *Social Science & Medicine* 200, 19-26.

Slone, M. & Mann, S. (2016). Effects of War, Terrorism and Armed Conflict on Young Children: A Systematic Review. *Child Psychiatry & Human Development* 47, 950–965.

Smith, P., Perrin, S., Yule, W. & Rabe-Hesketh, S. (2001). War exposure and maternal reactions in the psychological adjustment of children from Bosnia-Hercegovina. *The Journal of Child Psychology and Psychiatry and Allied Disciplines* 42, 395–404.

Timshel, I., Montgomery, E. & Dalgaard, N.T. (2017). A systematic review of risk and protective factors associated with family related violence in refugee families. *Child Abuse & Neglect* 70, 315–330.

Tol, W.A., Song, S. & Jordans, M.J.D. (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, 445–460.

UNHCR (2018). Syrian Regional Refugee Response. Retrieved June 20, 2018, from https://data2.unhcr.org/en/situations/syria.

UNHCR, WFP & UNICEF (2015). *Vulnerability Assessment of Syrian Refugees in Lebanon 2015 Report*. Beirut, Lebanon.

UNICEF (2010). *Child disciplinary practices at home: evidence from a range of low- and middle-income countries.* New York: UNICEF.

UNICEF (2016). Multiple Indicator Cluster Surveys. Retrieved May 5, 2016, from http://mics.unicef.org.

UNOCHA (2018). Syrian Arab Republic. Retrieved June 20, 2018, from http://www.unocha.org/syria.

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

Wang, L. L., Watts, A. S., Anderson, R. A., & Little, T. D. (2013). Common Fallacies in Quantitative Research Methodology. In *The Oxford Handbook of Quantitative Methods (Vol. 2)*. Oxford University Press.

Weathers, F.W., Litz, B.T., Herman, D.S., Huska, J.A. & Keane, T.M. (1993). The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility. In *Paper presented at the annual convention of the International Society for Traumatic Stress Studies*. San Antonio, TX.

Wilkins, K.C., Lang, A.J. & Norman, S.B. (2011). Synthesis of the psychometric properties of the PTSD checklist (PCL) military, civilian, and specific versions. *Depression and Anxiety* 28, 596–606.

Wilson, S. & Durbin, C.E. (2010). Effects of paternal depression on fathers' parenting behaviors: A meta-analytic review. *Clinical Psychology Review* 30, 167–180.

World Health Organization & King's College London (2011). *The humanitarian emergency settings perceived needs scale (HESPER): manual with scale.* Geneva: World Health Organization; London: King's College London.

# CHAPTER V. *DPhil Paper 3*: The promotive effects of social support for psychological and parenting resilience in a refugee context: a cross-sectional study with Syrian mothers in Lebanon

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This is the third paper of the DPhil thesis. The paper uses cross-sectional data from 291 Syrian refugee mothers to examine the role of perceived social support in promoting their psychological and parenting resilience. Social support emerged as a potential source of parental resilience in the qualitative findings reported in DPhil Paper 1 of this thesis. Given the potential for social support to be a modifiable target of intervention in refugee settings, this paper adopts the residual approach (Kim-Cohen et al., 2004) to operationalise resilience as better than expected mental health and parenting behaviour given level of war trauma exposure. Linear regression analyses were subsequently conducted to assess if mothers' perceived social support is associated with their psychological and parenting resilience.

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## Abstract

*Background:* Exposure to war trauma increases the risk of negative individual and family-level outcomes. However, not all trauma-exposed individuals exhibit mental health or family dysfunction, and some function better than expected given their level of trauma exposure. Research with at-risk populations, including refugees, suggests that social support may promote positive mental health and parenting behaviour in the face of adversity.

*Method:* We used cross-sectional data from 291 Syrian refugee mothers to test the role of perceived social support in promoting their psychological and parenting resilience, defined here as better than expected mental health and parenting behaviour given level of exposure to war trauma. Psychological and parenting resilience were operationalised using the residual approach, which assessed the difference between mothers' actual score on mental health and harsh discipline measures, and the score predicted by their level of trauma exposure. Linear regression models were used to test for associations between mothers' perceived social support and their psychological and parenting resilience.

*Results:* Results showed that mothers' perceived social support was associated with both psychological and parenting resilience, including after controlling for convariates. Exploratory analyses further suggested that emotional support, but not instrumental support, was associated with mothers' psychological resilience.

*Conclusion:* Social support may have a promotive effect on mothers' mental health and parenting behaviour in a context of ongoing conflict and displacement. Identifying intervention strategies to increase social support for refugees, within the

framework of a multi-layered intervention approach, could potentially contribute to children's psychosocial resilience via improved maternal mental health and parenting.

**Key words:** Social support; refugees; mental health; parenting; resilience.

## Introduction

There is growing evidence that parental factors, specifically caregiver mental health and parenting, are crucial to promoting the resilience of war-affected children (Betancourt & Khan, 2008; Werner, 2012; Reed, Fazel, Jones, Panter-Brick, & Stein, 2012; Tol, Song, & Jordans, 2013). Yet little is known about the variables and processes that promote the resilience of caregivers themselves. Luthar and colleagues define resilience as a "process encompassing positive adaptation within the context of significant adversity" (Luthar, Cicchetti, & Becker, 2000, p. 543). Drawing on this conceptualisation, *parental resilience* can be defined as "the capacity of parents to deliver competent, quality parenting to children despite adverse personal, family, and social circumstances" (Gavidia-Payne et al., 2015, p. 111). While a preponderance of research focuses on the deleterious effects of war trauma on psychosocial functioning, resilience literature highlights the variation in how individuals respond to adverse circumstances, with some demonstrating extraordinary competence despite their level of risk (Masten, 2001). Given the crucial role of caregivers in buffering children from the negative impacts of war and displacement, it is vital that resilience research moves beyond its traditional focus on the developmental trajectories of children to include exploration of the factors contributing to parental resilience.

Ecological approaches to understanding resilience posit that a range of variables at the individual, family, peer, and community levels interact with one another to increase or decrease the risk of negative outcomes in the face of adversity (Bronfenbrenner & Morris, 1998; Tol et al., 2013). Among these variables, social support has received considerable attention in the theoretical and empirical literature. Social support has been defined as "social relationships that provide (or can potentially provide) material and interpersonal resources that are of value to the recipient, such as

counselling, access to information and services, sharing of tasks and responsibilities, and skill acquisition" (Thompson, Flood, & Goodvin, 2006, p. 2). The multidimensional nature of social support is reflected in the various approaches used to define and operationalise the construct. For example, types of support can include emotional and instrumental support, where emotional support involves providing care and empathy, and instrumental support involves providing assistance through giving of one's time, skills or other resources (Thompson et al., 2006).

Social support theory uses two models, the main effect and stress-buffering models, to conceptualise the association between social support and wellbeing. The main effect model, as the name suggests, posits that social support has a direct, beneficial effect on the outcome regardless of the level of stress exposure. The stress-buffering model, on the other hand, suggests that social support protects against negative effects only in the context of stressful experiences, such that those with higher levels of stress show greater benefit of social support compared to those with lower levels of stress (Cohen & Wills, 1983). In general, empirical studies have shown more consistent support for the direct, promotive effects of social support on wellbeing, with more inconclusive evidence on whether social support has buffering effects in times of stress (Rueger, Malecki, Pyun, Aycock, & Coyle, 2016; Auerbach, Bigda-Peyton, Eberhart, Webb, & Ho, 2011; Burton, Stice, & Seeley, 2004).

In this study, we examine the hypothesised promotive (i.e. main) effects of social support in the domains of mental health and parenting among a highly vulnerable sample of Syrian refugee mothers. We chose to focus on social support as a promotive factor for psychosocial resilience because of the wealth of research on its beneficial effects among different at-risk populations, including those affected by armed conflict. For example, social support has been linked to fewer depressive symptoms among

children and youth who were medically or psychiatrically ill, abused, or low-income (Rueger et al., 2016), and higher levels of prosocial behaviour and adaptive functioning among former child soldiers in Sierra Leone (Betancourt et al., 2010). In a systematic review of 29 studies on the long-term mental health of refugees, lack of social support was associated with more depressive symptoms (Bogic, Njoku, & Priebe, 2015).

Social support also has the potential to influence parenting behaviour, both directly and indirectly. Belsky's (1984) model of the determinants of parenting posits that social support shapes parenting through three main functions: providing emotional support, providing instrumental assistance, and setting or reinforcing social norms. For example, social support may influence parenting behaviour through increased exposure to different parenting strategies. Previous research has found that mothers with larger social networks were more likely to praise their children and demonstrated less controlling behaviour (Jennings, Stagg & Connors, 1991). Studies have also found associations between social support and parenting behaviour among parents experiencing adversity. Results from a study with parents living in urban poverty found that more social support predicted greater increases in the frequency of positive parent-child interactions over time (Green, Furrer & McAllister, 2007). Less social support, on the other hand, increased the risk of child abuse among mothers experiencing the economic crisis in Croatia, as well as increased the effect of exposure to cumulative risk on child abuse potential (Ajduković, Rajter, & Rezo, 2018). Similarly, several longitudinal studies concluded that greater maternal social support was associated with breaking the intergenerational cycle of abuse among mothers with a history of childhood maltreatment (Jaffee et al., 2013; Tracy, Salo, & Appleton, 2018). Social support may also promote positive parenting indirectly through improving the mental

health of caregivers under stress, as evidenced by prior empirical work related to the Family Stress Model (Conger et al., 1992).

Finally, social support is of particular relevance in conflict settings as the degradation and destruction of support networks are a direct consequence of war and displacement. There have been some efforts to rebuild support structures as part of the response to the Syria refugee crisis, including peer-to-peer parenting support groups for refugee mothers in Lebanon (Mercy Corps, n.d.), and a group-based psychosocial intervention for Syrian refugee and Jordanian youth with a focus on promoting social support (Panter-Brick et al., 2018). However, the paucity of studies on social support as a potentially modifiable target of intervention among war-affected caregivers warrants more in-depth investigation on its utility in promoting psychological and parenting resilience.

*The present study*

In this study, we examine if social support is associated with psychological and parenting resilience among Syrian refugee mothers. Specifically, we test whether mothers' perceived social support is associated with better than expected maternal mental health and parenting behaviour given their level of past exposure to war-related trauma. Poor maternal mental health has been linked to negative parenting behaviour in numerous studies: results from a meta-analysis of 46 studies showed that maternal depression was consistently associated with higher levels of harsh, negative parenting and, to a lesser extent, with lower levels of positive, responsive parenting (Lovejoy, Graczyk, O'Hare, & Neuman, 2000). Hence, this study examines the role of social support in promoting mothers' psychological resilience as an important outcome in itself, as well as a significant correlate of parenting behaviour.

Researchers have used various methods of operationalising resilience, including using cut points to categorise "resilient" and "non-resilient" individuals (Wyman et al., 1999), and the detection of statistical interaction between specific risk exposures, protective resources, and outcomes (Luthar & Cushing, 2002). Another approach – broadly termed the "residual" approach – measures the continuum from vulnerability to resilience by using the standardised residual from a regression predicting the outcome from the risk exposure (Kim-Cohen, Moffitt, Caspi, & Taylor, 2004). Further regression analyses are then conducted to determine if hypothesised protective factors are associated with resilience, as operationalised by residual scores. This approach, which has been used in several studies of resilience (Agnafors et al., 2017; Miller-Lewis, Searle, Sawyer, Baghurst & Hedley, 2013; Bowes, Maughan, Caspi, Moffitt & Arseneault, 2010; Collishaw et al., 2016), has the advantage of retaining the conceptualisation of resilience as a continuum, while avoiding the methodological challenges of detecting potentially small and unstable interaction effects (Luthar & Cushing, 2002).

In this study, we adopt the residual approach to operationalise psychological resilience as less emotional distress than predicted given mothers' level of exposure to war trauma, and parenting resilience as less use of harsh punishment than predicted given mothers' trauma exposure. Using cross-sectional data from a sample of 291 Syrian refugee mothers in Lebanon, we conducted regression analyses to determine if perceived social support was associated with mothers' psychological and parenting resilience. We also conducted exploratory analyses on two specific dimensions of social support – emotional and instrumental support – to assess their relative contribution to mothers' psychological and parenting resilience.

The study hypotheses were as follows:

(1) Higher levels of past war trauma exposure would be associated with poorer maternal mental health, more rejecting parenting behaviour, and greater use of harsh punishment.

(2) Higher levels of perceived social support would be associated with greater psychological and parenting resilience (i.e. better than expected maternal mental health and parenting behaviour given level of past war trauma exposure).

Our ultimate aim is to inform the development of psychosocial and parenting interventions by assessing whether social support – a potentially modifiable protective resource – contributes to more positive mental health and parenting outcomes among war-affected caregivers.

## Methods

### *Procedure*

Data for this study were collected from August 2016 to March 2017 as part of a baseline assessment for the International Rescue Committee's (IRC) parenting programme for Syrian refugees in Lebanon. The IRC is a non-governmental organisation (NGO) providing economic, educational, and psychosocial services for Syrian refugees and vulnerable Lebanese communities. Sixteen female and two male IRC staff conducted community outreach meetings, home visits, and referrals to recruit Syrian caregivers of children aged 2 to 12 years (the target population for IRC's parenting programme) in Akkar, Arsal, Hermel and Tripoli districts. Field staff explained the purpose and procedures of the study by reading aloud from a script and obtained verbal consent for participation. Given the vulnerable status of refugees,

informed consent procedures emphasised that participation was voluntary and not linked to receiving assistance from the IRC or any other humanitarian organisation.

All interviewers completed training on research ethics, informed consent, and interview skills prior to commencing survey administration using the application Open Data Kit on electronic tablets. Pictorial response ratings (e.g. circles of increasing size to depict Likert scales) were also used during the interviews to aid participant comprehension. Individual interviews were conducted in Arabic at the participants' home or the IRC office prior to participation in the parenting programme. In response to adverse events such as participant distress or disclosure of abuse, interviewers followed a safety protocol that included procedures for referral to additional services if necessary. Interviewers also provided a list of local health and psychosocial support services if participants preferred. In order to respond to potential cases of child maltreatment, participant endorsement of the item "Beat him/her up, that is hit him/her over and over as hard as one could" were immediately flagged to the IRC child protection staff for follow up. The study protocol was reviewed by senior IRC staff and approved by the University of Oxford Social Sciences and Humanities Inter-divisional Research Ethics Committee (Ref No: R46541/RE001).

*Participants*

Participants' sociodemographic information is summarised in Table 4. At the time of data collection, participants had been displaced in Lebanon an average of 2 to 3 years. The mean age of mothers was 31.83 years ($SD$ = 8.18) and 53% had completed secondary school. The majority of participants were married (91.4%), 5.5% were widowed, and the remaining participants described themselves as in a relationship, or separated/divorced. Of the married participants, 86.9% were cohabiting with their

spouse at the time of the interview. The majority of participants (69.1%) lived in substandard housing defined as informal tented settlements, one-room structures, and converted or commercial spaces, and 73% lived in overcrowded conditions (i.e. more than 3 persons residing in a room). Only 12 percent of participants had worked for income in the last 30 days, and almost half (47.1%) did not have a working member of the household. Participants reported lacking food or money to buy food an average of 13.73 days (*SD* = 7.87) days in the previous month. War-related trauma exposure averaged 7.21 events (*SD* = 3.48), with witnessing bombardment or explosion most commonly reported. Approximately 16% of respondents reported believing that it was necessary to physically punish their child in order to raise him or her properly. This is comparable to a nine-country study (including Jordan) in which 17% of parents reported believing that corporal punishment was necessary (Lansford et al., 2010).

**Table 4. Sample characteristics**

| | Mothers (n = 291) | |
|---|---|---|
| | M (SD) | Minimum, maximum |
| *Demographics* | | |
| Age (year) | 31.83 (8.18) | 19, 56 |
| Marital status, married *n* (%) | 266 (91.4) | - |
| Children under 18 | 3.4 (1.50) | 1, 8 |
| Age of index child | 7.44 (3.23) | 2, 12 |
| Sex of index child, female *n* (%) | 135 (46.4) | - |
| Believe in need for physical punishment, yes *n* (%) | 47 (16.2) | - |
| War trauma (*N* lifetime events), 0-17 | 7.21 (3.48) | 0, 15 |
| Maternal mental health, 0-63 | 32.16 (13.18) | 3, 62 |
| Parental rejection, 0-72 | 20.78 (9.00) | 1, 49 |
| Harsh punishment, 0-32 | 9.47 (5.80) | 0, 29 |
| Social support, 0-32 | 15.43 (8.03) | 0, 32 |

Data are Mean (*SD*), unless otherwise indicated. Potential ranges are included next to each measure.

*Measures*

*Sociodemographic information*

Sociodemographic data such as maternal age and education, length of displacement, and shelter type, were collected using items from the United Nations Vulnerability Assessment of Syrian Refugees in Lebanon (UNHCR, WFP, & UNICEF, 2015).

*War trauma exposure*

The Traumatic Events Checklist, adapted from the Harvard Trauma Questionnaire and previously used with Syrian refugee youth in Jordan, was used to assess mothers' exposure to war trauma (Panter-Brick et al., 2018). The measure has 17 yes/no items such as "Been forcibly separated from your family" and "Been severely beaten." Item scores were summed to obtain an overall measure of war trauma exposure.

*Maternal mental health*

We assessed maternal mental health using the 21-item Depression Anxiety and Stress Scale (DASS) Short Form (Lovibond & Lovibond, 1995). The Arabic language version of the original 42-item measure was previously validated with Arabic-speaking immigrants in Australia (Moussa et al., 2016). Items evaluated symptoms in the last 30 days such as "I couldn't seem to experience any positive feeling at all" and "I felt I was close to panic." Responses ranged from 0 (*Did not apply to me at all*) to 3 (*Applied to me very much, or most of the time*) ($\alpha = 0.91$). The mean score in this sample falls above the cut-off score for "severe" depression, anxiety, and stress suggested by Lovibond & Lovibond (1995). However, there are no established norms for this study population as the measure has not been validated with Syrian refugees.

*Negative parenting*

The 24-item Parental Acceptance Rejection Questionnaire (PARQ) Short Form was used to assess mothers' rejecting parenting behaviour (e.g. "I see my child as a big nuisance") (Rohner & Khaleque, 2008). The PARQ has been translated into 28 languages and used in more than 60 countries. The original PARQ consists of four subscales: warmth/affection, hostility/aggression, indifference/neglect, and undifferentiated rejection. In this study, positive items were reverse-coded and all items summed to achieve an overall measure of parental rejection. Item responses ranged from 0 (*Almost never true*) to 3 (*Almost always true*) in the last 30 days ($\alpha = 0.79$).

We used 8 items from the Discipline Module of UNICEF's Multiple Indicator Cluster Survey (MICS) to assess mothers' use of harsh verbal and physical punishment in the last 30 days, such as "Shouted, yelled, or screamed at him/her" and "Hit or slapped him/her on the face, head or ears." (UNICEF, 2016). The originally dichotomous items were modified in this study to a five-point Likert scale with responses ranging from 0 (*Never*) to 4 (*Almost all the time*) ($\alpha = 0.78$).

*Social support*

The modified Medical Outcomes Study Social Support Survey (mMOS-SS) was used to assess mothers' perceived social support (Sherbourne & Stewart, 1991). The original 19 item-version covers four domains (emotional/informational support, tangible or instrumental support, positive social interaction, and affection). This study used the 8-item modified version that has two subscales for emotional (e.g. "How often is someone available to turn to for suggestions about how to deal with a personal problem?") and instrumental (e.g. "How often is someone available to help you if you were sick in bed?") support. Responses ranged from 0 (*None of the time*) to 4 (*All of*

*the time)*. A validity study conducted with data from patients in the United States reported excellent psychometric properties of the 8-item mMOS-SS that were similar to those of the original measure (Moser, Stuck, Silliman, Ganz, & Clough-Gorr, 2012). Cronbach's coefficient alpha in this study was 0.88 for the full measure, and 0.83 and 0.85 for the emotional and instrumental support subscales respectively.

*Covariates*

We assessed relative socioeconomic disadvantage using a scale defined as follows: (1) residing in substandard housing including informal tented settlements, one-room structures, and converted or commercial spaces (e.g. factory, garage); (2) residing in overcrowded shelter, defined by the United Nations Humans Settlements Programme as more than three people per room; (3) no working household member; and, (4) experienced lack of food or money to buy food in the last 30 days. Summing across these four items provided a composite index of relative socioeconomic disadvantage, ranging from 0 to 4 ($M$ = 2.89, $SD$ = 1.11). To assess the validity of the index, we tested the correlation between the socioeconomic disadvantage score and a measure of daily stressors (Humanitarian Emergency Settings Perceived Needs Scale, World Health Organization & King's College London, 2011). The correlation coefficient was $r$ = .481 ($p$ < .001).

Other covariates included maternal education level, number of children, and sex and age of child. Covariates were selected based on prior research suggesting that these factors are associated with maternal wellbeing and parenting (Lansford et al., 2015; Kohler, Behrman & Skytthe, 2005; Lovejoy et al., 2000; UNICEF, 2010).

*Data analysis*

Analyses were conducted in two steps in IBM SPSS Statistics 24, using the residual approach to operationalising resilience (Kim-Cohen et al., 2004). First, we ran univariate linear regression analyses to test for associations between maternal war trauma exposure and maternal mental health, rejecting parenting behaviour, and harsh punishment (Table 5). Significant associations were retained for the next stage of analysis, in which mothers' psychological and parenting resilience were defined by using standardised residuals from the respective regressions. Standardised residual scores were coded so that positive residuals indicate better than expected mental health and parenting behaviour given level of war trauma exposure. For example, mothers whose actual mental health problem score was lower than their score as predicted by their level of war trauma exposure have a positive residual reflecting psychological resilience, while mothers whose actual mental health problem score was higher than their predicted score have a negative residual reflecting vulnerability. Finally, we conducted univariate linear regressions to test if mothers' social support was associated with their psychological and parenting resilience.

## Results

*Is mothers' exposure to war trauma associated with maternal mental health and parenting behaviour?*

Mothers' exposure to war trauma was associated with poorer maternal mental health and greater use of harsh punishment, but not parental rejection (Table 5). Parental rejection was thus dropped from subsequent analyses and only the residual scores from

regressing harsh punishment on war trauma exposure were used to represent parenting resilience.

**Table 5. Univariate linear regressions testing associations between maternal war trauma exposure and maternal mental health problems, rejecting parenting behaviour, and harsh punishment**

| | Mental health problems (DASS) | Parental rejection (PARQ) | Harsh punishment (MICS) |
|---|---|---|---|
| Mothers' war trauma exposure | 0.42** [0.31, 0.52] | -0.01 [-0.13, 0.11] | 0.13* [0.02, 0.25] |

Standardised regression coefficients, with 95% confidence intervals shown in brackets. Significance level shown as: * $p \leq 0.05$, ** $p \leq 0.001$.

*Maternal psychological and parenting resilience*

To derive measures of maternal psychological and parenting resilience, we saved and reverse-coded residual scores from regressing maternal mental health and harsh punishment on level of war trauma exposure. Positive residual scores indicated mothers with better than expected mental health status given exposure to war trauma (i.e. psychological resilience, -30.34 to 35.12) and mothers using less harsh punishment than expected given exposure to war trauma (i.e. parenting resilience, -10.27 to 19.29). Scores for mothers' psychological and parenting resilience were correlated ($r = 0.24$, $p < 0.001$).

*Associations between covariates and maternal psychological and parenting resilience*

Table 6 shows that higher maternal education level was associated with greater psychological and parenting resilience. Having more children was associated with less psychological resilience, but did not have a significant relationship with parenting resilience. The age of the index child (i.e. the child about whom the mother reported using harsh punishment) was negatively correlated with mothers' psychological resilience and positively correlated with parenting resilience, suggesting that mothers reporting on older children were less psychologically resilient but used less harsh punishment than predicted by their level of war trauma exposure. Child gender and relative socioeconomic disadvantage were not associated with either maternal psychological or parenting resilience.

**Table 6. Associations between covariates and maternal psychological and parenting resilience**

| | Psychological resilience score | Parenting resilience score |
|---|---|---|
| Covariates | $\beta$ | $\beta$ |
| Relative socioeconomic disadvantage | -0.03<br>[-0.16, 0.09] | -0.05<br>[-.17, 0.08] |
| Maternal education | 0.22**<br>[0.11, 0.34] | 0.20**<br>[0.09, 0.32] |
| Number of children under 18 | -0.20**<br>[-0.32, -0.08] | -0.07<br>[-0.19, 0.50] |
| Age of index child | -0.12*<br>[-0.24. 0.00] | 0.13*<br>[0.01, 0.24] |
| Sex of index child | .07<br>[-0.05, 0.19] | .08<br>[-0.04, 0.19] |

Standardised regression coefficients, with 95% confidence intervals shown in brackets.

Significance level shown as: * $p \leq 0.05$, ** $p \leq 0.001$.

*Is mothers' perceived social support associated with maternal psychological and parenting resilience?*

Univariate linear regressions indicated that mothers' perceived social support was associated with greater psychological resilience ($\beta$ = 0.24, $p < 0.001$) and parenting resilience ($\beta$ = 0.18, $p$ = 0.002). After controlling for relative socioeconomic disadvantage, maternal education, number of children, and age and sex of index child, the associations between mothers' social support and their psychological ($\beta$ = 0.23, $p <$ 0.001) and parenting resilience ($\beta$ = 0.18, $p$ = 0.003) remained significant (Table 7).

**Table 7. Linear regression models testing for associations between mothers' perceived social support and psychological and parenting resilience to war trauma exposure**

| | Psychological resilience score | | Parenting resilience score | |
|---|---|---|---|---|
| | Unadjusted | Adjusted | Unadjusted | Adjusted |
| Perceived social support | 0.24**<br>[0.12, 0.35] | 0.23**<br>[0.11, 0.36] | 0.18*<br>[0.07, 0.30] | 0.18*<br>[0.06, 0.29] |

Standardised regression coefficients unadjusted and adjusted for covariates, with 95% confidence intervals shown in brackets. Covariates were socioeconomic disadvantage, maternal education, number of children, and age and sex of index child. Significance level shown as: * $p \leq 0.05$, ** $p \leq 0.001$.

*Which dimension of social support is the primary driver of maternal psychological and parenting resilience?*

We conducted secondary analyses using the emotional and instrumental subscales of the social support measure to assess whether a particular dimension of social support accounted for greater variance in mothers' psychological and parenting resilience. The sum scores for the emotional and instrumental subscales were correlated ($r = 0.58$, $p < .001$). As each subscale contains only 4 items, this part of the analysis is primarily exploratory.

Multivariate linear regression analysis indicated that emotional support ($\beta = 0.22$, $p = 0.004$), but not instrumental support ($\beta = 0.05$, $p = 0.655$), was associated with greater psychological resilience. After controlling for covariates, the association between mothers' emotional support and psychological resilience remained significant ($\beta = 0.20$ $p = 0.008$). While the overall measure of social support was associated with greater parenting resilience, the specific dimensions of emotional and instrumental support were not statistically significant (Table 8).

**Table 8. Multivariate linear regression models testing for associations between emotional and instrumental support and psychological and parenting resilience to war trauma exposure**

| | Psychological resilience score | | Parenting resilience score | |
|---|---|---|---|---|
| | Unadjusted | Adjusted for covariates | Unadjusted | Adjusted for covariates |
| Emotional support | 0.22* [0.07, 0.37] | 0.20* [0.05, 0.36] | 0.12 [-0.02, 0.26] | 0.10 [-0.05, 0.24] |
| Instrumental support | 0.05 [-0.10, 0.19] | 0.06 [-0.10, 0.21] | 0.09 [-0.05, 0.23] | 0.10 [-0.05, 0.25] |

Standardised regression coefficients unadjusted and adjusted for covariates, with 95% confidence intervals shown in brackets. Covariates were socioeconomic disadvantage, maternal education, number of children, and age and sex of index child. Significance level shown as: * $p \leq 0.05$, ** $p \leq 0.001$.

## Discussion

The purpose of this study was to examine whether mothers' perceived social support was associated with their psychological and parenting resilience in a context of ongoing war and displacement. Results were consistent with our hypothesis that social support would be associated with better than expected maternal mental health and parenting behaviour given mothers' level of past war trauma exposure. Furthermore, exploratory secondary analysis suggested that emotional support, rather than instrumental support, was the main driver of mothers' psychological resilience. While further investigation is necessary given the limited number of measurement items, this finding is consistent with evidence that perceived emotional support protects against depression (Santini, Koyanagi, Tyrovolas, Mason, & Haro, 2015). In displacement

settings characterised by high levels of need and scarce resources, it is likely that refugees are generally less able to provide instrumental support and more inhibited about seeking such support from their social network. For example, in a qualitative study with Syrian refugees in Lebanon, some parents pointed to the commonality of their difficult circumstances as a barrier to seeking and receiving help (Sim, Fazel, Bowes & Gardner, 2018).

Surprisingly, regression analyses assessing the relationship between war trauma exposure and negative parenting found a significant association between war trauma and harsh punishment, but not rejection. The lack of association between war trauma and parental rejection runs counter to theoretical frameworks focusing on the negative impacts of traumatic events on parent-child communication, emotional responsiveness, and parents' internal attachment representations of the self as caregiver (De Haene, Grietens, & Verschueren, 2010). However, there is little empirical evidence of the theorised link between parental war trauma exposure and rejecting parenting behaviour as the majority of research has focused on child maltreatment rather than parental rejection as the outcome variable (Catani, Jacob, Schauer, Kohila, & Neuner, 2008; Saile, Ertl, Neuner, & Catani, 2014). Additional studies assessing different dimensions of negative parenting are necessary to determine if and why war trauma might have differential impacts on various forms of parenting behaviour. For example, it is possible that the hyperarousal symptoms of post-traumatic stress, such as anger and irritability, are more directly associated with greater propensity for violence than with parental rejection, which encompasses a broader spectrum of negative parenting behaviours (e.g. indifference, neglect, lack of affection).

*Strengths and limitations*

This study contributes to the evidence base on the promotive effects of social support on mental health and parenting (Armstrong, Birnie-Lefcovitch, & Ungar, 2005; McConnell, Breitkreuz, & Savage, 2011). While this evidence base is well-established in non-war settings, little is known about the role of social support in promoting psychological and parenting resilience among an adult refugee population. This study is unique in its examination of potential resilience processes among highly vulnerable Syrian refugee mothers living in a context of ongoing armed conflict and displacement. Theoretical and empirical work on resilience has focused almost exclusively on the outcomes of children, with very little known about how some parents are able to do well despite considerable odds (Luthar, Sawyer & Brown, 2006). This study seeks to address this gap in the literature by assessing the role of social support in promoting the resilience of mothers, thus bringing a family systems perspective to the study of resilience processes in conflict settings. Furthermore, it investigates resilience in different domains, reflecting the multidimensional conceptualisation of the construct (Luthar, Cicchetti, & Becker, 2000). Importantly, results showing the wide range of positive residual scores highlights the capacity for resilience even under conditions of extreme duress. This is an important finding in itself given the enduring emphasis in the literature on the psychological sequela of war trauma, and serves as a reminder to investigate variables and processes that promote resilience in order to inform intervention development (Tol et al., 2013).

The study has several limitations. First, the sample, although recruited from four districts in Lebanon with a large refugee presence, was not representative. Thus, results cannot be generalised to the Syrian refugee population as a whole. Second, the cross-sectional nature of the data precludes causal inferences regarding the directionality of

effects. Prior research has shown that depression and anxiety, for example, can lead to less support seeking, suggesting that the relationship between social support and mental health is transactional and bidirectional (Hammen, 2006; Monroe, 1983). Third, all measures were maternal self-report only, which increases the risk of bias associated with common rater effects (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003). It is possible that better mental health status contributed to more positive appraisal of social support, rather than the other way around. Fourth, while most of the measures used in this study have been validated with Arabic-speaking samples, they have not been validated with the Syrian refugee population. As such, it is not known whether the measures have adequate psychometric properties (e.g. test-retest reliability; criterion validity) when applied to this population, or if there are culturally-specific parenting practices or local idioms of distress that are not captured by these measures (Kirmayer, 2001). Fifth, this study only examined two types of functional support, emotional and instrumental. Given the multidimensional nature of social support, future research should investigate additional dimensions of social support in relation to mental health and parenting among refugees, particularly the role of supportive intimate partner relationships given conceptual and empirical work positing its importance for positive parenting (Belsky, 1984; Jaffee et al., 2013; Sim et al., 2018). Finally, the residual approach used in this paper to operationalise resilience rests on the assumption of a linear dose-response relationship between war trauma exposure and maternal mental health and parenting behaviour. However, other possibilities exist, such as nonlinear threshold or inverted-U models (Masten & Narayan, 2012). Furthermore, most war events checklists, including the measure used in this study, do not capture the recurring nature of war events, the timing of their occurrence, and the relative impact of specific events, all of which may alter the exposure-response relationship (Miller & Rasmussen,

2014). The residual approach is an innovative and intuitive way of operationalising resilience in terms of "doing better than expected" given level of risk exposure. We recognise, however, that resilience is a complex phenomenon that is grounded in culturally-defined narratives and expectations of wellbeing (Panter-Brick, 2015). Multiple and complementary approaches are therefore required to capture the normative as well as functional dimensions of resilience.

Several of these limitations relate to the constraints of conducting research in an ongoing refugee crisis. Longitudinal designs, which are preferable to cross-sectional data for inferring causality, are particularly challenging to implement in a volatile security context where participants may be difficult to track over time. Partnering with an NGO to recruit participants, while crucial for safe access and dissemination of findings, meant that the study sample was primarily composed of mothers since they comprise the vast majority of participants in the NGO's parenting programme. We were therefore unable to assess if social support operates differently for male and female caregivers, an important area for future research given evidence of the gendered nature of mental health and parenting (Panter-Brick et al., 2014).

*Conclusion*

This study has potentially important implications for refugee policy and programming. Findings suggest that social support may have benefits for mothers' psychosocial functioning. However, prior research also calls for some caution when targeting social support for intervention, particularly among highly stressed individuals and communities that face cultural and contextual barriers to accessing support. Qualitative research with Syrian refugee parents in Lebanon, for example, found that support-seeking was hampered by separation from extended family, mistrust of others

in the community, and the perception that others were experiencing the same problems and thus unable to help (Sim et al., 2018). The same study also suggested that cultural norms may dissuade fathers, in particular, from seeking support from others outside the family. The daily stressors associated with displacement, and their effects on mental health, may also undermine caregivers' motivation or efforts to seek support. Previous research has found that economically stressed individuals often feel overwhelmed and lack the time, energy or hope to seek support from others (Thompson et al., 2006). In conditions of extreme adversity such as refugee settings, support-seeking may backfire if others are unable to provide support due to being in similarly difficult circumstances (Garbarino & Sherman, 1980). There is some evidence in the literature of reverse stress-buffering effects, whereby the benefits of social support may be dampened under particularly stressful conditions (Auerbach et al., 2011). For example, a study with low-income, single mothers found that the positive influence of social support in promoting nurturing parenting and reducing punitive strategies diminished as neighbourhood conditions worsened (Ceballo & McLoyd, 2002). In sum, the same adverse conditions that contribute to social isolation may make the enlistment of social support especially challenging and weaken any potential positive effects.

Given the complex nature of social support, future research on its role in developing resilience will need to consider the interaction between the individual and the unique ecological conditions engendered by forced displacement (Taraban & Shaw, 2018). In particular, research aimed at intervention development will need to incorporate a nuanced analysis of refugee caregivers' environments, including the characteristics, capacities, and limitations of potential providers of support (Thompson et al., 2006). Group-based parenting programmes have shown some promise in addressing both the psychosocial and parenting needs of caregivers affected by war

(Murphy, Rodrigues, Costigan, & Annan, 2017). For example, a cluster randomised trial of a parenting intervention targeting maternal wellbeing and child development in northern Uganda found positive effects on maternal mental health, parenting practices, and child cognitive outcomes, with mother's perceived social support and active ways of coping mediating intervention effects on maternal depressive symptoms (Singla, Kumbakumba, & Aboud, 2015). Another cluster randomised trial of a parenting programme for adolescents and their caregivers in South Africa found a positive effect on caregivers' social support (Cluver et al., 2018). It is possible that parenting interventions, which are often delivered in a group format, can be a vehicle through which caregivers increase their social networks, access emotional and informational support, and mutually reinforce positive behaviour change. However, given the paucity of research on social support as a potential mechanism through which parenting interventions may improve caregiver mental health and parenting, more research on mediator and moderator effects, including potential reverse stress-buffering effects, is necessary.

Prior research indicating the limitations of mutual help and support under certain adverse conditions suggests that simply improving social supports is not enough if those supports are under constant threat. Multi-layered interventions are necessary to promote refugees' psychological and parenting resilience, from macro-level policy to address the social and structural determinants of psychosocial functioning, to targeted mental health and parenting interventions for those most at-risk.

## References

Agnafors, S., Svedin, C. G., Oreland, L., Bladh, M., Comasco, E., & Sydsjö, G. (2017). A Biopsychosocial Approach to Risk and Resilience on Behavior in Children Followed from Birth to Age 12. *Child Psychiatry and Human Development*, *48*(4), 584–596.

Ajduković, M., Rajter, M., & Rezo, I. (2018). Individual and contextual factors for the child abuse potential of Croatian mothers: The role of social support in times of economic hardship. *Child Abuse & Neglect*, *78*, 60–70.

Armstrong, M. I., Birnie-Lefcovitch, S., & Ungar, M. T. (2005). Pathways Between Social Support, Family Well Being, Quality of Parenting, and Child Resilience: What We Know. *Journal of Child and Family Studies*, *14*(2), 269–281.

Auerbach, R. P., Bigda-Peyton, J. S., Eberhart, N. K., Webb, C. A., & Ho, M.-H. R. (2011). Conceptualizing the Prospective Relationship Between Social Support, Stress, and Depressive Symptoms Among Adolescents. *Journal of Abnormal Child Psychology*, *39*(4), 475–487.

Belsky, J. (1984). The Determinants of Parenting: A Process Model. *Child Development*, *55*(1), 83–96.

Betancourt, T. S., Borisova, I. I., Williams, T. P., Brennan, R. T., Whitfield, T. H., De La Soudiere, M., … Gilman, S. E. (2010). Sierra Leone's Former Child Soldiers: A Follow-Up Study of Psychosocial Adjustment and Community Reintegration: Sierra Leone's Former Child Soldiers. *Child Development*, *81*(4), 1077–1095.

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

Bogic, M., Njoku, A., & Priebe, S. (2015). Long-term mental health of war-refugees: a systematic literature review. *BMC International Health and Human Rights*, *15*(1).

Bowes, L., Maughan, B., Caspi, A., Moffitt, T. E., & Arseneault, L. (2010). Families promote emotional and behavioural resilience to bullying: evidence of an environmental effect: Families promote resilience to bullying. *Journal of Child Psychology and Psychiatry*, *51*(7), 809–817.

Bracken, P. J., Giller, J. E., & Summerfield, D. (1995). Psychological responses to war and atrocity: the limitations of current concepts. *Social Science & Medicine*, *40*(8), 1073–1082.

Bronfenbrenner, U., & Morris, P. (1998). The ecology of developmental processes. In R. M. Lerner (Ed.), *Theoretical models of human development: Volume 1 of the Handbook of Child Psychology* (5th ed., pp. 993–1028). New York: Wiley.

Brumley, L. D., & Jaffee, S. R. (2016). Defining and distinguishing promotive and protective effects for childhood externalizing psychopathology: a systematic review. *Social Psychiatry and Psychiatric Epidemiology*, *51*(6), 803–815.

Burton, E., Stice, E., & Seeley, J. R. (2004). A Prospective Test of the Stress-Buffering Model of Depression in Adolescent Girls: No Support Once Again. *Journal of Consulting and Clinical Psychology*, *72*(4), 689–697.

Catani, C., Jacob, N., Schauer, E., Kohila, M., & Neuner, F. (2008). Family violence, war, and natural disasters: A study of the effect of extreme stress on children's mental health in Sri Lanka. *BMC Psychiatry*, *8*(1).

Ceballo, R., & McLoyd, V. C. (2002). Social support and parenting in poor, dangerous neighborhoods. *Child Development*, *73*(4), 1310–1321.

Cluver, L. D., Meinck, F., Steinert, J. I., Shenderovich, Y., Doubt, J., Romero, R. H., … Tsoanyane, S. (2018). Parenting for Lifelong Health: a pragmatic cluster randomised controlled trial of a non-commercialised parenting programme for adolescents and their families in South Africa. *BMJ Global Health*, *3*(1), e000539.

Cohen, S., & Hoberman, H. M. (1983). Positive Events and Social Supports as Buffers of Life Change Stress. *Journal of Applied Social Psychology*, *13*(2), 99–125.

Collishaw, S., Hammerton, G., Mahedy, L., Sellers, R., Owen, M. J., Craddock, N., … Thapar, A. (2016). Mental health resilience in the adolescent offspring of parents with depression: a prospective longitudinal study. *The Lancet Psychiatry*, *3*(1), 49–57.

Conger, R. D., Conger, K. J., Elder, G. H., Lorenz, F. O., Simons, R. L., & Whitbeck, L. B. (1992). A family process model of economic hardship and adjustment of early adolescent boys. *Child Development*, *63*(3), 526–541.

De Haene, L., Grietens, H., & Verschueren, K. (2010). Adult attachment in the context of refugee traumatisation: the impact of organized violence and forced separation on parental states of mind regarding attachment. *Attachment & Human Development*, *12*(3), 249–264.

Garbarino, J., & Sherman, D. (1980). High-Risk Neighborhoods and High-Risk Families: The Human Ecology of Child Maltreatment. *Child Development*, *51*(1), 188.

Gavidia-Payne, S., Denny, B., Davis, K., Francis, A., & Jackson, M. (2015). Parental resilience: A neglected construct in resilience research: Parental resilience: A neglected construct. *Clinical Psychologist*, *19*(3), 111–121.

Green, B. L., Furrer, C., & McAllister, C. (2007). How Do Relationships Support Parenting? Effects of Attachment Style and Social Support on Parenting Behavior in an At-Risk Population. *American Journal of Community Psychology*, *40*(1–2), 96–108.

Hammen, C. (2006). Stress generation in depression: Reflections on origins, research, and future directions. *Journal of Clinical Psychology*, *62*(9), 1065–1082.

Jaffee, S. R., Bowes, L., Ouellet-Morin, I., Fisher, H. L., Moffitt, T. E., Merrick, M. T., & Arseneault, L. (2013). Safe, Stable, Nurturing Relationships Break the Intergenerational Cycle of Abuse: A Prospective Nationally Representative Cohort of Children in the United Kingdom. *Journal of Adolescent Health*, *53*(4), S4–S10.

Jennings, K. D., Stagg, V., & Connors, R. E. (1991). Social Networks and Mothers' Interactions with Their Preschool Children. *Child Development*, *62*(5), 966.

Kim-Cohen, J., Moffitt, T. E., Caspi, A., & Taylor, A. (2004). Genetic and environmental processes in young children's resilience and vulnerability to socioeconomic deprivation. *Child Development*, *75*(3), 651–668.

Kirmayer, L. J. (1989). Cultural Variations in the Response to Psychiatric Disorders and Emotional Distress. *Social Science & Medicine*, *29*(3), 327–339.

Kohler, H.-P., Behrman, J. R., & Skytthe, A. (2005). Partner + children = happiness? The effects of partnerships and fertility on well-being. *Population and Development Review*, *31*(3), 407–445.

Lansford, J. E., Alampay, L. P., Al-Hassan, S., Bacchini, D., Bombi, A. S., Bornstein, M. H., … Zelli, A. (2010). Corporal Punishment of Children in Nine Countries as a Function of Child Gender and Parent Gender. *International Journal of Pediatrics*, *2010*, 1–12.

Lansford, J. E., Godwin, J., Uribe Tirado, L. M., Zelli, A., Al-Hassan, S. M., Bacchini, D., … Alampay, L. P. (2015). Individual, family, and culture level contributions to child physical abuse and neglect: A longitudinal study in nine countries. *Development and Psychopathology*, *27*(4pt2), 1417–1428.

Lovejoy, M. C., Graczyk, P. A., O'Hare, E., & Neuman, G. (2000). Maternal depression and parenting behavior: A meta-analytic review. *Clinical Psychology Review, 20*(5), 561–592.

Lovibond, P. F., & Lovibond, S. H. (1995). The Structure of Negative Emotional States: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy, 33*(3), 335–343.

Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development, 71*(3), 543–562.

Luthar, S. S., & Cushing, G. (2002). Measurement issues in the empirical study of resilience. In *Resilience and development* (pp. 129-160). Springer, Boston, MA.

Luthar, S. S., Sawyer, J. A., & Brown, P. J. (2006). Conceptual Issues in Studies of Resilience: Past, Present, and Future Research. *Annals of the New York Academy of Sciences*, *1094*(1), 105–115.

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, *56*(3), 227–238.

Masten, A. S., & Narayan, A. J. (2012). Child Development in the Context of Disaster, War, and Terrorism: Pathways of Risk and Resilience. *Annual Review of Psychology*, *63*(1), 227–257.

McConnell, D., Breitkreuz, R., & Savage, A. (2011). From financial hardship to child difficulties: main and moderating effects of perceived social support: Main and moderating effects of perceived social support. *Child: Care, Health and Development*, *37*(5), 679–691.

Mercy Corps. (n.d.). One mother to another, Syrian refugees learn to cope. Retrieved May 22, 2018, from https://www.mercycorps.org/articles/lebanon-syria/one-mother-another-syrian-refugees-learn-cope.

Miller, K. E., & Rasmussen, A. (2014). War experiences, daily stressors and mental health five years on: elaborations and future directions. *Intervention*, *12*, 33–42.

Miller-Lewis, L. R., Searle, A. K., Sawyer, M. G., Baghurst, P. A., & Hedley, D. (2013). Resource factors for mental health resilience in early childhood: An analysis with multiple methodologies. *Child and Adolescent Psychiatry and Mental Health*, *7*(1), 6.

Monroe, S. M. (1983). Social support and disorder: Toward an untangling of cause and effect. *American Journal of Community Psychology*, *11*(1), 81–97.

Moser, A., Stuck, A. E., Silliman, R. A., Ganz, P. A., & Clough-Gorr, K. M. (2012). The eight-item modified Medical Outcomes Study Social Support Survey: psychometric evaluation showed excellent performance. *Journal of Clinical Epidemiology*, *65*(10), 1107–1116.

Murphy, K. M., Rodrigues, K., Costigan, J., & Annan, J. (2017). Raising children in conflict: An integrative model of parenting in war. *Peace and Conflict: Journal of Peace Psychology*, *23*(1), 46–57.

Panter-Brick, C. (2015). Culture and Resilience: Next Steps for Theory and Practice. In L. C. Theron, L. Liebenberg, & M. Ungar (Eds.), *Youth Resilience and Culture* (Vol. 11, pp. 233–244). Dordrecht: Springer Netherlands.

Panter-Brick, C., Burgess, A., Eggerman, M., McAllister, F., Pruett, K., & Leckman, J. F. (2014). Practitioner Review: Engaging fathers - recommendations for a game change in parenting interventions based on a systematic review of the global evidence. *Journal of Child Psychology and Psychiatry*, *55*(11), 1187–1212.

Panter-Brick, C., Dajani, R., Eggerman, M., Hermosilla, S., Sancilio, A., & Ager, A. (2018). Insecurity, distress and mental health: experimental and randomized controlled trials of a psychosocial intervention for youth affected by the Syrian crisis. *Journal of Child Psychology and Psychiatry*, *59*(5), 523-541.

Podsakoff, P. M., MacKenzie, S. B., Lee, J.-Y., & Podsakoff, N. P. (2003). Common method biases in behavioral research: A critical review of the literature and recommended remedies. *Journal of Applied Psychology*, *88*(5), 879–903.

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. (2008). *Handbook for the study of parental acceptance and rejection*. Storrs, Connecticut: Rohner Research.

Rueger, S. Y., Malecki, C. K., Pyun, Y., Aycock, C., & Coyle, S. (2016). A meta-analytic review of the association between perceived social support and depression in childhood and adolescence. *Psychological Bulletin*, *142*(10), 1017–1067.

Saile, R., Ertl, V., Neuner, F., & Catani, C. (2014). Does war contribute to family violence against children? Findings from a two-generational multi-informant study in Northern Uganda. *Child Abuse & Neglect*, *38*(1), 135–146.

Santini, Z. I., Koyanagi, A., Tyrovolas, S., Mason, C., & Haro, J. M. (2015). The association between social relationships and depression: a systematic review. *Journal of Affective Disorders*, *175*, 53–65.

Sherbourne, C. D., & Stewart, A. L. (1991). The MOS social support survey. *Social Science & Medicine*, *32*(6), 705–714.

Sim, A., Fazel, M., Bowes, L., & Gardner, F. (2018). Pathways linking war and displacement to parenting and child adjustment: A qualitative study with Syrian refugees in Lebanon. *Social Science & Medicine*, *200*, 19–26.

Singla, D. R., Kumbakumba, E., & Aboud, F. E. (2015). Effects of a parenting intervention to address maternal psychological wellbeing and child development and growth in rural Uganda: a community-based, cluster-randomised trial. *The Lancet Global Health*, *3*(8), e458–e469.

Taraban, L., & Shaw, D. S. (2018). Parenting in context: Revisiting Belsky's classic process of parenting model in early childhood. *Developmental Review*, *48*, 55–81.

Thompson, R. A., Flood, M. F., & Goodvin, R. (2006). Social support and developmental psychopathology. In *Developmental Psychopathology* (pp. 1–37). Hoboken, New Jersey: John Wiley & Sons.

Tol, W. A., Song, S., & Jordans, M. J. D. (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.

Tracy, M., Salo, M., & Appleton, A. A. (2018). The mitigating effects of maternal social support and paternal involvement on the intergenerational transmission of violence. *Child Abuse & Neglect*, *78*, 46–59.

UNHCR, WFP, & UNICEF. (2015). *Vulnerability Assessment of Syrian Refugees in Lebanon 2015 Report*. Beirut, Lebanon.

UNICEF. (2010). *Child disciplinary practices at home: evidence from a range of low- and middle-income countries.* New York: UNICEF.

UNICEF. (2016). Multiple Indicator Cluster Surveys. Retrieved May 5, 2016, from http://mics.unicef.org.

Werner, E. E. (2012). Children and war: Risk, resilience, and recovery. *Development and Psychopathology*, *24*(2), 553–558.

World Health Organization, & King's College London. (2011). *The humanitarian emergency settings perceived needs scale (HESPER): manual with scale.* Geneva; [London: World Health Organization ; King's College London.

Wyman, P. A., Cowen, E. L., Work, W. C., Hoyt-Meyers, L., Magnus, K. B., & Fagen, D. B. (1999). Caregiving and developmental factors differentiating young at-risk urban children showing resilient versus stress-affected outcomes: A replication and extension. *Child Development*, *70*(3), 645–659.

# CHAPTER VI. DISCUSSION

The overall objective of this DPhil thesis was to develop and test an empirically-based conceptual model of the intergenerational impact of war. The thesis used mixed methods to pursue the following research aims, resulting in three interrelated papers:

1) Understanding the effects of war and displacement on parenting and child adjustment, as perceived by refugee parents and children (*DPhil Paper 1*, published in *Social Science and Medicine*);

2) Modelling the associations between war trauma, daily stressors, maternal mental health, negative parenting, and child psychosocial difficulties (*DPhil Paper 2*, in press in *Global Mental Health*);

3) Examining the role of social support in promoting refugee mothers' psychological and parenting resilience (*DPhil Paper 3*, revised and resubmitted to *Prevention Science*).

This concluding chapter of the thesis synthesises and integrates the qualitative and quantitative results from the three papers. Adopting a multidisciplinary approach, concepts from developmental systems theory (Lerner, 2002), medical anthropology (Farmer, 2004), transcultural psychiatry (Kirmayer, 1989), and the life course perspective (Elder, 1998) are used to discuss and extend the findings. The chapter ends with a discussion of the implications of these findings for policy, practice, and future research in humanitarian contexts, and a summary of dissemination activities conducted thus far to maximise research impact and uptake.

*6.1 Synthesis of results*

An important and unique feature of mixed methods research is the process of synthesising and integrating results from both qualitative and quantitative components, thereby capitalising on the strengths of multiple methods to triangulate, complement, and interpret results (Greene, Caracelli & Graham, 1989). Taken together, results from the three DPhil papers support the following conclusions:

1) Current daily stressors, along with past war trauma, are a key determinant of parental mental health and parenting behaviour;
2) Negative parental and child mental health outcomes are linked via impairments to parenting quality;
3) Attempts at adaptation are constrained by the environment, but social support may be a pathway to parental resilience.

*Current daily stressors, along with past war trauma are a key determinant of parental mental health and parenting behaviour*

Results from the qualitative component of this thesis suggest that post-migration daily stressors exert a significant, negative influence on parental mental health and parenting behaviour. This finding is also supported by results from the quantitative component of the thesis. In DPhil Paper 2, SEM analyses found that past exposure to war trauma in Syria had a significant direct effect on mothers' PTS symptoms and general psychological distress, which is consistent with the large body of evidence on the negative impacts of war trauma on mental health (Porter & Haslam, 2005; Fazel et al., 2005; Attanayake et al., 2009). Results also showed, however, that post-migration stressors mediated the relationship between war trauma and maternal mental health

problems. This finding suggests that the stressful social and economic environment in which refugees are currently living plays an important role in determining their mental and emotional wellbeing (Hynie, 2018).

The qualitative results in DPhil Paper 1 provide useful detail and depth to the daily stressors experienced by refugee families in Lebanon. Respondents described suffering from economic deprivation, restrictions on freedom of movement, discrimination and harassment, lack of affordable healthcare, and inequitable treatment by aid agencies. Rather than being the natural or inevitable consequences of displacement, respondents identified macro-level structures and policies as the source of their suffering. For example, many parents cited the onerous requirements for obtaining a Lebanese residency permit as a significant source of stress that had ripple effects on their ability to find work, access healthcare, and move around safely with their families. Structural violence, a term coined by sociologist John Galtung (1969) to describe the violence of injustice and inequity produced by political, economic, and social structures, highlights how the social suffering experienced by refugees is often the result of policies enacted by host governments and the international aid regime (Kleinman, 2000).

According to the qualitative results in DPhil Paper 1, the "everyday violence" (Scheper-Hughes, 1993) of living in displacement, rather than the experience of war trauma, was the most significant cause of parental distress and reduced parenting quality. For example, parents described how economic deprivation undermined their capacity to perform the fundamental parenting tasks of providing safety, sustenance, and support for their children. Parents' inability to provide for their children's needs was a significant source of distress, which in turn contributed to less parental responsiveness and warmth, and in some cases, more violent parenting behaviour.

Framing the negative effects of displacement on parental mental health and parenting as social suffering, or the "lived experience of distress and injustice" (Rylko-Bauer & Farmer, 2016, p. 2), exposes the close linkage between individual and societal problems. Findings demonstrate how the public violence of war has cascading effects across time and space, from the structural violence inherent in the laws, policies, and systems that constrain the everyday lives of refugees, to the violence experienced by children in the private sphere of the family. This continuum or cascade of violence (Kleinman, 2000) has been observed in other contexts rife with multiple forms of violence, including Afghanistan (Eggerman & Panter-Brick, 2010), Haiti (Farmer, 2004), and the shantytowns of Brazil (Scheper-Hughes, 1993).

In contrast to their emphasis on daily stressors, parents in the qualitative study did not make explicit links between past war trauma or trauma-related psychopathology, and negative changes in parenting behaviour. This finding, while unexpected, is consistent with results from the SEM analyses reported in DPhil Paper 2, which found that mothers' general psychological distress, but not PTS, was associated with negative parenting and child psychosocial difficulties. The null association between maternal PTS and parenting and child outcomes is contrary to the bulk of literature demonstrating evidence of a relationship between parental traumatisation, harsh parenting, and child outcomes. For example, a longitudinal cohort analysis of refugees resettled in Australia found associations between caregiver PTSD and more harsh parenting, and in turn, higher levels of child emotional and behavioural problems (Bryant et al., 2018). However, it is important to note that the authors cite the lack of assessment of other forms of parental psychological distress as a weakness of their study. Indeed, the exclusive focus on parental PTSD as a predictor of negative

parenting in conflict settings is typical of the limited research in this area (Saile et al., 2014; Catani et al., 2008; Halevi et al., 2016).

Research demonstrating differential pathways from war exposure to mental health may offer some insight into these unexpected results. For example, a study of war-affected Sierra Leonan youth found that war exposure was directly associated with PTS symptoms, but not depression scores (Newnham, Pearson, Stein, & Betancourt, 2015). Instead, daily stressors fully mediated the relationship between war exposure and depression. Similarly, among tsunami-affected Sri Lankan adolescents, daily stressors mediated a larger proportion of the association between trauma exposure, impaired functioning, and emotional and behavioural problems, compared to the association between trauma exposure and PTS (Ponnamperuma & Nicholson, 2018). Indeed, a growing body of evidence suggests that post-migration stressors are stronger predictors of generalised distress such as depression and impaired functioning, while war exposure tends to be more strongly associated with PTSD (Ellis, MacDonald, Lincoln, & Cabral, 2008; Gorst-Unsworth & Goldenberg, 1998; Miller et al., 2002).

Extrapolating from these findings, it is possible that general psychological distress resulting from or exacerbated by daily stressors has a greater negative effect on parenting behaviour than PTS symptoms resulting from past war trauma. However, this remains conjecture as extant research has not systematically investigated the relative influence of caregiver PTS and generalised distress on parenting behaviour. Furthermore, sensitivity analyses found significant associations between maternal PTS, negative parenting, and child psychosocial difficulties when including only PTS in the model, suggesting that the null effects of PTS in the full model may be due to the high collinearity between maternal PTS and general psychological distress. Finally, the methodological challenges described in Chapter 2 of this thesis and the limitations

section of DPhil Paper 2 (i.e. poor discriminant validity of the PTS measure, and high comorbidity of PTS and other mental health problems) preclude drawing any firm conclusions about the null association between maternal PTS and negative parenting.

Some scholars argue that PTSD is an entirely socially constructed category that unnecessarily medicalises and pathologises a normal response to atrocity (Summerfield, 2001). According to Summerfield, one of the most prominent critics of PTSD as a psychiatric disorder, PTSD is a political and cultural product of the Vietnam War era in the United States, and far from a universal and cross-culturally valid syndrome that can be identified and treated anywhere with therapies developed in the West. He further argues that transporting the assumptions underlying the concept of PTSD to non-Western settings ignores the role of social, political, and cultural forces in shaping the experience and meaning of trauma, the way in which trauma-related distress is expressed, and the type of support that is available and appropriate (Bracken, Giller & Summerfield, 1995). Indeed, the emphasis on war trauma and PTSD in the public and academic discourse around refugee mental health may result in over-investment in trauma-focused psychotherapies to the exclusion of interventions that address the social determinants of the suffering experienced by refugees (Pedersen, 2002).

While this thesis does not discount the potentially severe and disabling effects of war trauma exposure, it is evident from scholarship in transcultural psychiatry that meanings and expressions of mental health, trauma, and support differ across sociocultural contexts (Kirmayer, 2001; Kienzler, 2008; Wylie et al., 2018). In a study on refugees and internally displaced people, for example, Yeomans and Forman (2009) noted that PTSD may be an overly narrow characterisation of traumatic stress across different cultures, emphasising instead experiences of somatisation, anxiety, and

depression. Clearly, there is a need for more context and culture-specific investigation into the relative influence of post-migration daily stressors and pre-migration war trauma in shaping parental mental health and parenting behaviour. Gaining a more nuanced understanding of traumatic stress, and how it interacts with everyday suffering to affect parent-child relationships, will enable more informed decision-making around intervention focus and content.

*Negative parental and child mental health outcomes are linked via impairments to parenting quality*

Results from both qualitative and quantitative components of this thesis demonstrate how reduced parenting quality mediates the relationship between poor parental and child mental health indicators among Syrian refugees in Lebanon. In DPhil Paper 1, parents describe a mental health pathway in which the insecurity and injustice of life as a refugee contribute to feelings of despair, hopelessness, anger, and frustration, which in turn lead to an increase in negative parenting behaviours such as harsh punishment. Furthermore, parents attributed the increase in children's emotional and behavioural problems to the negative changes in their parenting behaviour, along with children's own exposure to war trauma and daily stressors. Similarly, results from the structural equation model in DPhil Paper 2 found that increased parental rejection and harsh punishment partially mediated the association between maternal psychological distress and children's emotional and behavioural difficulties.

These findings support the family stress model pioneered by Glen Elder (1985), in which parental distress and impaired parenting are the central links between socioeconomic adversity and child wellbeing. This thesis expands on the family stress model by including not only economic hardship, but also other forms of adversity, as

determinants of parental mental health and parenting. In describing and modelling stressors found in the Syrian refugee context as well as other conflict settings around the world, this thesis proposes and provides empirical support for a *refugee family stress model*. Such application and extension of Elder's family stress model to other contexts can be found in work by Gewirtz and colleagues (2018), for example, which found associations between deployment-related stressors and parent, child, parenting, and dyadic adjustment among military families.

Results from this thesis also resonate with key tenets of life course theory emphasising linked lives and intergenerational effects (Elder, 1998). The life course perspective argues that societal and individual experiences are linked through the family and its network of shared relationships. Thus, macro-level events such as war and displacement affect parental mental health, which in turn can affect parent-child relationships and ultimately, child psychosocial outcomes. Lives are thus linked across generations, with past events and experiences shaping the present and future. The construct of the "life course" is distinct from that of the "life span," as it emphasises the historical and structural antecedents of change rather than the ontogenetic development of individual behaviour (Bengston & Allen, 1993). As such, the life course perspective is particularly useful in examining the transitions and changes that occur in the lives of children, parents, and families as they navigate the experience of being forcibly displaced.

Of course, parental mental health and parenting are not the only pathways through which war and displacement affect children's developmental trajectories. As described in the Introduction to this thesis, there is already a significant body of research demonstrating the adverse effects of direct war exposure on child psychosocial outcomes. However, in examining parental factors as a central link between war and

child psychosocial wellbeing, this thesis addresses an area that has traditionally been under-explored in research on refugee children and youth.

*Attempts at adaptation are constrained by the environment, but social support may be a pathway to parental resilience*

Despite the extreme adversity and deprivation faced by refugees in Lebanon, this thesis found evidence of some parents making choices and taking action to improve their circumstances within the opportunities and constraints of their new environment. In DPhil Paper 1, for example, some mothers described adopting new roles as income earners in order to compensate for the decline in their household's economic security. This adaptation exemplifies the concept of control cycles, whereby individuals and families modify their expectations and behaviour in response to resource changes (Elder, 1974). Increased parental control is another example of how some parents adapt their behaviour to manage contextual risk. In DPhil Paper 1, parents described keeping children indoors and restricting their interactions with peers in an effort to keep them safe from harm and negative influences. This parenting strategy of confining and isolating children has also been found in research on parenting in improverished, inner-city neighbourhoods in the United States, where high strictness and monitoring of children may be more adaptive than a democratic, authoritative parenting style (Jarrett, 1997; Luthar, 1999).

Examples of parental adaptation described above support a transactional perspective, in which person and environment constantly define and transform each other over time (Lerner et al., 2002). However, qualitative findings also point to the costs and tradeoffs involved in parents' attempts to adapt to their new circumstances. Mothers who started working in order to help meet their household's financial needs

attributed their worsening relationship with their children and the increase in children's behavioural problems to their time away from home. While a high degree of parental control may keep children away from harmful interactions or influences, limiting their opportunities for play and peer interactions may also inhibit their physical and social-emotional development. These findings suggest that although refugee parents are far from passive victims of their circumstances, the highly constrained context in which they live and parent often dictate the choices they are able to make.

While the adverse conditions faced by Syrian refugees challenge positive adaptation, results from this thesis draw attention to the capacity for resilience even under conditions of extreme duress. In DPhil Paper 3, mothers' psychological and parenting resilience was operationalised by regressing maternal distress and harsh punishment on war trauma exposure, and coding standardised residual scores such that positive residuals indicated better than expected mental health and parenting behaviour given level of trauma exposure. Results showing the wide range of positive residual scores (psychological resilience, -30.34 to 35.12; parenting resilience, -10.27 to 19.29) highlight the variation in how individuals respond to adverse circumstances, with some demonstrating extraordinary competence despite their level of risk (Masten, 2001).

Results from DPhil Paper 3 show that perceived social support could help explain this variation in mothers' psychological and parenting resilience or vulnerability. Regression analyses found that more social support was associated with less maternal psychological distress and harsh punishment than expected given mothers' level of exposure to war events. These findings support Belsky's (1984) classic parenting process model, which highlights social support as a key contextual predictor of parenting behaviour. Results are also consistent with empirical evidence of associations

between social support, mental health, and positive parenting among high-risk mothers (Green et al., 2007; Marra et al., 2009).

Exploratory analyses further suggest that emotional support, rather than instrumental support, may be a better predictor of psychological resilience among Syrian refugee mothers. While further investigation and replication of this finding are warranted, data from the qualitative component of the thesis provide some potential insight. Although a few respondents described receiving social support from their family members, relatives, and neighbours, others pointed to the commonality of their difficult circumstances as a barrier to seeking and receiving help. In displacement settings characterised by high levels of need and scarce resources, support-seeking may be unfeasible, or even counter-productive. Indeed, some studies have found that the benefits of social support may be dampened under particularly stressful conditions, the so-called reverse stress-buffering effect (Auerbach et al., 2011). For example, a study with low-income, single mothers found that the positive influence of social support in promoting nurturing parenting and reducing punitive strategies diminished as neighbourhood conditions worsened (Ceballo & McLoyd, 2002). Related research has also found mixed results on the buffering effects of social support on the intergenerational transmission of abuse (Tracy et al., 2018; Schofield, Lee, & Merrick, 2013), suggesting that social support may operate differently depending on the quality, provider, timing, and content of the support.

Furthermore, results suggesting the potential for social support to promote the resilience of war-affected caregivers should not negate other findings highlighting the need for structural interventions to improve the social and material ecology in which refugees are embedded. Emphasis on individual and communal self-reliance may be politically and economically expedient given the continued decline in humanitarian

funding and rising anti-refugee and immigrant sentiment (Vindevogel, 2017). However, social support and mutual self-help can only go so far in conditions of extreme deprivation and adversity. Multi-layered interventions are necessary to promote parental resilience, from macro-level policy to psychosocial and parenting interventions.

In sum, findings from this DPhil thesis provide support for a developmental systems and life course perspective highlighting the powerful connections between children, parents, and the historical, political, and socioeconomic context across time (Lerner et al., 2002; Elder, 1998). The thesis shows how historical and political forces in the form of the Syrian conflict, combined with the structural violence of displacement, produce social suffering that shapes the lived experiences of refugee families and the developmental trajectories of future generations. As Lerner and colleagues (2002, p. 317) argue: "parents and parenting provide bases of human development … not through their sole, main, or direct effects on children but, instead, through their embeddedness in a dynamic, multilevel system. As such, neither parents nor parenting are alone responsible for the development of children. Systems effects must be understood, and variables from any level of analysis may be, for a given behavioural development at a given point in time, integral in providing the significant variance that drives the system forward."

### *6.2 Implications for policy and practice*

Results from this DPhil thesis have several implications for policy and practice in humanitarian settings. First, *structural interventions* to improve the social and economic environment in which refugees live are essential to promoting the psychosocial wellbeing of children and parents. As exemplified by the three DPhil

papers, individual and family-level outcomes are tied to, and often constrained by, structural features of the macro-level environment, such as governmental policies that restrict refugee employment and freedom of movement. In order to have meaningful and sustained effects, efforts to promote positive mental health and parenting outcomes among refugee families must therefore be accompanied by interventions to improve the environment in which families are embedded (Hynie, 2018). Such interventions should include removing structural barriers to economic self-sufficiency, particularly given the negative and cascading effects of economic hardship on parental mental health and parent-child interactions. For example, the Jordan Compact aims to increase formal labour market access to Syrian refugees in Jordan through the creation of special economic zones and the issuance of work permits (Barbelet, Hagen-Zanker, & Mansour-Ille, 2018; Betts & Collier, 2015). While not without its challenges, this macro-level policy exemplifies how structural interventions could potentially disrupt intergenerational cycles of displacement-related adversity via improved economic security and positive downstream effects on parental mental health and family functioning.

Second, a *family systems approach* to intervention development and implementation is crucial to promoting the mental health and psychosocial resilience of refugee children and caregivers (Slobodin & de Jong, 2015). Family systems theory combines ecological and developmental perspectives to view the family in relation to the broader sociocultural context, and problems as resulting from the interaction between individual and family vulnerability, and the effect of stressful life experiences and social contexts (Walsh, 2002). Results from this thesis highlighting the notion of "linked lives" advocate for family-based intervention strategies. For example, a family resilience approach was used to develop a programme for Bosnian and Kosovar refugee

families in the United States (Walsh, 2002). A basic premise of the approach is that stressful events and challenges affect the whole family, and in turn, key family processes mediate the recovery and resilience of individual family members as well as the family unit (Walsh, 1996). Contrary to a deficit-based model of mental health care, this programme used the strong family-centred values in Bosnian and Kosovar culture to affirm family resources and capacity to overcome past and present challenges (Weine et al., 2004). Similarly, one of the key findings from an assessment of mental health services for refugees and immigrants in Canada is the need for a family-based model of care that acknowledges collective experiences and impacts of trauma and adversity (Wylie et al., 2018). More research is needed to assess the effectiveness of family-based interventions for refugees, however, with a systematic review finding only two studies of such interventions that employed a randomised controlled trial design (Slobodin & de Jong, 2015).

Even interventions aimed at improving individual children's mental health outcomes can be designed to more actively and meaningfully engage caregivers in facilitating and sustaining their children's recovery. For example, the Common Elements Treatment Approach for Youth (CETA-Youth) is a transdiagnostic intervention developed to treat comorbid presentations of depression, anxiety, traumatic stress, and externalising symptoms among Somali refugee children in Ethiopia (Murray et al., 2018). Recognising the importance of the caregiving environment, the intervention included separate sessions for parents and caregivers to learn the cognitive behavioural techniques that their children were using, as well as positive parenting skills such as praise and appropriate limit-setting. In post-intervention qualitative interviews, caregivers described learning how to help their children change maladaptive thoughts and help them feel calm, suggesting the untapped

potential for caregivers to support positive child adjustment even in extremely adverse conditions (Murray et al., 2018).

Third, interventions to improve the parenting behaviour of refugee caregivers should explicitly address *parental mental health and its impact on parenting*. Results from both the qualitative and quantitative components of this study highlight the relationship between parental mental health problems stemming from war trauma exposure and daily stressors, and negative parenting behaviour. It is therefore essential for parenting interventions to not only include the common components of behavioural parenting skills training such as praise and limit setting, but to also address psychological distress as one of the key determinants of negative parenting among refugee caregivers.

There are now several examples of parenting interventions in LMICs that combine parenting skills training with content on stress management or emotion regulation. For example, the Parents Make the Difference programme for families in post-conflict Liberia as well as the Sinovuyo Teen Programme in South Africa both include sessions on parent self-care and stress management (Puffer et al., 2015; Cluver et al., 2018). A cluster randomised controlled trial of the Sinovuyo Teens Programme found significant reductions in caregiver depression and parenting stress at 5 to 9 month post-intervention. While the Liberia trial did not include caregiver mental health as an outcome, qualitative data collected from programme participants suggest an improvement in emotional regulation (Giusto et al., 2017). In both these examples, however, only one or two sessions were devoted to managing and reducing parental distress and its impact on parenting. Given the high levels of psychological distress indicated among refugee populations, and the direct and indirect links between parental

distress, negative parenting, and child outcomes, there is a need for more deliberate inclusion and testing of mental health components in parenting interventions.

For example, parenting interventions for refugee caregivers could incorporate components of mental health interventions that have shown to be feasible and efficacious in other conflict settings. A systematic review of psychological therapies for the treatment of mental disorders in conflict-affected LMICs found large or moderate effects in reducing PTSD, depressive, and anxiety symptoms among adults, albeit based on generally low quality evidence (Purgato, van Ommeren, Tol, & Barbui, 2018). The transdiagnostic Common Elements Treatment Approach (CETA) described above, for instance, has demonstrated positive effects on a range of mental health and psychosocial outcomes among Burmese refugees in Thailand (Bolton et al., 2014) and survivors of systematic violence in Iraq (Weiss et al., 2015). Another recently developed mental health intervention to enhance psychological flexibility – i.e. how a person adapts to fluctuating situational demands, shifts perspective, and balances competing needs – was found to be feasible for South Sudanese refugees in Uganda, and could be particularly relevant for contexts of protracted displacement (Tol et al., 2018). There is also emerging evidence that parenting interventions, which are often delivered in a group format, can be a vehicle through which caregivers increase their social networks, and access emotional and informational support (Cluver et al., 2018). Given the potential for social support to promote the psychological and parenting resilience of war-affected parents, this is an area for further intervention development and research.

*6.3 Implications for research*

There are several implications for future research arising from this DPhil thesis. First, in order to capture the dynamic interactions among individuals, families, and the social, political, and economic context of war and displacement, future research should adopt a *systems approach* (Lerner et al., 2002) to investigating the determinants and nature of parenting in war. A systems approach requires explicit consideration of multilevel and multidimensional influences on parental and child outcomes over time. The use of longitudinal data and multilevel modelling techniques would also enable the detection of bidirectional effects across different levels of the developmental system, thus clarifying how parents and children may themselves exert influence on their proximal environment.

While longitudinal research is better suited to causal inference than cross-sectional designs, the time and expense involved in collecting multiple waves of data are often prohibitive in humanitarian settings. As argued by Masten (2002, p. 293), "urgent problems may not wait for thorough and gradual accretion of a solid knowledge base on risk-reducing or asset-enhancing and other protective processes." *Intervention research* grounded in scientific theory, empirical evidence, and the practical experience of parents, children, and service providers, offers an alternative approach to unpacking the mechanisms underlying the intergenerational impact of war. The scale of the Syrian refugee crisis and the risk of significant, lifelong, and multi-generational adverse effects, justify the use of experimental designs to test and iteratively refine risk and resilience hypotheses, thereby accelerating efforts to disrupt cycles of adversity.

Another important direction for future research is to investigate *potential differential pathways* from parental PTS and generalised distress to various dimensions

of parenting and child psychosocial difficulties. For example, Bryant et al. (2018) found that caregiver PTSD among refugees resettled in Australia directly affected children's emotional problems but not other domains of children's difficulties. Findings from this thesis question the salience of parental traumatisation, highlighting instead the pathways between general psychological distress, negative parenting, and child psychosocial adjustment. Efforts to disentangle the effects of trauma-related psychopathology from other forms of parental distress are stymied by the lack of validated mental health measures for the Syrian refugee population. Future research will need to adopt *transcultural assessment approaches* that take into account sociocultural contexts that may shape the way trauma and adversity are experienced and expressed (Weine et al., 2018). Multi-informant, multi-method designs will also be crucial to increasing the reliablity and validity of future research by minimising the risk of bias associated with self-reported data.

*Fathers, and the effects of war and displacement on their parenting behaviour*, remain significantly under-researched despite evidence suggesting that contextual influences on parenting may be gendered (Taraban & Shaw, 2018; Panter-Brick et al., 2014). The qualitative results reported in DPhil Paper 1, for instance, suggest that Syrian fathers experience an additional mental health burden related to being unable to fulfil their traditional gender role as provider. Yet, fathers in this sociocultural setting may also have less access to social support. Future research will need to make concerted efforts to include fathers as well as mothers, not only to enable investigation of potential gender effects on parenting in times of war, but also to design interventions that address the specific needs and challenges that fathers face.

Finally, it is imperative that research in conflict settings shift away from a sole focus on trauma and psychopathology, towards a *resilience promotion agenda*.

Examining protective processes across multiple levels of context and analysis – from societal-level variables, to the proximal environments of family and community, to individual attributes – is essential to advancing theory and designing strategies to promote the resilience of war-affected populations (Luthar et al., 2000; Motti-Stefanidi, 2018). Specifically, future research on resilience processes among refugee families should interrogate the definition and criteria for resilience in the context of ongoing displacement. Recognising that meanings and expressions of resilience are variable across different cultural and socio-political contexts (Motti-Stefanidi, 2018; Panter-Brick, 2015), it is necessary to understand how refugees themselves define "doing well" in an environment of ongoing armed conflict and displacement.

Lastly, it is time that resilience research considers parents and caregivers as worthy subjects. Developmental science and the life course perspective view human development as a lifelong process, with individuals continually developing and changing in response to their social context (Lerner, 1995; Bengtson and Allen, 1993; Elder, 1998). Future research should investigate the processes that contribute to parental resilience within a context of enormous upheaval and change, not only for the sake of their own mental and emotional wellbeing, but also in the interest of the children who depend on them. As argued in this thesis, the outcomes of refugee parents and children are linked through the joint forces of social, political, economic, and family contexts. By understanding how to promote the resilience of parents, we contribute to the positive adaptation of their children.

### *6.4 Dissemination and impact*

From the outset, the goal of this thesis was to produce high quality, translational research that would have direct and concrete implications for humanitarian policy and

practice. Collaboration with the IRC, a leading humanitarian agency in the response to the Syrian crisis, ensured that the questions addressed through this research would be relevant to the issues that policy makers, practitioners, and refugee communities were facing on the ground, as well as facilitated widespread dissemination of research findings to local, national, and global stakeholders.

In addition to publications in peer-reviewed journals, dissemination activities have included presentations to the following academic, policy, and practitioner audiences: 25th biennial meeting of the International Society for the Study of Behavioural Development; Centre for Evidence-Based Intervention Research Group at the Department of Social Policy and Intervention; UNICEF, the Government of Lebanon, and the National Child Protection Working Group in Lebanon; Alliance for Child Protection in Humanitarian Action Family Strengthening Task Force; and, staff at the IRC in Lebanon and the Violence Prevention and Response Technical Unit at the IRC headquarters in London and New York. Findings from this research were also presented to representatives from refugee communities in Lebanon and local field staff who had participated in data collection.

This research is particularly timely as family-based approaches, and parenting interventions in particular, continue to be a core part of the IRC's programming in Lebanon and the Middle East region. In December 2017, the IRC and Sesame Workshop received a USD $100 million grant from the MacArthur Foundation to promote early childhood development among Syrian refugee children (MacArthur Foundation, 2017). Caregiver suppport, focusing on caregiver responsiveness, mental wellbeing and resilience, is one of the pillars of this large-scale intervention. Findings from this thesis, which elucidate the pathways linking war and displacement to

caregiver and child outcomes, will be a key resource to the IRC and its partners as they develop this ambitious new initiative.

### *6.5 Conclusion*

The forced displacement of millions worldwide due to war, violence, and persecution is one of the most urgent issues of our time. This DPhil thesis examined the pathways underlying the intergenerational impacts of war and displacement, with the aim of identifying risk and resilience processes that can inform the development of interventions. In DPhil Paper 1, qualitative findings showed multiple pathways contributing to child psychosocial difficulties via impaired parenting: economic hardship and parental adaptation, parental psychological distress, and increased parental control. In DPhil Paper 2, structural equation modelling supported a conceptual model linking war trauma to maternal mental health via daily stressors, and maternal psychological distress to child psychosocial difficulties via negative parenting. Finally, DPhil Paper 3 found that social support may be a promotive resource for refugee mothers' psychological and parenting resilience.

As a whole, this DPhil thesis contributes to the nascent literature on parenting in war by demonstrating how parents and families are embedded in, constrained by, and adapt to the political, social, and economic environment created by war and displacement. While Syrians who have fled to Lebanon are now, for the most part, safe from the horrors of war, they continue to suffer the everyday effects of structural violence which impinge on parents' own wellbeing, as well as their capacity to protect and promote the wellbeing of their children. The intergenerational transmission of trauma and adversity is not inevitable, however. Polices and interventions that position

the family as a "micro-social group within a macro-social context" (Bengston & Allen, 1993, p. 470), and embrace the principle of linked lives, have the potential to disrupt the continuum of violence and support the resilience of refugee children, caregivers, and families.

*6.6 References*

Auerbach, R. P., Bigda-Peyton, J. S., Eberhart, N. K., Webb, C. A., & Ho, M.-H. R. (2011). Conceptualizing the Prospective Relationship Between Social Support, Stress, and Depressive Symptoms Among Adolescents. *Journal of Abnormal Child Psychology*, *39*(4), 475–487.

Barbelet, V., Hagen-Zanker, J., & Mansour-Ille, D. (2018). The Jordan Compact.

Belsky, J. (1984). The Determinants of Parenting: A Process Model. *Child Development*, *55*(1), 83–96.

Bengtson, V. L., & Allen, K. R. (1993). The Life Course Perspective Applied to Families Over Time. In P. Boss, W. J. Doherty, R. LaRossa, W. R. Schumm, & S. K. Steinmetz (Eds.), *Sourcebook of Family Theories and Methods* (pp. 469–504). Boston, MA: Springer US.

Betts, A., & Collier, P. (2015). Help refugees help themselves: Let displaced Syrians join the labor market. *Foreign Affairs*, *94*, 84.

Bolton, P., Lee, C., Haroz, E. E., Murray, L., Dorsey, S., Robinson, C., … Bass, J. (2014). A transdiagnostic community-based mental health treatment for comorbid disorders: development and outcomes of a randomized controlled trial among Burmese refugees in Thailand. *PLoS Medicine*, *11*(11), e1001757.

Bryant, R. A., Edwards, B., Creamer, M., O'Donnell, M., Forbes, D., Felmingham, K. L., … McFarlane, A. C. (2018). The effect of post-traumatic stress disorder on refugees' parenting and their children's mental health: a cohort study. *The Lancet Public Health*, *3*(5), e249–e258.

Catani, C., Jacob, N., Schauer, E., Kohila, M., & Neuner, F. (2008). Family violence, war, and natural disasters: A study of the effect of extreme stress on children's mental health in Sri Lanka. *BMC Psychiatry*, *8*(1).

Ceballo, R., & McLoyd, V. C. (2002). Social support and parenting in poor, dangerous neighborhoods. *Child Development*, *73*(4), 1310–1321.

Cluver, L. D., Meinck, F., Steinert, J. I., Shenderovich, Y., Doubt, J., Romero, R. H., … Tsoanyane, S. (2018). Parenting for Lifelong Health: a pragmatic cluster randomised controlled trial of a non-commercialised parenting programme for adolescents and their families in South Africa. *BMJ Global Health*, *3*(1), e000539.

Eggerman, M., & Panter-Brick, C. (2010). Suffering, hope, and entrapment: Resilience and cultural values in Afghanistan. *Social Science & Medicine*, *71*(1), 71–83.

Elder, G. H. (1974). *Children of the Great Depression*. Chicago: University of Chicago.

Elder, G. H. (1998). The Life Course as Developmental Theory. *Child Development*, *69*(1), 1.

Elder, G. H., van Nguyen, T., & Caspi, A. (1985). Linking Family Hardship to Children's Lives. *Child Development*, *56*(2), 361.

Ellis, B. H., MacDonald, H. Z., Lincoln, A. K., & Cabral, H. J. (2008). Mental health of Somali adolescent refugees: The role of trauma, stress, and perceived discrimination. *Journal of Consulting and Clinical Psychology*, *76*(2), 184–193.

Farmer, P. (2004). An Anthropology of Structural Violence. *Current Anthropology*, *45*(3), 305–325.

Galtung, J. (1969). Violence, Peace, and Peace Research. *Journal of Peace Research*, *6*(3), 167–191.

Gavidia-Payne, S., Denny, B., Davis, K., Francis, A., & Jackson, M. (2015). Parental resilience: A neglected construct in resilience research. *Clinical Psychologist*, *19*(3), 111–121.

Gewirtz, A. H., DeGarmo, D. S., & Zamir, O. (2018). Testing a Military Family Stress Model. *Family Process*, *57*(2), 415–431.

Giusto, A., Friis, E., Sim, A. L., Chase, R. M., Zayzay, J. O., Green, E., & Puffer, E. (2017). A qualitative study of mechanisms underlying effects of a parenting intervention in rural Liberia. *The European Journal of Development Research*, *29*(5), 964–982.

Gorst-Unsworth, C., & Goldenberg, E. (1998). Psychological Sequelae of Torture and Organised Violence Suffered by Refugees from Iraq. *British Journal of Psychiatry*, *172*, 90–94.

Green, B. L., Furrer, C., & McAllister, C. (2007). How Do Relationships Support Parenting? Effects of Attachment Style and Social Support on Parenting Behavior in an At-Risk Population. *American Journal of Community Psychology*, *40*(1–2), 96–108.

Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a Conceptual Framework for Mixed-method Evaluation Designs. *Educational Evaluation and Policy Analysis*, *11*(3), 255–274.

Halevi, G., Djalovski, A., Vengrober, A., & Feldman, R. (2016). Risk and resilience trajectories in war-exposed children across the first decade of life. *Journal of Child Psychology and Psychiatry*, *57*(10), 1183–1193.

Hynie, M. (2018). The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review. *The Canadian Journal of Psychiatry*, *63*(5), 297-303.

Hynie, M. (2018). Refugee integration: Research and policy. *Peace and Conflict: Journal of Peace Psychology*, *24*(3), 265.

Jarrett, R. L. (1997). African American family and parenting strategies in impoverished neighborhoods. *Qualitative Sociology*, *20*(2), 275–288.

Kienzler, H. (2008). Debating war-trauma and post-traumatic stress disorder (PTSD) in an interdisciplinary arena. *Social Science & Medicine*, *67*(2), 218–227.

Kirmayer, L. J. (1989). Cultural Variations in the Response to Psychiatric Disorders and Emotional Distress. *Social Science & Medicine*, *29*(3), 327–339.

Kleinman, A. (2000). The violences of everyday life. In *Violence and Subjectivity* (pp. 226–241). Berkeley: University of California Press.

Lerner, R. M. (1995). Developing Individuals Within Changing Contexts: Implications of Developmental Contextualism for Human Development Research, Policy, and Programs. In *Development of Person-context Relations* (pp. 13–33). New York: Psychology Press.

Lerner, R. M., Rothbaum, F., Boulos, S., & Castellino, D. R. (2002). Developmental Systems Perspective on Parenting. In *Handbook of parenting* (2nd ed, pp. 315–344). Mahwah, N.J: Erlbaum.

Luthar, S. S. (1999). *Poverty and Children's Adjustment*. Thousand Oaks, CA: SAGE Publications.

Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, *71*(3), 543–562.

MacArthur Foundation. (2017, December). Sesame Workshop & International Rescue Committee Awarded $100 Million for Early Childhood Education of Syrian Refugees - MacArthur Foundation. Retrieved September 4, 2018, from https://www.macfound.org/press/press-releases/sesame-workshop-and-international-rescue-committee-awarded-100-million-early-childhood-education-syrian-refugees/.

Marra, J. V., McCarthy, E., Lin, H.-J., Ford, J., Rodis, E., & Frisman, L. K. (2009). Effects of social support and conflict on parenting among homeless mothers. *American Journal of Orthopsychiatry*, *79*(3), 348–356.

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, *56*(3), 227–238.

Masten, A. S. (2002). Resilience Comes of Age: Reflections on the Past and Outlook for the Next Generation of Research. In *Resilience and Development: Positive Life Adaptations* (pp. 281–296). Boston, MA: Springer US.

Miller, K. E., Weine, S. M., Ramic, A., Brkic, N., Bjedic, Z. D., Smajkic, A., … Worthington, G. (2002). The relative contribution of war experiences and exile-related stressors to levels of psychological distress among Bosnian refugees. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies*, *15*(5), 377–387.

Motti-Stefanidi, F. (2018). Resilience among immigrant youth: The role of culture, development and acculturation. *Developmental Review*.

Murray, L. K., Hall, B. J., Dorsey, S., Ugueto, A. M., Puffer, E. S., Sim, A., … Bolton, P. A. (2018). An evaluation of a common elements treatment approach for youth in Somali refugee camps. *Global Mental Health*, *5*.

Newnham, E. A., Pearson, R. M., Stein, A., & Betancourt, T. S. (2015). Youth mental health after civil war: The importance of daily stressors. *British Journal of Psychiatry*, *206*(2), 116–121.

Panter-Brick, C. (2015). Culture and Resilience: Next Steps for Theory and Practice. In L. C. Theron, L. Liebenberg, & M. Ungar (Eds.), *Youth Resilience and Culture* (Vol. 11, pp. 233–244). Dordrecht: Springer Netherlands.

Panter-Brick, C., Burgess, A., Eggerman, M., McAllister, F., Pruett, K., & Leckman, J. F. (2014). Practitioner Review: Engaging fathers - recommendations for a game change in parenting interventions based on a systematic review of the global evidence. *Journal of Child Psychology and Psychiatry*, *55*(11), 1187–1212.

Ponnamperuma, T., & Nicolson, N. A. (2018). The Relative Impact of Traumatic Experiences and Daily Stressors on Mental Health Outcomes in Sri Lankan Adolescents: Mental Health Impact of Trauma and Daily Stressors. *Journal of Traumatic Stress*, *31*(4), 487–498.

Puffer, E. S., Green, E. P., Chase, R. M., Sim, A. L., Zayzay, J., Friis, E., … Boone, L. (2015). Parents make the difference: a randomized-controlled trial of a parenting intervention in Liberia. *Global Mental Health*, *2*.

Purgato, M., van Ommeren, M., Tol, W., & Barbui, C. (2018). Addressing stress, depression, and anxiety in people exposed to traumatic events in humanitarian settings: A systematic review and meta-analysis of psychosocial interventions. *Journal of Psychosomatic Research*, *109*, 127.

Rylko-Bauer, B., & Farmer, P. (2016). Structural violence, poverty, and social suffering. *The Oxford Handbook of the Social Science of Poverty*, 47.

Saile, R., Ertl, V., Neuner, F., & Catani, C. (2014). Does war contribute to family violence against children? Findings from a two-generational multi-informant study in Northern Uganda. *Child Abuse & Neglect*, *38*(1), 135–146.

Scheper-Hughes, N. (1993). *Death without weeping: The violence of everyday life in Brazil*. Berkeley: University of California Press.

Schofield, T. J., Lee, R. D., & Merrick, M. T. (2013). Safe, Stable, Nurturing Relationships as a Moderator of Intergenerational Continuity of Child Maltreatment: A Meta-Analysis. *Journal of Adolescent Health*, *53*(4), S32–S38.

Slobodin, O., & de Jong, J. T. V. M. (2015). Family interventions in traumatized immigrants and refugees: A systematic review. *Transcultural Psychiatry*, *52*(6), 723–742.

Summerfield, D. (2001). The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *BMJ*, *322*(7278), 95–98.

Taraban, L., & Shaw, D. S. (2018). Parenting in context: Revisiting Belsky's classic process of parenting model in early childhood. *Developmental Review*, *48*, 55–81.

Tol, W. A., Augustinavicius, J., Carswell, K., Brown, F. L., Adaku, A., Leku, M. R., … van Ommeren, M. (2018). Translation, adaptation, and pilot of a guided self-help intervention to reduce psychological distress in South Sudanese refugees in Uganda. *Global Mental Health*, *5*.

Tracy, M., Salo, M., & Appleton, A. A. (2018). The mitigating effects of maternal social support and paternal involvement on the intergenerational transmission of violence. *Child Abuse & Neglect*, *78*, 46–59.

Vindevogel, S. (2017a). Resilience in the context of war: A critical analysis of contemporary conceptions and interventions to promote resilience among war-affected children and their surroundings. *Peace and Conflict: Journal of Peace Psychology*, *23*(1), 76–84.

Walsh, F. (1996). The concept of family resilience: Crisis and challenge. *Family Process*, *35*(3), 261–281.

Walsh, F. (2002). A family resilience framework: Innovative practice applications. *Family Relations*, *51*(2), 130–137.

Weine, S., Muzurovic, N., Kulauzovic, Y., Besic, S., Lezic, A., Mujagic, A., … Ware, N. (2004). Family consequences of refugee trauma. *Family Process*, *43*(2), 147–160.

Weiss, W. M., Murray, L. K., Zangana, G. A. S., Mahmooth, Z., Kaysen, D., Dorsey, S., … Bolton, P. (2015). Community-based mental health treatments for survivors of torture and militant attacks in Southern Iraq: a randomized control trial. *BMC Psychiatry*, *15*(1).

Wylie, L., Van Meyel, R., Harder, H., Sukhera, J., Luc, C., Ganjavi, H., … Wardrop, N. (2018). Assessing trauma in a transcultural context: challenges in mental health care with immigrants and refugees. *Public Health Reviews*, *39*(1).

Yeomans, P. D., & Forman, E. M. (2009). Cultural factors in traumatic stress. In *Culture and Mental Health: Sociocultural Influences, Theory, and Practice* (pp. 221–244). Wiley.

# APPENDICES

*Appendix A. Data Collection Tools*

## Appendix A.1 Parent Focus Group Discussion Guide

Instructions for facilitators

- Before participants arrive, make sure there is tea/coffee available and set up enough chairs in a circle. Make sure you have the participant list. Test the tape recorder to make sure it is working.
- Greet and welcome participants as they arrive and invite them to have tea/coffee
- Check their name off the participant list
- When all the participants have arrived, invite them to sit in a circle
- Introduce yourself and the note taker and thank everyone for making the time to participate
- Remind everyone that the purpose of the discussion is to understand the experience of being a parent as a refugee in Lebanon. Their experience and opinions will help IRC and other organisations develop better programs to help Syrian children and caregivers in Lebanon.
- Explain that we are particularly interested in their experience with their children who are aged between 2 and 9 years old.
- Remind everyone that everything they say is confidential so no names will be used to identify them. Remind everyone that participation is voluntary and they

can choose to not answer a question or stop at any time with no negative consequences.

- Explain that if someone discloses information that leads you to be concerned about immediate risk of harm to them or someone else, you may have to report this to your supervisor. If so, you will discuss this with them in private.
- Point out the tape recorder and explain that you will be recording the discussion to make sure you have accurate notes. Remind everyone that the recording will not be shared with anyone else.
- Request that everyone is respectful of one another's opinions, listens carefully to one another and gives each person the opportunity to speak. Remind participants to respect one another's privacy and to not discuss with other people what is shared during the group.
- Before you start, ask if anyone has any questions or concerns.
- TURN ON THE TAPE RECORDER

<u>Focus group discussion questions</u>

1. We know that there are many difficulties for Syrians here in Lebanon. For our discussion today, we're particularly interested in your experience as a parent. Please start by telling us about your children, how many sons and daughters you have, and how old they are.
2. What challenges or concerns do you have as a parent of young children here?
    a. How do you deal with these challenges and concerns?

3. What kinds of things affect the way you behave as a parent here, for example, the way that you talk to or interact with your child?
4. Has the way you parent your young child changed since the war in Syria and coming here to Lebanon? How has it changed or stayed the same?
5. What are the differences in how fathers and mothers interact with their young children here?
6. What are some problems you have with your young children?
    a. How do you deal with these problems?
7. How has your young child behaved since the war in Syria and coming here to Lebanon?
    a. What do you do in response to these behaviors in your child?
8. What are your dreams and hopes for your children?
9. What kind of information or support would you like to have to deal with the challenges and concerns you've mentioned today?

Thank you for sharing your experiences with us today. We know that sometimes it can be difficult to talk about such things. How is everyone feeling?

Does anyone have anything else to add? Does anyone have any questions?

## Appendix A.2 Child Focus Group Discussion Guide

Instructions for facilitators

- Before participants arrive, make sure there is water/juice available and set up enough chairs in a circle. Make sure you have the participant list. Test the tape recorder to make sure it is working.
- Greet and welcome participants as they arrive and invite them to have water/juice
- Check their name off the participant list
- When all the participants have arrived, invite them to sit in a circle
- Introduce yourself and the note taker and thank everyone for coming
- Remind everyone that they're here today to talk about how their parents behave with them and how they behave with their parents
- Remind everyone that everything they say is confidential so no names will be used to identify them. Remind everyone that participation is voluntary and they can choose to not answer a question or stop at any time with no negative consequences.
- Explain that if you become concerned about a child's safety, you will have to tell your supervisor who will be able to help the child.
- Point out the tape recorder and explain that you will be recording the discussion to make sure you have accurate notes. Remind everyone that the recording will not be shared with anyone else.
- Request that everyone is respectful of one another's opinions, listens carefully to one another and gives each person the opportunity to speak. Remind participants

to respect one another's privacy and to not discuss with other people what is shared during the group.

- Ask if anyone has any questions or concerns.
- Start by playing a fun game to get the children comfortable and relaxed
- Once the children are seated again, TURN ON THE TAPE RECORDER

Child focus group discussion questions

1. Let's start by talking about our families. Tell us about the people in your family like your mother, father, brothers and sisters.
2. How do you and your parents usually spend time together here?
    a. What are the differences between how your mother spends time with you and how your father spends time with you?
3. All children behave well sometimes and don't behave well other times. This is totally normal. When you behave well, what do your parents do?
    a. What are the differences between what your mother does and what your father does?
4. When you don't behave well, what do your parents do?
    a. What are the differences between what your mother does and what your father does?
5. Everyone feels sad or angry or afraid sometimes. This is totally normal. What do you do when you have such feelings?

6. What do your parents do when you have such feelings?
    a. What are the differences between what your mother does and what your father does?
7. What do you want to be when you grow up?

Thank you for talking with us today. How is everyone feeling? Does anyone have anything else to add? Does anyone have any questions?

End the session with a fun game.

## Appendix A.3 Individual Parent Interview Guide

Instructions for interviewer

- Before the interview, test the tape recorder to make sure it is working
- Greet and welcome the participant and invite them to have tea/coffee (if available)
- Introduce yourself and the note taker and thank the participant for making the time to participate
- Remind the participant that the purpose of the interview is to understand the experience of being a parent as a refugee in Lebanon. Their experience and opinions will help IRC and other organisations develop better programs to help Syrian children and caregivers in Lebanon.
- Explain that we are interested in their experience as a parent of a child aged between 2 and 9 years old.
- Remind the participant that everything they say is confidential so no names will be used to identify them. Also remind them that participation is voluntary and they can choose to not answer a question or stop at any time with no negative consequences.
- Explain that if the participant discloses information that leads you to be concerned about immediate risk of harm to them or someone else, you may have to report this to your supervisor. If so, you will discuss this with them first.
- Point out the tape recorder and explain that you will be recording the discussion to make sure you have accurate notes. Remind the participant that the recording will not be shared with anyone else.

- Before you start, ask the participant if they have any questions or concerns.
- TURN ON THE TAPE RECORDER

Interview questions

1. We know that there are many difficulties for Syrians here in Lebanon. For our discussion today, we're particularly interested in your experience as a parent. Please start by telling us about your children, how many sons and daughters you have, and how old they are.
2. How has life for your family changed since leaving Syria and coming to Lebanon?
3. What affects the way you behave towards your young child, for example, the way you spend time with him/her, the way you talk to him/her, or the way you discipline him/her?
4. What do you find most difficult about being a parent to a young child here?
    a. How do you deal with these difficulties?
5. All children sometimes behave well and other times don't behave so well. This is totally normal.
    a. Why do you think young children misbehave?
    b. What do you do when your young child misbehaves?
    c. What do you do when your young child behaves well?
    d. What do you do to encourage your child to behave well?

6. How do you and your partner or other members of your family share the responsibility of caring for your child, including spending time together and teaching your child how to behave well?
    a. Has this changed since the war in Syria and coming here to Lebanon? How has it changed or stayed the same?
7. Has the way you parent your young child changed since the war in Syria and coming here to Lebanon? How has it changed or stayed the same?
8. How has your young child behaved since the war in Syria and coming here to Lebanon?
    a. What do you do in response to these behaviors in your child?
9. What are some things that parents can do to help their young children cope with the difficulties of being a refugee?
10. Parenting young children can be stressful, especially under these circumstances. What do you do when you are feeling stressed or upset?
11. What kind of information or support would you like to have to deal with the challenges and concerns you've mentioned today?

Thank you for sharing your experiences with us today. We know that sometimes it can be difficult to talk about such things. How are you feeling?

Do you have anything else to add? Do you have any questions?

**Appendix A.4 Caregiver Survey Questionnaire**

| | |
|---|---|
| sur1 | Participant code |
| sur2 | Interviewer name |
| sur3 | Location<br>1 Beirut<br>2 Mount Lebanon<br>3 Hermel<br>4 Arsal<br>5 Akkar<br>6 Tripoli<br>7 Zahle |
| dem1 | Participant gender<br>0 Male<br>1 Female |
| dem2 | How old are you? |
| note0 | Now I'm going to ask you some questions about your household. By household, I mean a group of people who live in the same place, share the same food, and share the same budget that is managed by the head of household. |
| dem3 | How many people are in your household, including yourself? |
| dem4 | How many children under 18 years old are currently living with you? |
| dem5 | What is the sex of the head of your household?<br>0 Male<br>1 Female |
| dem6 | Are you married? |

| | |
|---|---|
| | 0 Never married<br>1 In a relationship<br>2 Married<br>3 Widowed<br>4 Separated/divorced<br>999 Don't know/refuse to answer |
| dem7 | Are you currently living with your husband/wife under the same roof?<br>1 Yes<br>0 No<br>999 Don't know/refuse to answer |
| dem8 | What level of education have you completed?<br>0 No formal schooling<br>1 Pre-school/kindergarten<br>2 Primary school<br>3 Intermediate/complementary school<br>4 Secondary school<br>5 Technical course<br>6 University<br>7 Post-graduate<br>999 Don't know/refuse to answer |
| dem9 | What is your nationality?<br>1 Syrian<br>999 Don't know/refuse to answer |
| dem10 | When did you arrive in Lebanon? |

| | |
|---|---|
| | 1 Less than 1 month ago<br>2 1-3 months ago<br>3 4-6 months ago<br>4 7 months-1 year ago<br>5 1-2 years ago<br>6 2-3 years ago<br>7 4-5 years ago<br>8 More than 5 years ago<br>999 Don't know/refuse to answer |
| note1 | I am going to ask you a few questions about your status in Lebanon. This is just to understand the situation of refugees. I will not give this information to anyone and it will not be used for any other purpose besides this research. |
| dem11 | Are you registered by UNHCR?<br>1 Yes<br>0 No<br>999 Don't know/refuse to answer |
| dem12 | Are all other members of your household registered by UNHCR?<br>1 Yes<br>0 No<br>999 Don't know/refuse to answer |
| dem13 | Do you have a valid residency permit?<br>1 Yes<br>0 No<br>999 Don't know/refuse to answer |
| dem14 | Do all other members of your household have a valid residency permit? |

| | |
|---|---|
| | 1 Yes<br>0 No<br>999 Don't know/refuse to answer |
| se1 | What type of housing do you live in?<br>1 House/apartment (not shared)<br>2 House/apartment (shared with other families)<br>3 One room structure<br>4 Factory/warehouse/garage/shop, etc.<br>5 Unfinished building<br>6 Collective shelter (6 families or more)<br>7 Tent in informal settlement<br>8 Homeless/no shelter<br>9 Other<br>999 Don't know/refuse to answer |
| se1_other | Specify |
| se2 | How many rooms do your family members use to sleep in? |
| se4 | How many days did you work in the last 30 days? |
| se5 | How many household members, including yourself, worked in the last 30 days? |
| se6 | In the last 30 days, what was the main source of cash/income to sustain your household?<br>1 Sale of crops<br>2 Sale of livestock and animal produce<br>3 Agricultural waged labor<br>4 Non-agricultural casual labor |

| | | |
|---|---|---|
| | 5 | Skilled work |
| | 6 | Formal commerce |
| | 7 | Informal commerce |
| | 8 | Sale of assets (e.g. bicycle, jewelry) |
| | 9 | Remittances |
| | 10 | Savings |
| | 11 | Formal credit (e.g. banks) |
| | 12 | Informal credit (e.g. friends, shops) |
| | 13 | Gifts from family/relatives |
| | 14 | Sale of food aid (e.g. food vouchers/parcels) |
| | 15 | Sale of non-food assistance |
| | 16 | Cash from humanitarian organizations |
| | 17 | Cash from charitable organizations |
| | 18 | Food voucher/e-card |
| | 19 | Begging |
| | 20 | Other |
| | 999 | Don't know/refuse to answer |
| se6_other | Specify | |
| se9 | In the last 30 days, how many days did you experience lack of food or money to buy enough food to meet the needs of all your household members? | |
| se10 | Have you received any kind of assistance from the UN or NGOs (e.g. food, cash, hygiene kits) over the last 3 months? | |
| | 1 | Yes |
| | 0 | No |
| | 999 | Don't know/refuse to answer |

| | |
|---|---|
| se11 | What kind of assistance did you receive?<br>1 Food assistance (ecard/voucher)<br>2 Food assistance (in kind)<br>3 Healthcare/drugs<br>4 Psychosocial support<br>5 Fuel subsidy<br>6 Rent subsidy<br>7 Hygiene kits<br>8 Other non-food items<br>9 Unconditional cash<br>10 Other (specify)<br>999 Don’t know/refuse to answer |
| se11_other | Specify |
| index1 | Enter the code of the child selected for this participant. |
| index2 | Now I am going to ask you some questions about (NAME). For the rest of the questions, please think about (NAME) when answering. Is (NAME) a boy or girl?<br>0 Male<br>1 Female |
| index3 | How old is (NAME)? |
| index4 | During the last school year, did your child go to school/ learning center?<br>1 Yes<br>0 No<br>999 Don't know/refuse to answer |
| index5 | In the last month that they attended school, how many days did they go? |

| | |
|---|---|
| index6 | How many days in the last 30 days did (NAME) work to earn income in cash, food or other goods? |
| index7 | What is your relationship to (NAME)?<br>1 Biological mother<br>2 Biological father<br>3 Stepmother<br>4 Stepfather<br>5 Grandmother<br>6 Grandfather<br>7 Uncle<br>8 Aunt<br>9 Brother<br>10 Sister<br>11 Other<br>999 Don't know/refuse to answer |
| index7_other | Specify |
| index8 | Who spends the most time taking care of (NAME), for example, playing and talking together, teaching him/her how to behave well, and disciplining him/her when he/she does something wrong?<br>1 Self<br>2 Other parent<br>3 Grandparent<br>4 Uncle/aunt<br>5 Sibling (above 18)<br>6 Sibling (under 18)<br>7 Other relative (e.g. cousin) |

| | |
|---|---|
| | 8 Other<br>999 Don't know/refuse to answer |
| index8_other | Specify |
| index9 | Who else looks after (NAME) when you are busy or not at home?<br>1 No one<br>2 Other parent<br>3 Child's grandparent<br>4 Child's aunt or uncle<br>5 Sibling (above 18)<br>6 Sibling (under 18)<br>7 Other relative (e.g. cousin)<br>8 Neighbor<br>9 Other<br>999 Don't know/refuse to answer |
| index9_other | Specify |
| sdq | SDQ |
| note2 | I am going to read you some descriptions of how children can behave. For each description, please think about (NAME) and tell me if the description is Not True, Somewhat True or Very True of (NAME) in the last 30 days.<br>0 Not true<br>1 Somewhat true<br>2 Very true<br>999 Don't know/refuse to answer |
| sdq1 | Considerate of other people’s feelings |
| sdq2 | Restless, overactive, cannot stay still for long |

| | |
|---|---|
| sdq3 | Often complains of headaches, stomachaches or sickness |
| sdq4 | Shares readily with other children, for example, toys, treats, pencils |
| sdq5 | Often loses temper |
| sdq6 | Rather solitary, prefers to play alone |
| sdq7 | Generally well behaved, usually does what adults request |
| sdq8 | Many worries or often seems worried |
| sdq9 | Helpful if someone is hurt, upset or feeling ill |
| sdq10 | Constantly fidgeting or squirming |
| sdq11 | Has at least one good friend |
| sdq12 | Often fights with other children or bullies them |
| sdq13 | Often unhappy, depressed or tearful |
| sdq14 | Generally liked by other children |
| sdq15 | Easily distracted, concentration wanders |
| sdq16 | Nervous or clingy in new situations, easily loses confidence |
| sdq17 | Kind to younger children |
| sdq18 | Often lies or cheats |
| sdq19 | Picked on or bullied by other children |
| sdq20 | Often offers to help others (e.g. parents, teachers, other children) |
| sdq21 | Thinks things out before acting |
| sdq22 | Takes things from home, school or elsewhere without permission |
| sdq23 | Gets along better with adults than with other children |
| sdq24 | Many fears, easily scared |
| sdq25 | Good attention span, sees work through to the end |

| | |
|---|---|
| parq | PARQ |
| note3 | I'm going to read you some statements that describe the way parents sometimes behave towards their children. Listen carefully to each statement and think about how well it describes the way you behaved towards NAME in the last 30 days. Remember, there is no right or wrong answer to any statement, so be as honest as you can. Respond to each statement the way you feel you really treated NAME rather than how you would like to treat her/him.<br>0 Almost never true<br>1 Rarely true<br>2 Sometimes true<br>3 Almost always true<br>999 Don't know/refuse to answer |
| parq1 | I say nice things about my child |
| parq2 | I pay no attention to my child |
| parq3 | I make it easy for my child to confide in me |
| parq4 | I hit my child even when (s)he may not deserve it |
| parq5 | I see my child as a big nuisance |
| parq6 | I punish my child when I am angry |
| parq7 | I am too busy to answer my child's questions |
| parq8 | I resent my child |
| parq9 | I am really interested in what my child does |
| parq10 | I say many unkind things to my child |
| parq11 | I pay no attention to my child when (s)he asks for help |
| parq12 | I make my child feel wanted and needed |
| parq13 | I pay a lot of attention to my child |

| | |
|---|---|
| parq14 | I hurt my child's feelings |
| parq15 | I forget important things my child thinks I should remember |
| parq16 | I make my child feel unloved if (s)he misbehaves |
| parq17 | I make my child feel what (s)he does is important |
| parq18 | When my child does something wrong, I frighten or threaten him/her |
| parq19 | I care about what my child thinks, and encourage him/her to talk about it |
| parq20 | I feel other children are better than my child |
| parq21 | I let my child know (s)he is not wanted |
| parq22 | I let my child know I love him/her |
| parq23 | I pay no attention to my child as long as (s)he does nothing to bother me |
| parq24 | I treat my child gently and with kindness |
| parqadd25 | I spend time with my child doing things that he/she enjoys. |
| abq1 | I get so preoccupied that I don't know or forget where my child is and what he/she is doing. |
| abq2 | I don't tell my child where I am going. |
| abq3 | I leave my child at home without an adult watching him/her. |
| mics | MICS |
| note4 | All adults use certain ways to teach children the right behavior or to correct bad behavior. Please tell me how often you used this method with (name) in the last 30 days.<br>0 Never<br>1 Rarely<br>2 Sometimes<br>3 Often<br>4 Almost all the time |

| | |
|---|---|
| | 999 Don’t know/refuse to answer |
| mics1 | Took away privileges, forbade something (s)he liked, or did not allow him/her to leave the house. |
| mics2 | Explained why his/her behaviour was wrong. |
| mics3 | Shook him/her. |
| mics4 | Shouted, yelled, or screamed at him/her. |
| mics5 | Gave him/her something else to do. |
| mics6 | Spanked, hit, or slapped him/her on the bottom with bare hands. |
| mics7 | Hit him/her on the bottom or elsewhere on the body with something like a belt, hairbrush, stick or other hard object. |
| mics8 | Called him/her dumb, lazy, or another name like that. |
| mics9 | Hit or slapped him/her on the face, head or ears. |
| mics10 | Hit or slapped him/her on the hand, arm, or leg. |
| mics11 | Beat him/her up, that is hit him/her over and over as hard as one could. |
| mics12 | Do you believe that in order to bring up (name) properly, you need to physically punish him/her?<br>1 Yes<br>0 No<br>999 Don't know/refuse to answer |
| famcon | Family |
| famcon1 | In the past 30 days, how often were there arguments among the adults in your family involving shouting or screaming?<br>0 Never<br>1 Rarely<br>2 Sometimes |

| | |
|---|---|
| | 3 Often<br>4 Almost all the time<br>999 Don’t know/refuse to answer |
| famcon2 | In the past 30 days, how often were there arguments among the adults in your family involving hitting, pushing or kicking?<br>0 Never<br>1 Rarely<br>2 Sometimes<br>3 Often<br>4 Almost all the time<br>999 Don’t know/refuse to answer |
| mos | MOS |
| note5 | People sometimes look to others for companionship, help or other types of support. I am going to ask you some questions about the types of support that is available to you if you needed it. Please answer based on the past 30 days. If you needed it, how often is someone available…<br>0 None of the time<br>1 A little of the time<br>2 Some of the time<br>3 Most of the time<br>4 All of the time<br>999 Don't know/refuse to answer |
| mos1 | To help you if you were sick in bed? |
| mos2 | To take you to the doctor if you need it? |
| mos3 | To prepare your meals if you are unable to do it yourself? |
| mos4 | To help with daily chores if you were sick? |

| | |
|---|---|
| mos5 | To have a good time with? |
| mos6 | To turn to for suggestions about how to deal with a personal problem? |
| mos7 | Who understands your problems? |
| mos8 | To love and make you feel wanted? |
| mos9 | To look after your children when you are sick or have to leave the house? |
| dass | DASS |
| note6 | I am going to read a few statements describing how people can feel. For each statement, please tell me how much it applied to you over the past 30 days. There are no right or wrong answers so please feel free to answer openly.<br>0 Did not apply to me at all<br>1 Applied to me to some degree, or some of the time<br>2 Applied to me to a considerable degree, or a good part of time<br>3 Applied to me very much, or most of the time<br>999 Don't know/refuse to answer |
| dass1 | I found it hard to wind down |
| dass2 | I was aware of dryness of my mouth |
| dass3 | I couldn't seem to experience any positive feeling at all |
| dass4 | I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion) |
| dass5 | I found it difficult to feel motivated to do things in my everyday life |
| dass6 | I tended to over-react to situations |
| dass7 | I experienced trembling (e.g. in the hands) |
| dass8 | I felt that I was using a lot of nervous energy |
| dass9 | I was worried about situations in which I might panic and make a fool of myself |

| | |
|---|---|
| dass10 | I felt that I had nothing to look forward to |
| dass11 | I found myself getting agitated |
| dass12 | I found it difficult to relax |
| dass13 | I felt down-hearted and blue |
| dass14 | I was intolerant of anything that kept me from getting on with what I was doing |
| dass15 | I felt I was close to panic |
| dass16 | I was unable to become enthusiastic about anything |
| dass17 | I felt I wasn't worth much as a person |
| dass18 | I felt that I was easily upset or irritated |
| dass19 | I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat) |
| dass20 | I felt scared without any good reason |
| dass21 | I felt that life was meaningless |
| hes | HESPER |
| note7 | I am going to ask you about the serious problems that you may currently be experiencing. We are interested in finding out what you think. A serious problem is a problem that you consider serious. If you don't have this problem, then choose "no serious problem".<br>0 No serious problem<br>1 Somewhat serious problem<br>2 Very serious problem<br>999 Don't know/refuse to answer |
| hes1 | Do you have a serious problem because you do not have enough water that is safe for drinking or cooking? |

| | |
|---|---|
| hes2 | Do you have a serious problem with food? For example, because you do not have enough food, or good enough food, or because you are not able to cook food. |
| hes3 | Do you have a serious problem because you do not have a suitable place to live in? |
| hes4 | Do you have a serious problem because you do not have easy and safe access to a clean toilet? |
| hes5 | For men: Do you have a serious problem because it is difficult to keep clean in your situation? For example, because you do not have enough soap, water or a suitable place to wash?<br>For women: Do you have a serious problem because it is difficult to keep clean in your situation? For example, because you do not have enough soap, sanitary materials, water or a suitable place to wash? |
| hes6 | Do you have a serious problem because you do not have enough, or good enough, clothes, shoes, bedding or blankets? |
| hes7 | Do you have a serious problem because you do not have enough income, money or resources to live? |
| hes8 | Do you have a serious problem with your physical health? For example, because you have a physical illness, injury or disability. |
| hes9 | For men: Do you have a serious problem because you are not able to get adequate health care for yourself? For example, treatment or medicines.<br>For women: Do you have a serious problem because you are not able to get adequate health care for yourself? For example, treatment or medicines, or healthcare during pregnancy or childbirth. |
| hes10 | Do you have a serious problem because you feel very distressed? For example, very upset, sad, worried, scared, or angry. |
| hes11 | Do you have a serious problem because you or your family are not safe or protected where you live now? For example, because of conflict, violence or crime in your community, city or village. |
| hes12 | Do you have a serious problem because your children are not in school, or are not getting a good enough education? |
| hes13 | Do you have a serious problem because it is difficult to care for family members who live with you? For example, young children in your family, or family members who are elderly, physically or mentally ill, or disabled. |

| | |
|---|---|
| hes14 | Do you have a serious problem because you are not getting enough support from people in your community? For example, emotional support or practical help. |
| hes15 | Do you have a serious problem because you are separated from family members? |
| hes16 | Do you have a serious problem because you do not have the proper legal documents to stay in Lebanon? |
| hes17 | Do you have a serious problem because you do not have enough information? For example, because you do not have enough information about the aid that is available, or because you do not have enough information about what is happening in your home country or home town. |
| hes18 | Do you have a serious problem because of inadequate aid? For example, because you do not have fair access to the aid that is available, or because aid agencies are working on their own without involvement from people in your community. |
| hes19 | Do you have a serious problem because you do not feel respected? For example, because of the situation you are living in, or because of the way people treat you. |
| hes20 | Do you have a serious problem because you are not able to move between places? For example, going to another village or town. |
| hes21 | Do you have a serious problem because you have too much free time in the day? |
| note6_0 | Note to the interviewer: take a break and offer refreshments. |
| trauma | Trauma |
| note6 | Now I am going to ask you about very stressful events that you may have experienced during the war in Syria. For each event, please tell me whether or not you experienced it during the war in Syria. We will not tell anyone your answers. If you feel distressed at any point, please let me know and we can take a break. It's okay if you don't want to answer any questions, just let me know. Have you ever...<br>1 Yes<br>0 No<br>999 Don't know/refuse to answer |

| | |
|---|---|
| trauma1 | Had no access to medical care when severely ill |
| trauma2 | Been forced to leave your home |
| trauma3 | Been forcibly separated from your family |
| trauma4 | Been homeless (had no shelter) |
| trauma5 | Witnessed the demolition of your house or other people's houses |
| trauma6 | Had your home forcibly searched |
| trauma7 | Known about 'stealing people' (abduction) or the disappearance of a family member, a close relative, or a friend |
| trauma8 | Seen someone else severely beaten, shot or killed |
| trauma9 | Had a family member, relative or friend wounded or killed (not a natural death) |
| trauma10 | Had your life in danger |
| trauma11 | Had a serious injury due to knife/gunshot, landmine or explosion |
| trauma12 | Been severely beaten |
| trauma13 | Seen a family member severely beaten |
| trauma14 | Been imprisoned |
| trauma15 | Directly witnessed a bombardment or rocket explosions related to war |
| trauma16 | Seen a wounded or dead body, as a result of war (not a natural death) |
| trauma17 | Witnessed or experienced torture (torture means any action that intentionally causes severe physical or psychological pain in order to intimidate, punish or get information from someone) |
| trauma18 | OTHER than the situations described above, has anything else ever happened to you that was very frightening, dangerous or violent? |
| trauma19 | If YES, are you comfortable telling me what the event was? |
| pcl | PCL |

| | |
|---|---|
| note7 | Thank you for answering those questions. I know it must be difficult to think about such things. We are almost finished. I am going to ask you some questions about problems that people may have in reaction to the very stressful events I just asked you about. Please tell me how much you have been bothered by each of these problems in the past 30 days.<br><br>0 Not at all<br><br>1 A little bit<br><br>2 Moderately<br><br>3 Quite a bit<br><br>4 Extremely<br><br>999 Don't know/refuse to answer |
| pcl1 | In the past 30 days, how much were you bothered by repeated, disturbing memories, thoughts, or images of the stressful experience? |
| pcl2 | In the past 30 days, how much were you bothered by repeated, disturbing dreams of the stressful experience? |
| pcl3 | In the past 30 days, how much were you bothered by suddenly acting or feeling as if the stressful experience were happening again (as if you were reliving it)? |
| pcl4 | In the past 30 days, how much were you bothered by feeling very upset when something reminded you of the stressful experience? |
| pcl5 | In the past 30 days, how much were you bothered by having physical reactions (e.g. heart pounding, trouble breathing, or sweating) when something reminded you of the stressful experience from the past? |
| pcl6 | In the past 30 days, how much did you avoid thinking about or talking about the stressful experience or avoid having feelings related to it? |
| pcl7 | In the past 30 days, how much did you avoid activities or situations because they remind you of the stressful experience? |
| pcl8 | In the past 30 days, how much did you have trouble remembering important parts of the stressful experience? |
| pcl9 | In the past 30 days, how much were you bothered by loss of interest in things that you used to enjoy? |

| | |
|---|---|
| pcl10 | In the past 30 days, how much were you bothered by feeling distant or cut off from other people? |
| pcl11 | In the past 30 days, how much were you bothered by feeling emotionally numb or being unable to have loving feelings for those close to you? |
| pcl12 | In the past 30 days, how much were you bothered by feeling as if your future will somehow be cut short? |
| pcl13 | In the past 30 days, how much were you bothered by having trouble falling or staying asleep? |
| pcl14 | In the past 30 days, how much were you bothered by feeling irritable or having angry outbursts? |
| pcl15 | In the past 30 days, how much were you bothered by having difficulty concentrating? |
| pcl16 | In the past 30 days, how much were you bothered by being “super alert” or watchful on guard? |
| pcl17 | In the past 30 days, how much were you bothered by feeling jumpy or easily startled? |
| note8 | Thank you for answering these questions. I know that it can be difficult to talk about such things. How are you feeling? If you are feeling distressed and would like to get help, please let me know. I can also give you information about places you can go to receive health or counselling services. I am very grateful to you for taking the time to answer these questions. I want to reassure you that everything we have discussed today will remain between us only. Your contribution to this research will help the IRC and other organizations better meet the needs of Syrian families. Do you have any questions? |
| post1 | Where was the interview conducted?<br>1 IRC office<br>2 Participant's home<br>3 School<br>4 Other |
| post1_other | Specify |
| post2 | Was the interview conducted in private without anyone hearing? |

| | |
|---|---|
| | 0 No<br>1 Yes<br>2 Partly |
| post3 | Did the participant get upset or angry at any point during the interview?<br>0 No<br>1 Yes |
| post4 | Did the participant disclose abuse (e.g. child abuse, exploitation or neglect, intimate partner violence) or intention to hurt him/herself or others?<br>0 No<br>1 Yes |
| post5 | Participant code |

*Appendix B. Ethical Approvals*

## Appendix B.1 Research Ethics Approval for Qualitative Component

SOCIAL SCIENCES & HUMANITIES
INTER-DIVISIONAL RESEARCH ETHICS COMMITTEE

Research Services, University of Oxford, Wellington Square, Oxford OX1 2JD
Tel: +44(0)1865 616576 Fax: +44(0)1865 280467
ethics@socsci.ox.ac.uk

UNIVERSITY OF OXFORD

30 March 2016

Ms Amanda Sim
Department of Social Policy & Intervention

Dear Ms Sim,

**Research Ethics Approval (CUREC 2)**
**Ref No: R44582/RE001**
**Title: Perceived effects of war trauma and adversity on parenting practices and parent-child relationships: a qualitative study of Syrian refugees in Lebanon**

The above application has been considered on behalf of the Social Sciences and Humanities Inter-divisional Research Ethics Committee (IDREC) in accordance with the procedures laid down by the University for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and accordingly approval has been granted.

Should there be any subsequent changes to the project, which raise ethical issues not covered in the original application, you should submit details to the IDREC for consideration.

Yours sincerely,

Claudia Kozeny-Pelling

Claudia Kozeny-Pelling
Research Ethics Manager and Secretary SSH IDREC

cc: Humaira Erfan-Ahmed

## Appendix B.2 Research Ethics Approval for Quantitative Component

SOCIAL SCIENCES & HUMANITIES
INTER-DIVISIONAL RESEARCH ETHICS COMMITTEE

Research Services, University of Oxford, Wellington Square, Oxford OX1 2JD
Tel: +44(0)1865 616576 Fax: +44(0)1865 280467
ethics@socsci.ox.ac.uk




7 July 2016

Ms Amanda Sim
Department of Social Policy & Intervention

Dear Ms Sim,

**Research Ethics Approval (CUREC 2)**
**Ref No: R46541/RE001**
**Title: Feasibility of a parenting intervention to improve parenting practices and parental and child mental health among Syrian refugees in Lebanon**

The above application has been considered on behalf of the Social Sciences and Humanities Inter-divisional Research Ethics Committee (IDREC) in accordance with the procedures laid down by the University for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and accordingly approval has been granted.

Should there be any subsequent changes to the project, which raise ethical issues not covered in the original application, you should submit details to the IDREC for consideration.

Yours sincerely,

Claudia Kozeny-Pelling

Claudia Kozeny-Pelling
Research Ethics Manager and Secretary SSH IDREC

cc: Professor Frances Gardener, ethics@spi.ox.ac.uk

*Appendix C. Risk Assessment*

| **Completed risk assessment form for feasibility study of a parenting intervention to improve parenting practices and parental and child mental health among Syrian refugees in Lebanon** | | | |
|---|---|---|---|
| **Department** | Social Policy and Intervention | | |
| **Name of assessor(s)** | Amanda Sim | **Date of OSCB/other training** | 22 Jan 2016 |
| | | **Date of assessment** | 28 April 2016 |
| **Describe/outline the activity that is under assessment:**<br>Mixed methods study involving surveys and focus group discussions with Syrian refugee children and parents/guardians in Lebanon | | | |
| **To distribute to all staff, students, volunteers involved in running the activity (list names)**<br>Sara Mabger, Child Protection Coordinator, International Rescue Committee (IRC) Lebanon<br>Joelle Wakim, Child Protection Manager, International Rescue Committee (IRC) Lebanon<br>Hiba Ali, Technology and Innovation Officer, International Rescue Committee (IRC) Lebanon<br>Riwa Maktabi, Monitoring and Evaluation Officer, International Rescue Committee (IRC) Lebanon | | | |

| **Hazard**<br>*case and consequences* | **Affected Group**<br>*Who might be harmed, and how?* | **Level of risk**<br>*see matrix example* | **Existing Controls (if any in place)**<br>*What are you already doing?* | **Further Action (if necessary)**<br>*Do you need to do anything else to control the risk?* | **Action by**<br>**Who?** | **Date completed**<br>**When?** |
|---|---|---|---|---|---|---|
| **Breach in confidentiality/ loss of data** | Participant (personal data revealed leading to identification of participant) | Low | Study protocols are in place to regulate the safe collection, storage, transportation and destruction of data. Focal points have been designated to file and secure data. Confirmation of security of online server for storing electronic data. | Pre-data collection training for staff on study protocols. Application of passwords to electronic files. | Amanda Sim to deliver training and monitor adherence to protocols | July 2016 |
| **Participant may experience emotional distress during the course of the focus group or interview** | Participant (distress)<br><br>Staff (distress, and wish to resolve the issue) | Medium | Risk of harm protocol in place to guide staff on how to respond. Information sheet on available counselling services available for staff to distribute. Staff have regular meetings to provide mutual support and problem-solving. | Pre-data collection training for staff on risk of harm protocol. Staff to be clearly advised on the scope of their role (i.e. to refer not to resolve problems).<br>IRC Manager on call to respond to urgent cases.<br>Researcher to debrief with designated IRC staff focal point daily. | Amanda Sim to deliver training and conduct daily debriefing. IRC | July 2016<br><br>July-Dec 2016 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | Manager to be on call. | |
| **Participant may report/disclose abuse at home/ elsewhere** | Participant and other family members (physical or emotional harm)<br><br>Staff (distress, and wish to resolve the issue) | Medium | Risk of harm protocol in place to guide staff on how to respond. Information sheet on available counselling services available for staff to distribute. Staff have regular meetings to provide mutual support and problem-solving. | Pre-data collection training for staff on risk of harm protocol. Staff to be clearly advised on the scope of their role (i.e. to refer not to resolve problems).<br>IRC Manager on call to respond to urgent cases and facilitate referrals.<br>Researcher to debrief with designated IRC staff focal point daily. | Amanda Sim to deliver training and conduct daily debriefing.<br>IRC Manager to be on call. | July 2016<br><br>July-Dec 2016 |
| **Participant may reveal intention to self-harm** | Participant and other family members (physical or emotional harm)<br><br>Staff (distress, and wish to resolve the issue) | Low | Risk of harm protocol in place to guide staff on how to respond. Information sheet on available counselling services available for staff to distribute. Staff have regular meetings to provide mutual support and problem-solving. | Pre-data collection training for staff on risk of harm protocol. Staff to be clearly advised on the scope of their role (i.e. to refer not to resolve problems).<br>IRC Manager on call to respond to urgent cases and facilitate referrals.<br>Researcher to debrief with designated IRC staff focal point daily. | Amanda Sim to deliver training and conduct daily debriefing.<br>IRC Manager to be on call. | July 2016<br><br>July-Dec 2016 |
| **Research assistant may experience distress from hearing participant accounts** | Staff (distress) | Medium | Training for staff will include module on researcher distress and self-care. | Pre-data collection training for staff on researcher distress and self-care.<br>Researcher to debrief with designated IRC staff focal point daily. | Amanda Sim to deliver training and conduct daily debriefing. | July 2016 |
| **Security in the study site may worsen** | Participant and other family members (physical harm) | Medium | IRC has dedicated security personnel and security procedures in place to monitor the security situation and put | Researcher to receive security orientation from IRC security officer upon arrival in country. | Amanda Sim and IRC | July 2016 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Researcher (physical harm)<br><br>Staff (physical harm) | | in place contingency plans. Staff will receive a daily security update and will follow security procedures in all movements to study sites. | Researcher to register with Consular-General of the Republic of Singapore in Beirut. | security officer | |

*Appendix D. Risk of Harm Protocol*

This protocol provides guidance on how to respond if the following ethical issues or adverse events occur during the research study:

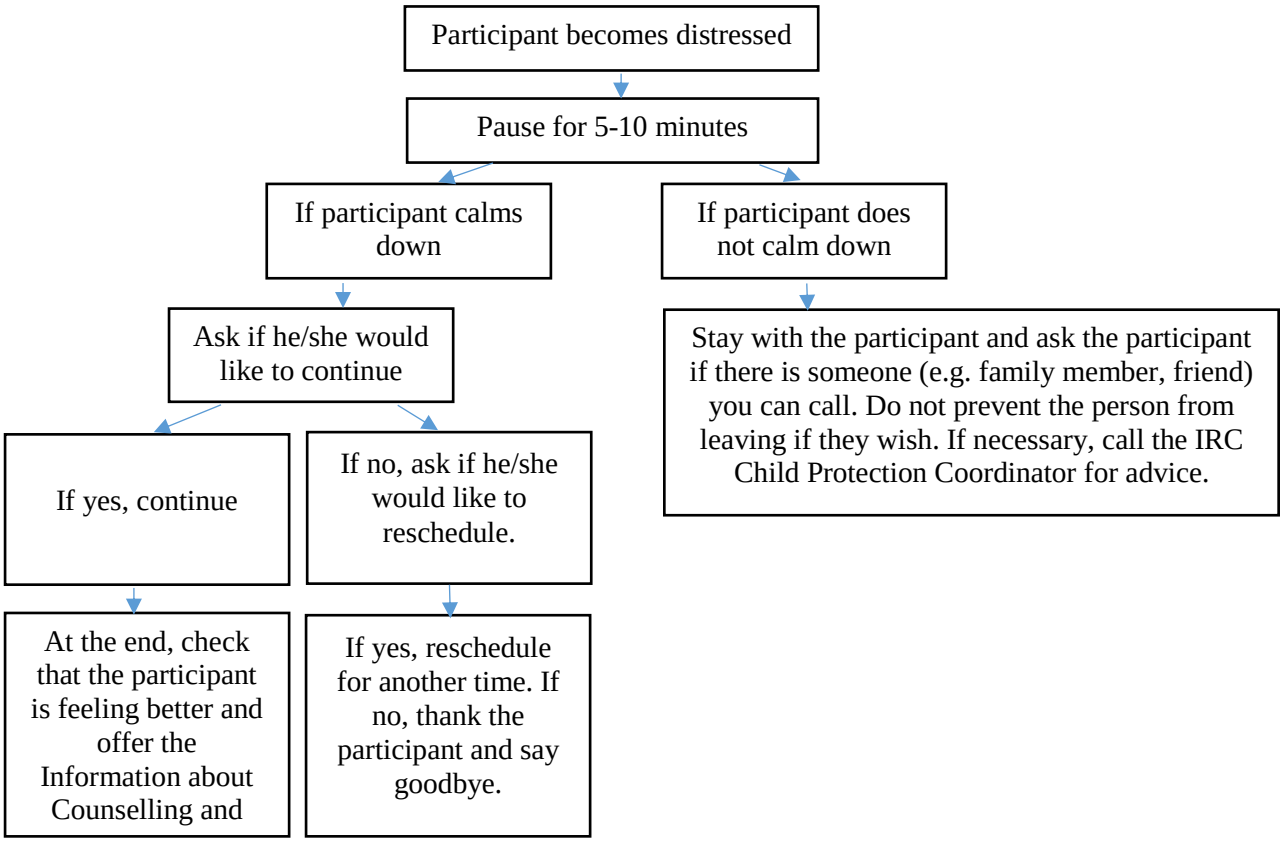
- Participant distress
- Disclosure of child abuse, neglect or exploitation
- Disclosure of intimate partner violence or other forms of gender-based violence
- Intention to self-harm

It is very important to inform Amanda Sim, the University of Oxford researcher, and Sara Mabger, the Child Protection Coordinator, as soon as you return to the office if any of these issues arise.

Participant distress

It is possible that an adult or child participant may become distressed, upset or angry during the interview. The participant may start to cry, raise their voice or become agitated. If this happens, pause the interview for 5-10 minutes. Offer the participant a tissue or some water and give him/her some time to calm down. If the participant calms down after some time, ask if he/she would like to continue. If he/she agrees, continue the interview. If not, ask if the participant would like to reschedule. If the participant remains extremely distressed and is unable to calm down, stop the interview. Stay with the participant and ask if there is someone (e.g. family member, friend) you can call. If the participant is an adult, do not prevent the person from leaving if they wish. If the participant is a child, ensure that the child leaves with a parent/guardian. If necessary, contact the IRC Child Protection Coordinator for advice.

**Decision Tree**



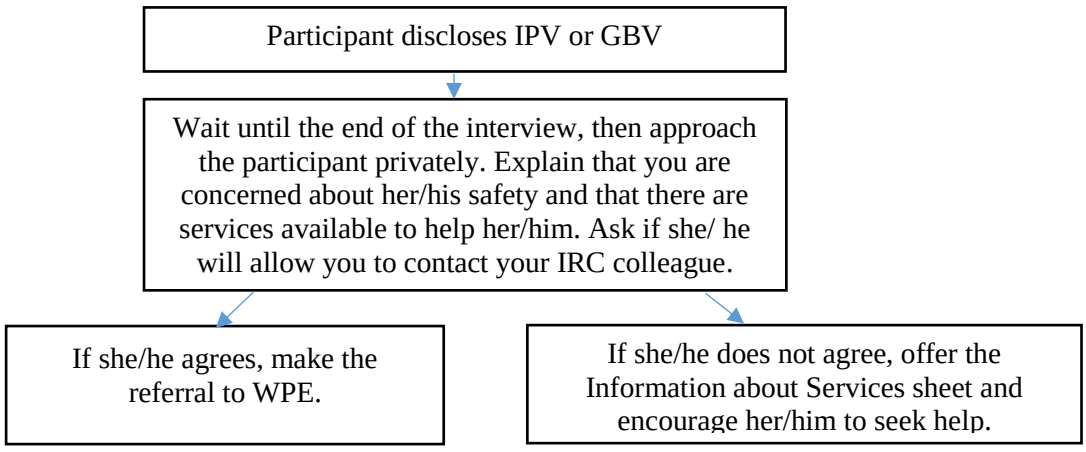

Disclosure of child abuse

It is possible that an adult or child participant discloses abuse of a child during the interview. Child abuse refers to physical, emotional or sexual abuse, or severe neglect or exploitation of a child under the age of 18. If child abuse is disclosed, wait until the interview is finished. Then speak to the participant privately and explain that you are mandated to report this to your supervisor, the IRC Child Protection Coordinator, in order to ensure the child is safe. Explain that staff from the IRC Child Protection team will contact the participant to speak with him/her further and help ensure the child is safe. Reassure the participant that the IRC staff are trained to handle such cases and will prioritise the best interest of the child. Refer the case to the IRC Child Protection team.

Disclosure of intimate partner violence or other forms of gender-based violence

It is possible that an adult participant discloses that she is being abused by an intimate partner and/or another member of the community. Intimate partner violence (IPV) refers to physical, emotional or sexual violence by an intimate partner such as a spouse. Gender-based violence (GBV) refers to violence perpetrated against someone due to her/his gender and social and cultural gender norms. If intimate partner violence or another form of gender-based violence is disclosed, wait until the focus group or interview is finished. Then ask to speak to the participant privately. Explain that you are concerned about his/her safety and that there are services available to help her/him. Ask if she/he will allow you to contact your colleague at the IRC who specialises in such cases. If she/he agrees, make the referral to the IRC Women's Protection and Empowerment (WPE) team. If she/he does not agree, offer the Information about Services sheet and encourage her/him to seek help.

**Decision Tree**




Intention to self-harm

It is possible that an adult or child participant reveals the intention to self-harm (e.g. injure him/herself; kill him/herself). If this happens, wait until the interview is

finished. Then speak to the participant privately and explain that you are concerned about his/her safety and that you want to make sure he/she gets help. Ask if you can refer him/her to get help from a counsellor. Provide the Information about Counselling and Health Services sheet and ask if you can visit him/her the next day to see how he/she is doing. If you are concerned that the participant is in immediate danger, do not leave and call the IRC Child Protection Coordinator for advice. Participant consent to receive assistance may be overridden in situations where the IRC Child Protection Coordinator deem there is a high risk of immediate danger to life.

**In the event of an emergency, call 140 for the Lebanese Red Cross.**

Additional notes for staff

- If a case is identified and needs cannot be fully met by the IRC Child Protection department or IRC's other departments, complete an inter-agency referral form for the case to be transferred to the appropriate responding agency.
- For all cases expected to be covered under UNHCR medical insurance, IRC staff should refer to selected mental health organisations for the preliminary assessment in line with UNHCR protocols to ensure that any cases that might require temporary hospitalisation are not delayed.
- In the unlikely event of an accident, the IRC has insurance that covers injuries of beneficiaries during activities. Staff should have the contact information of Fidelity Insurance focal points.
- For further information or advice, contact Sara Mabger, Child Protection Coordinator.