Exploring the parenting challenges and meeting the needs of families in preresettlement contexts

A thesis submitted to the University of Manchester for the degree of PhD in Clinical Psychology in the Faculty of Medical and Human Sciences

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SCHOOL OF PSYCHOLOGICAL SCIENCES
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General Abstract
Thesis Abstract

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A thesis submitted for the degree of PhD in Clinical Psychology in the Faculty of Medical and Human Sciences

Thesis Title: Exploring the parenting challenges and meeting the needs of families in preresettlement contexts

BACKGROUND: Children who are exposed to war are at great risk of suffering mental health and developmental problems. The care children receive from parents during and after conflict is highly important, acting as a significant protective factor. The stress and difficulties of war and displacement, often leaves parents unable to give children the care they need. By supporting families through the use of parent interventions, it may be possible to weaken the link between war and displacement, and psychological difficulties in children.

AIMS: The present project had two main aims. Firstly, to examine the parenting needs and challenges of refugee families living in preresettlement contexts. Secondly, to test the feasibility of disseminating parenting information to families living in conflict zones. The project took place in Syria and Turkey with families that had experienced the conflict in Syria.

METHOD: First, a systematic review was carried out to explore previous evaluations of parenting programmes in preresettlement contexts. Then, a qualitative study was carried out exploring the parenting challenges and needs of refugee families, and the coping strategies parents utilised in caring for their children in preresettlement contexts. Thematic analysis was carried out to identify key issues from the data, and parental experiences. The final study tested the feasibility of large-scale distribution of parenting information leaflets and feedback questionnaires in a conflict zone in Syria. Descriptive statistics were used to explore the sample characteristics of the respondents and t-tests were utilised to examine the usefulness of the parenting leaflet. In addition, a content analysis methodology was used to code respondent comments that had been written on feedback questionnaires.

CONCLUSION: The current available evidence base on parenting interventions in preresettlement contexts is poor. However, very soon after the immediate extreme stress of displacement, parents are very keen to access information on how best to parent their children. It may be possible to design and deliver interventions for parents in this context based on theoretical parenting principles and identified needs, to inform holistic interventions and culturally appropriate policy responses. The successful delivery of parenting information to families in a conflict zone demonstrates the scope for using existing humanitarian supply routes, both to distribute information and to receive feedback directly from recipients, even in high risk settings. Further research is required to investigate the efficacy and effectiveness of such an intervention in practice.
Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.
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Acknowledgments

This thesis would not have been possible without the inspiration and support of a number of wonderful individuals. First, I would like to thank my main supervisor, Professor Rachel Calam, for the expertise, understanding and patience that she has given me so generously throughout this journey. She has nurtured and shared my passion in this research area, and taught me that working with both your heart and mind can be a very powerful combination. I would also like to thank my two co-supervisors, Dr. Fiona Ulph and Dr. Sarah Peters for sharing with me their knowledge and expertise and also their invaluable advice and guidance. I gratefully acknowledge my colleague Dr. Kim Cartwright, who gave her friendship and shared her research expertise so warmly. My deepest and most sincere gratitude goes to my parents Samar and Mahmoud, for giving me the opportunities and experiences that have made me who I am, and teaching me to strive for knowledge and for positive change. Having them as my role models will always be my greatest blessing. A special acknowledgment is due to the wind beneath my wings, my husband Ammar. He has selflessly, and with great warmth, encouraged me to explore new opportunities and seek my own path. And finally, to my beautiful children Shatha and Mohammad, their smiles and love continue to be a powerful source of inspiration, motivation and hope.
Dedication

This thesis is dedicated to the precious souls that we have lost along its journey; my beautiful grandmother Nemat, the NGO colleagues and the thousands of Syrians. May your souls be resting in peace.
Rationale for alternative (paper) format

This thesis is presented in alternative format given that a systematic review and two empirical studies were carried out. Each study represented itself individually with different aims. Also, this format was deemed appropriate in order to increase the likelihood of early publication. At the time of submission, two papers are under review and one is in preparation.

Contributions to each paper

The design, data collection and write up of the following thesis were carried out by Aala El-Khani under close supervision of her supervisory team, Professor Rachel Calam (all papers), Dr. Fiona Ulph (Papers 1 and 2), and Dr. Sarah Peters (Papers 1 and 2). Dr. Kim Cartwright was also involved in the design of the study presented in paper 3, and led on the study material preparation of this paper.
SECTION I - GENERAL INTRODUCTION
Children who are exposed to war and political violence are at very high risk of suffering mental health and developmental problems (Ehntholt, & Yule, 2006; Diab, Peltonen, Qouta, Palosaari, & Punamäki, 2015; Thabet, Abed, & Vostanis, 2002; Tol, Song, & Jordans, 2013; Khamis, 2005). One of the most significant modifiable risk factors contributing to the development of problems in children is the quality of parenting they receive (Borkowski, Landesman, & Bristol-Power, 2009). Research on the protective factors associated with war for children identify the care that children receive from parents as highly important (Dimitry, 2011). However, the traumas associated with experiencing war, and often the consecutive displacement, leaves parents themselves struggling to give the care their children need. Their circumstances may force a focus on survival, altering and potentially compromising the usual caring role they may have held (McElroy, Spittal, Atim, Tebere, & Muyinda, 2012). Also, parents themselves may experience mental disturbances and react to war and refugee stress with ineffective coping skills, on some occasions resulting in them being the perpetrator of physical abuse to their children (IDMC, 2012). By targeting parenting factors it may be possible to weaken the link between war and displacement, and psychological difficulties in children (Diab et al., 2015; Tol, Barbui, Galappatti, Silove, Betancourt, Souza, & Van Ommeren, 2011).

In the broader literature on parenting, there are several meta-analyses highlighting the effectiveness of parenting programmes in dealing with children’s current problems and in preventing future difficulties in various settings (Barlow, Smailagic, Ferriter, Bennett, & Jones 2010; Furlong, McGilloway, Bywater, Hutchings, Smith, & Donnelly, 2012; Zwi, Jones, Thorgaard, York, & Dennis, 2011). Research on the effectiveness of parenting interventions with families affected by war is often limited to refugees that have been resettled, and are residing in high income countries (Renzaho, & Vignjevic, 2011). Parenting programmes and evidence-based child and family psychosocial interventions, in general, are scarce in many low-income countries and particularly in post war conflict-affected settings (Kakuma, Minas, van Ginneken, Dal Poz, Desiraju, Morris, Saxena, & Scheffler, 2011; Kieling, Baker-Henningham, Belfer, Conti, Ertem, Omigbodun, & Rahman, 2011; Williams, 2010). Most often, the only available help to
families post-conflict is psychosocial support targeting children, which has often not been empirically validated and may not be evidence based (Tol et al., 2011).

Both researchers and international organisations are becoming more aware of the importance of interventions in preresettlement contexts that have a family or parent component (Betancourt, McBain, Newnham, & Brennan, 2013; Williams, 2012; UNHCR, 2006). The preresettlement stage, in which families who are displaced are often forced to live in refugee camps or sheltered accommodation, is commonly recognised as a very chaotic, stressful and worrying phase, during which adults and children are physically, emotionally and mentally vulnerable (IDMC, 2012). Research has indicated benefits of early interventions with families, as opposed to waiting until later on in the journey of those affected by conflict (Dyregrov, 2002).

The present research was designed and developed to expand the knowledge base on preresettlement parenting. This addressed two main areas, firstly to explore the parenting needs and challenges of displaced refugees living in preresettlement contexts, and secondly to explore the feasibility of distributing parenting information and gathering research data in a conflict zone.

The studies included in this thesis were carried out with Syrian refugees displaced by conflict. Syria’s on-going crisis has reached global concern, with over 12 million people in need of humanitarian assistance, including 7.6 million internally displaced (UNHCR, 2015). The refugee emergency is rapidly intensifying with over 4 million Syrians externally displaced as refugees to neighbouring countries such as Turkey, Lebanon and Jordan. Over half those affected by the conflict are children (UNICEF, 2013). The conflict has impacted 14 million children (UNICEF, 2015), 41%-60% of displaced Syrian children experience posttraumatic stress (PTS) and 54-60% depression (Abou-Saleh, & Mobayed, 2013; Marwa, 2013; Mobayed, 2014; Ozer, Sirin, & Oppedal 2013). Displaced Syrian refugee youth in Jordanian refugee camps have highlighted the importance of supportive parent-child relationships for resilience (IMC & UNICEF, 2013). In addition, explorations of Syrian refugees has shown that caregiver stress may reduce the capacity to maintain positive parenting strategies, contributing to maladaptive practices (IMC & UNICEF, 2013; IMC & UNICEF, 2014). The rapidly growing number of displaced Syrians as a results of the Syrian crisis is showing no sign of
easing, humanitarian agencies (IMC & UNICEF, 2013; IMC & UNICEF, 2014; UN Refugee Agency, 2013; UNICEF, 2014; War Child Holland, 2013) and systematic reviews (Quosh, Eloul, & Ajlani, 2013) stress the urgent need for culturally appropriate community and family based mental health care to increase family cohesion and reduce child aggression amongst Syrians. Understanding their parenting challenges and needs and finding appropriate ways of delivery information is important to better inform effective interventions and culturally appropriate policy responses. In addition, the methods and results of the studies in this thesis can potentially be taken as case examples for replication in other countries and refugee contexts.

**General aims of this project**

The specific aims for each study are presented in the following chapters. The overall aims of the research for this thesis were:

(i) To identify parenting interventions that have been carried out with displaced families in preresettlement contexts after armed conflict.

(ii) To explore the parenting challenges Syrian families were facing raising their children in refugee camps and similar shelters and the coping strategies they were adopting in this process.

(iii) To test the feasibility of distributing parenting information leaflets inside Syria and receiving feedback from families on the leaflets usefulness.
References


SECTION II - GENERAL METHODS
This thesis uses a mixed methods approach and comprises three studies with different designs and methods, drawing on both qualitative and quantitative approaches. This section presents an overview of the methods used and a rationale for the design of the methods of each study, along with procedure details. A critical analysis of all methods used can be found in the general discussion of this thesis (Section IV). Table 1 presents a summary of each study, the methodology and analysis approach employed.

**Table 1**

*Summary of Methodology*

<table>
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<tr>
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<th>Title</th>
<th>Methodology</th>
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<td>Paper 1</td>
<td>Parenting programmes supporting refugee families of war in pre-resettlement contexts; A systematic review</td>
<td>Systematic review</td>
</tr>
<tr>
<td>Paper 2</td>
<td>Syria: An exploration of parenting needs and challenges in preresettlement Contexts</td>
<td>Qualitative: One-to-one interviews and Focus groups</td>
</tr>
<tr>
<td>Paper 3</td>
<td>Daily bread: A novel vehicle for dissemination and evaluation of psychological “first aid” for families exposed to armed conflict in Syria</td>
<td>Quantitative: t-tests Qualitative: Content analysis</td>
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**Paper 1: Literature review**

A systematic review of the literature was conducted to identify interventions in peer reviewed journals that included a parenting component in work with displaced families residing in preresettlement contexts. A systematic review methodology was chosen as it is considered a form of evidence-based practice, in other words, a process of integrating the best evidentiary information available with “clinical expertise and client values” (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). Such a review involves a specific sequence of steps, these are, (1) defining the research question, (2) determining the types of studies needed to answer research questions, (3) conducting a comprehensive search of the literature, (4) deciding which research can be included or excluded based on inclusionary criteria, (5) critically appraising the included studies,
(6) synthesising the studies and assess for homogeneity, and (7) disseminating the findings (Petticrew, & Roberts, 2006). The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines for conducting a systematic review were used (Moher, Liberati, Tetzlaff, & Altman, 2009).

Paper 2: Qualitative study of parenting challenges and needs

Paper 2 reports a qualitative study carried out to explore the parenting challenges and coping strategies parents experienced while residing in preresettlement contexts. These papers share the same sample and data set. Twenty nine participants took part, comprising eight interviews and four focus groups with nineteen mothers and two interviews with professional aid workers. This research was carried out by the researcher in two phases that consisted of two research field trips to both Syria and Turkey. Phase one was in November 2012, and Phase two in March 2013.

Setting

The research was carried out in four sites; two inside Syria and two in Turkey. Three were refugee camps accepting newly arrived refugees and one was a building that temporarily housed refugees who had very recently arrived in Turkey. The two refugee camps in Syria were Qah Refugee Camp and Bab-Al-Salam Refugee Camp, both in Northern Syria. The refugee camp accessed in Turkey was Bakhsheem refugee camp in Southern Turkey. The refugee building was in the town of Reyhanli in Southern Turkey close to Bakhsheen refugee camp. This research was carried out in partnership with Watan, an NGO working inside Syria and Turkey to support Syrian families affected by the conflict. Watan logistically facilitated all research activities. These four sites were chosen as Watan had permission and access to enter and work in these sites.

Study Design

A qualitative approach was chosen to explore the research questions, as this approach provides rich explanatory data (Creswell, Hanson, Plano, & Morales, 2007), and has previously been utilised successfully in refugee research (e.g. Khawaja, White, Schweitzer, & Greenslade, 2008; Nakamanya, Siu, Lassman, Seeley, & Tann). This approach can be valuable in providing information regarding parents’ points of view
and in-depth explorations of their experiences (Camic, Rhodes, & Yardley, 2003). Rather than administering surveys to gather information from refugees as other studies in humanitarian contexts have done (e.g. Ahmad, Smetana, & Klimstra, 2014; Hall, Puffer, Murray, Ismael, Bass, Sim, & Bolton, 2014), both individual semi-structured interviews and focus groups were used.

Participants were recruited from all sites, in both phases, by the researcher approaching families with the study information sheet, which described the aim of the research and the activities involved in participation (Appendix A). In Phase one, participants gave written consent (Appendix B) and took part in semi-structured interviews with the researcher the following day. In Phase two participants were given study information sheets and took part in focus groups on the same day. Participant interviews were carried out in refugee schools and tents, and all focus groups were conducted in parents’ tents.

During Phase one, semi-structured interviews were used to elicit participants’ views and experiences of the topic. During the design planning of the study, the preferred method of data collection was to use focus groups, because of their potential to draw out narratives of people who are most affected by an issue (Shalhoub-Kevorkian, 2003; 2009). Previous research has drawn upon the dialogic nature of focus groups allowing for “collective testimony” (Madriz, 1998), and providing participants with a shared space to explore problems that may previously have been individualised (Kamberelis, & Dimitriadis, 2005; Madriz, 1998). However, during Phase one semi-structured interviews were adopted instead for several reasons. A disadvantage of focus groups is that anonymity cannot be maintained from other participants, which may inhibit sharing sensitive information. In recognition that questioning participants in this context may elicit experiences or challenges that they may not be comfortable sharing with others, it was recognised that the privacy that using individual interviews allowed, would be more suitable. Also, the use of semi-structured interviews has been recognised as an appropriate tool for healthcare research (Britten, 2011) and refugee settings (Meyer, Murray, Puffer, Larsen, & Bolton, 2013). In addition the research team did not have previous experience in carrying out qualitative research in refugee settings and thus did not know how feasible it would be to arrange focus groups.
Research has indicated that both focus groups and interviews can be successfully used in refugee contexts (Meyer, et al 2013; Paardekooper, De Jong, & Hermanns, 1999), but time restraints and the uncertainty of what would be feasible once in field conditions, led semi-structured interviews, rather than focus groups to be chosen as a means of collecting data.

Subsequently, focus groups were adopted (Phase two) for three reasons. Firstly, during Phase one the researcher found that families were very open in discussing their challenges and often during an interview, would suggest that another mother should join the discussions. Often conversations around the research topics did not end once the interview was over. As participants and the researcher would walk out of the interview tent or room, participants sometimes then introduced the researcher to other mothers that they knew, initiating a discussion on the research topic. Secondly, it was very difficult to ensure complete privacy during individual interviews with participants. Due to the cramped spaces of refugee camps and schools, it was common that despite efforts from the researcher, the participants involved and the facilitating NGO, that other individuals would walk into the spaces in which the interviews were taking place. Finally, as the researcher had gained experience in conducting research in refugee settings, she felt confident in her ability to conduct focus groups in such a setting.

In the planning stage of the study in the UK, while in discussions with Watan employees in Turkey, it became evident that their experiences and understanding of the refugee context and those working directly with refugee families, would be very useful to this study. In line with exploratory qualitative approach, it was anticipated that a diversity in the sample of parents and those working to support parents would give a rich data set of various issues and approaches (Peters, 2010). Therefore two individual Interviews were carried out with professional aid workers working in refugee camps. Interviews with professionals were conducted in an aid agency office in a refugee camp.
Interview schedule

The interview schedule (Appendix C) was developed by the research team, which included experts in qualitative research and child mental health. An interview schedule is a list of structured questions that the researcher asks in a particular order, the interviewer follows the guide but is able to follow topical issues that may stray from the schedule when he or she feels it is appropriate (Smith, 1995). It covered three areas; 1) changes and challenges in the parenting experience, 2) what coping strategies parents were using and 3) what, if any, challenges parents wanted support with. Much focus was placed on the need to ensure sensitivity when carrying out the interviews and focus groups with participants and as much as possible, to attempt to focus the discussion on present challenges and not past trauma and recall of traumatic memories. The main researcher undertook training from her multidisciplinary research team and also advice from The University of Manchester’s Humanitarian Conflict Response Institute. An exploration of qualitative research in which interviews with participants on potentially sensitive topics was also undertaken to gain additional insight.

Pilot studies can be very useful to both refine the interview schedule and to highlight any gaps or research challenges that may occur (Sampson, 2004). For this reason, the interview schedule was piloted using one-to-one interviews with two mothers, via Skype, who were residing in Gaza and had experienced the 2009 Israeli attacks. The pilot stage was indeed useful, the interview schedule was then altered accordingly. The main adaptation was to more direct questions and prompts as well as the addition of more Arabic terms for the word ‘parenting’.

Ethical considerations

Ethical approval was granted by The University of Manchester research ethics committee (Ethical committee reference number 12102, 124110 & 13285). The procedure for this study was guided by The University of Manchester ethical regulations, the researcher’s school policy on risk assessment and by the advice and instructions given by the NGO who facilitated access to recruitment areas and advised on and planned for researcher safety. Several measures of protection were put into
place to protect both the main researcher and participants from any psychological distress as a result of this study. Permission was gained from a medical organisation that was working and had contacts in all the recruitment sites, to give information on how they could be contacted should any participants feel distressed after participation. This support was also available for the researcher, in addition to the opportunity to Skype with the main supervisors after each interview, providing a chance to debrief.

The original ethical approval stipulated that a 24 hour window had to be maintained between potential participant’s receiving study participant information sheets and then consenting and taking part in the study. During data collection in Phase one, it was difficult to recruit participants due to the practical challenge of gaining access to the same refugee camps the following day and locating the same families. On return to the UK, a request for an amendment was submitted to allow immediate consent and participation of participants. After meetings and discussions with the university ethics committee to address reservations over the need for this amendment, this was approved. As a result, during the second study recruitment stage, participants took part in the study on the same day they received information from the researcher.

Reflections on the ethical issues raised and recommendations for the need for understanding and flexibility from ethical boards when making decisions on research in conflict affected areas has since been published by the researcher (El-khani, Ulph, Redmond, & Calam, 2013).

Data handling

All data collection was carried out in Arabic by the first author who then transcribed the data directly into English. No funding was available for a complete second independent transcription to be made, instead, sections of the data were checked with a professional translator. The few minor discrepancies found were resolved through discussion with the researcher (who had conducted the interviews) and the professional translator. This iterative process allowed exploration of choices inherent in translation that ultimately affect the analysis and interpretation of cross-language data (Esposito, 2001; Larkin, de Casterle, & Schotsmans, 2007; Wong, & Poon, 2010). The researcher was aware that should funds have been available, a complete
independent cross-check would have been very valuable to ensure translation quality assurance (Lincoln, and Gonzalez, 2008; Squires, 2008), however the minor nature of the discrepancies in the checks that were undertaken lend confidence to the quality of the transcription and translation process.

**Data Analysis**

Analyses of data were conducted using thematic analysis (Braun, & Clarke, 2006), which is defined as a method in which the researcher searches for themes which are considered important to the description of the phenomenon (Daly, Kellehear, & Gilksman, 1997). Thematic analysis has often been used in the analysis of the experiences of displaced refugees (Khawaja et al., 2008; Patel, Muyinda, Sewankambo, Oyat, Atim, & Spittal, 2012; Sideris, 2003). It involves reading and re-reading the data until a pattern is recognised. Dominant themes were identified through close examination of the data, transcripts were read and re-read to ensure a very high level of familiarity with the data. The analysis was conducted by the researcher under the supervision of members of her supervisory team with qualitative expertise. A detailed description of the analysis is found within the methodology section of this paper.

**Paper 3: Feasibility Study**

**Study design**

The qualitative research carried out (Paper 2), revealed that very soon after the immediate extreme stress of conflict, parents were very keen to access information on how best to parent their children. Funding was gained (ESRC) for a feasibility study that employed both quantitative and qualitative methodology to be carried out to test a novel approach to large-scale distribution of information and data collection in a conflict zone suggested by a humanitarian agency. Using routine daily deliveries of bread by a bakery run by the NGO Watan, parenting information leaflets and feedback questionnaires were distributed to adults looking after children in conflict zones inside Syria. The study was undertaken remotely with study materials and a research protocol emailed to an assigned project worker in Turkey. Leaflets and questionnaires requesting feedback from families were printed, transported alongside supplies to a bakery in Syria, then packed with flatbreads in transparent bags and distributed by volunteers. Returned questionnaires were taken to Turkey and despatched to the UK.
The UK Foreign office advice deemed it unsafe for the researcher to undertake the research directly on site. Instead, two field-based, highly experienced local employees of the NGO Watan were assigned to conduct the research, one as a project manager and one as a field officer. The project manager prepared all materials following the guidance of the research protocol (Appendix D) and facilitated the transport of the study materials to the Turkey-Syria border. The field officer led the study inside Syria, managing the distribution and return of materials.

A detailed protocol was designed by the research team which covered material preparation and research strategy (Appendix D). In addition data collection records (Appendix E) and bakery collection record forms (Appendix F), were also utilised by the field officer and project manager to record study material movement and data collection at each stage. These materials were all translated into Arabic and emailed to the NGO. The protocol called for additional activities for the NGO workers in Turkey, such as printing of the study materials and the transportation of them to the Turkey-Syria border. From the Syrian border onwards, all research activity was only made alongside other aid delivery activities, to ensure no staff were placed under any additional risk in an already dangerous environment. The protocol also instructed that the collection point for feedback questionnaires, should only be locations that families would be routinely visiting anyway, so that participants too would not be put in any risk. In addition, we were conscious of the risks posed if materials were deemed not acceptable, and of the security of the data itself. At the NGO’s request, all study materials carried no identifying information regarding their source.

**Study materials**

Parenting leaflets (Appendix G) and feedback questionnaires (Appendix H) were designed by the research team. The information on the leaflets were based on a number of open access sources and the research team’s extensive knowledge of general parenting programme principles. In addition information was drawn from the qualitative research previously carried out by the research team (Paper 2) to include topics that families deemed as most challenging. Finally, a consultation group was set
up in Manchester with refugee parents who had experienced the conflict in Syria and had fled to the UK. This group was valuable in reviewing the leaflets and providing feedback on acceptability and need. The feedback questionnaires covered perceived usefulness of the parenting leaflets. One open ended item on the questionnaires allowed for participants to leave comments.

**Data handling**

All materials were translated into Arabic by a professional translator with back translation to ensure fidelity. Also, all stages of the study were photographed to verify activity (Appendix I). “WhatsApp”©, which allows photographs to be shared, and, when available, email and “Skype”© were used to monitor the progress of the study. Feedback questionnaires were photocopied in Turkey to prevent data loss before being despatched to the UK. Photocopies held in Turkey were destroyed confidentially following receipt of the original questionnaires in the UK. The single-item free text comments that were left on the questionnaire were translated by the researcher who is bilingual and back checked by both a second bilingual adult and also the project field officer to ensure fidelity.

**Data analysis**

Descriptive statistics were used to explore the sample characteristics of the respondents, and t-tests to examine the ratings of usefulness of the parenting leaflet. In addition, a content analysis, which is a method of analysing verbal or written communication in a systematic way (Krippendorf, 2004) was used to code respondent comments that had been written on the feedback questionnaires. Inter-rater reliability was ensured by a second researcher independently coding the data set and then a third researcher comparing and synthesising the two data sets into one.
References


SECTION III - MAIN PAPERS
PAPER 1 – Systematic Literature Review
Parenting programmes supporting families who are refugees of war in preresettlement contexts: A systematic review

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Abstract

The experiences of war and displacement leave children at high risk for the development of psychological and behavioural problems. The quality of care children receive from parents and primary caregivers during flight and displacement can act as a significant protective factor. By enhancing context-relevant parenting knowledge and skills it may be possible to weaken links between war, displacement and psychological difficulties in children. While parenting interventions have been shown to be effective for families in a range of different settings, to date, research on their use with refugees in preresettlement contexts, before the family settles into a more permanent home, is limited. The aim of the present paper was to identify peer reviewed intervention studies that have been conducted with parents in preresettlement contexts, in order to explore challenges, opportunities and directions for future research. In stage one, a systematic review was carried out of databases of peer-reviewed publications, which identified only two studies meeting the review criteria. In stage two, searches of non-academic ‘grey’ literature were made in databases of international organisations (Google Scholar, WHOLIS, Medicine Sans Frontiers, UNBIS, UNICEF) for references to parent, caregiver or family programmes in refugee camps and preresettlement contexts. Related identified reviews and reports were hand searched at this stage. No additional studies were identified. Opportunities for programme implementation and research are identified and discussed.

Keywords: children, parenting intervention, preresettlement, war, conflict, refugee
Introduction

War significantly affects families, leaving children at risk of distress, mental health difficulties (Attanayake, McKay, Joffres, Singh, Burkle, & Mills, 2009) and developmental problems (Diab, Peltonen, Qouta, Palosaari, & Punamäki, 2015; Tol, Song, & Jordans, 2013). Challenges and risks arise at every stage of the journey that families make as refugees of war (Kirkmayer, Narasiah, Munoz, Rashid, Ryder, Guzder, Hassan, Rousseau, & Pottie, 2011; Lustig, Kia-Keating, Knight, Geltman, Ellis, Kinzie, & Saxe, 2004). There is extensive literature on the prevention of emotional, behavioural and mental health difficulties through addressing risk and protective factors (Institute of Medicine, 2009), and ecologically grounded models identify family factors as central to this (Bronfenbrenner, 1979; Reed, Fazel, Jones, Panter-Brick, & Stein, 2012; Williams, 2010). This paper presents an examination of evidence based interventions designed to educate and train parents to develop appropriate and necessary parenting skills to care for their children living through conflict, flight, and temporary living arrangements, before they finally settle into more permanent living arrangements, focussing specifically on transitional, prere resettlement contexts.

Mental health needs of refugees

Worldwide, over 1.5 billion people live in countries affected by armed conflict (World Bank, 2012). In response many people are forced to flee their country in search of safety, resulting in over 15 million refugees worldwide. The United Nations Refugee Convention for Refugees, (UNHCR), describes a refugee as a person, who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country (Global Trends, 2011). In 2011 alone, an estimated 4.3 million people were displaced by conflict. The majority of refugees (80%) are hosted by developing countries that are already struggling economically (Global Trends, 2011). Refugees do not necessarily leave their home country; currently there are over 27.5 million internally displaced persons (IDPs). IDP’s are persons or groups of persons who have been forced or obliged to flee or leave their homes or places of habitual
residence, in particular as a result of, or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border (Global Trends, 2011). Over half of those displaced as IDP’s or refugees are women and children. In addition, over two-thirds of refugees in the world are in protracted refugee situations, defined as areas with over 25,000 or more refugees who have been in exile for 5 years or longer (UNHCR, 2010).

The World Health Organisation (WHO, 2001) states that 10 % of the people who experience traumatic events as a result of armed conflicts will have serious mental health problems and another 10% will develop behaviours that will affect their ability to function effectively. Consistent with the WHO, research with refugee’s highlights that they may have increased morbidity, decreased life expectancy, and a susceptibility to illness and poor health habits (Schnurr, 1996). Much of the literature on the effects of war on refugees has focused on the mental health of children exposed to war and military violence (Attanayake et al., 2009; Dimitry, 2011; Dyregrov, Gjestad, & Raundalen, 2002). A systematic review of child mental health in ongoing or post-war situations showed elevated levels of PTSD (47%; seventeen studies), depression (43%; four studies) and anxiety (27%; three studies) (Attanayakey et al., 2009). Other studies have shown that children exposed to war are also at high risk of developing various types of psychopathology (Pfefferbaum, 1997; Shaw, 2003; Thabet, Abed, & Vostanis, 2004).

Meta-analysis of the most robust epidemiological surveys (those using random samples and diagnostic interviews), in conflict affected populations, showed an average prevalence of 15-4% (30 studies) for post traumatic stress disorder (PSTD) and 17-3 % (26 studies) for depression (Steel, Chey, Silove, Marnane, Bryant, & Van Ommeren, 2009). Recently studies have reported that refugees often suffer from depression, anxiety and PTSD, more so than immigrants who arrive at new host countries for economic reasons (Jamil, Farrah, Hakim-Larson, Kafaji, Abdulkhaleq, & Hammad, 2007). Prevalence estimates of mental disorders for refugees vary extensively, most likely due to the influence of differing methodological approaches, the variability in trauma and differing flight experience in addition to cultural
applications of assessments (Murray K, Davidson G, Schweitzer, & 2010). Though it is difficult to determine actual rates of PTSD in refugees, most studies suggest much higher rates than non-refugee samples. For example, in one meta-analytic study, refugee children and adults showed prevalence rates ten times higher than an age matched non refugee sample (9% and 11% respectively), (Porter, & Haslam, 2001). Other studies suggest prevalence rates ranging from 4 to 44%, with larger and more rigorously designed studies identifying an average of 9% prevalence for PTSD (Porter, & Haslam, 2005). A systematic review of 181 studies of adults who had experienced conflict and displacement showed a prevalence of more than 30% for both PTSD and depression (Steel et al., 2009). The nature of the trauma experienced is important for the development of mental health (Peltonen, & Punamaki. 2010), with war stress often multiple, chronic and continuous such as recurrent exposure to attacks, torture, bombings and death (Macksoud, 1992; Thabet, Tawahina, Sarraj, & Vostanis, 2008).

An overview of mental health interventions for refugees

The treatment of refugee populations has only recently been considered as a distinct area in the field of mental health (De Jong, & Van Ommeren, 2002; Miller, & Rasco, 2004). There is now growing recognition of the importance of mental health and psychosocial support for refugees through their journey to resettlement (IASC, 2007). Such support is becoming increasing integrated into humanitarian assistance programmes (Mollica, Cardozo, Osofsky, Raphael, Ager, & Salama, 2004; Sphere, 2011; IASC, 2007). These guidelines recommend implementing multi-layered packages of services, including preventive and treatment interventions, to take into account the diversity of mental health and psychosocial needs in humanitarian settings. In the past decade there have been several reviews that have highlighted the growing number of published interventions for adults and children affected by war (Peltonen, & Punamaki 2010; Steel et al., 2009; Van Wyk, & Schweitzer, 2014; Wong, Marshall, Schell, Elliott, Hambarsoomians, Chun, & Berthold, 2006).

A recent review of interventions for mental health and psychosocial wellbeing in humanitarian settings identified 160 reports (Tol, Barbui, Galappatti, Silove, Betancourt, Souza, & Van Ommeren, 2011). The five most commonly reported
activities were individual basic counselling (39%); facilitation of community support of vulnerable individuals (23%); provision of child-friendly spaces (21%); support of community-initiated social support (21%), and basic counselling for groups and families (20%). They found that overall, research and evidence focused on a number of interventions that are infrequently implemented, whereas the most commonly used interventions had little published rigorous scrutiny. Of the 160 reports, thirty two controlled studies of interventions were identified, thirteen of which were randomised controlled trials (RCTs) that met the criteria for meta-analysis. Two studies showed effects for strengthening community and family supports. In adults with symptoms of PTSD, meta-analysis of seven RCTs showed beneficial effects for several interventions (psychotherapy and psychosocial supports) compared with usual care or waiting list. For children, meta-analysis of four RCTs found limited evidence for the effectiveness of child and adolescent psychological interventions for treating internalizing symptoms. This review amongst others (Fazel, Reed, Panter-Brick, & Stein, 2012; Reed, Fazel, Jones, Panter-Brick, & Stein, 2012), does not indicate the stage of the refugee journey that the populations that took part in interventions were at.

Another recent systematic review of evidence based published interventions in humanitarian contexts revealed forty two studies targeting adults and children populations affected by armed conflict (Blanchet, Sistenich, Ramesh, Frison, Warren, Hossain, & Roberts, 2013). Nine studies were carried out with internally displaced populations and categorised as high quality with measures of pre and post intervention and ten were carried out in refugee camps of which eight studies had pre and post intervention measures.

Several authors have concluded there is a lack of evidence for affordable mental health interventions in low and middle income countries and complex emergencies, such as displacement due to war, for both children and adults (Barenbaum, Ruchkin, & Schwab-stone, 2004; Patel, Flisher, Nikapota, & Malhotra, 2008). For example, one worldwide systematic review on evidence-based primary interventions programmes includes only studies in high income countries (Flament, Nguyen, Furino, Schachter, MacLean, Wasserman, & Remschmidt, 2007). Often reviews have stressed the limited number of high quality controlled trials (Nickerson, Aloe, Livingston, & Feeley, 2011;
Silove, 2012; Tol et al., 2011). For example, in a review of PTSD specific treatment studies by the Institute of Medicine (IOM, 2007), only two studies with refugees (Hinton, Chhean, Pich, Safren, Hofmann, & Pollack, 2005; Neuner, Schauer, Klaschik, Karunakara, Elbert, & 2004), met the criteria of well-designed studies to be included in the review.

A study by McFarlane and Kaplan (2012), reviewed research evidence on psychosocial interventions for refugee adult survivors of torture and trauma at different stages of the refugee journey. They identified a total of forty studies from 1980 to 2010, including RCTs (11 out of 40), non-RCTs (8 out of 40) and single cohort studies (21 out of 40). While single cohort studies were the most common approach in the field, RCT’s examining the efficacy of applied treatments with asylum seekers and refugees were very few, and included small samples. RCT’s mainly examined individual psychotherapies that targeted PTSD symptoms. In thirty six of the forty studies (90%) significant improvements on at least one outcome indicator after an intervention was shown. Most studies (60%) included participants who had high levels of posttraumatic stress symptomatology. Improvements in symptoms of posttraumatic stress, depression, anxiety, and somatic symptoms were found following a range of interventions.

Recently, more focus has been placed on interventions that aim to conceptualise and understand refugee experiences and challenges to support strength and capacity building among individuals and families (Papadopoulos, 2007). Researchers and practitioners are increasingly incorporating approaches that acknowledge cultural differences in meaning and distress and that demonstrate culture-specific methods to responding to traumatic events (Dossa, 2010; von Peter, 2008). Systematic reviews have highlighted a focus on individual rather than family level evidence as major limitations of the evidence base of child mental health in humanitarian contexts (Panter-Brick, Grimon, & Eggerman 2014; Betancourt et al., 2013; Panter-Brick, Goodman, Tol, & Eggerman, 2011; Reed et al., 2011).
Conceptual framework of the refugee experience

It is essential to view the experiences that refugee families experience within the context of their migration journey, in other words, what they are experiencing at any given time in their journey and what they have already experienced (Williams, 2010). Bronfenbrenner’s ecological model of development (1979) provides a central conceptual framework for analysing the interrelated stages and relationships involved in the impact of conflict, highlighting the role of the environment and external influences. His original model defines key developmental contexts in terms of microsystems, mesosystems, exosystems and macrosystems. The individual is firstly situated in a microsystem, consisting of the direct activities and roles of the individual. The mesosystem is comprised of the interrelations among two or more of these sets of relationships, such as the individual and their family. Subsequently, these systems are nested within an exosystem, which the individual may not actively participate in, but which influences them, such as their community. Finally, the macrosystem represents consistencies in the form of their culture or community that permeate the micro, meso, and exosystems. Thus, the individual is embedded in an interconnected system of family, peers and society. This model is highly relevant to the changes experienced by children, families and communities as they flee conflict in search of safety and stability.

Research has differentiated the stages of migration that refugees experience with various titles, the most common being pre-flight, flight and resettlement (Birman, Beehler, Harris, Everson, Batia, Liautaud, & Cappella, 2008; Kirkmayer et al., 2010; Lustig et al., 2004; Potocky-Tripody, 2002; Simich, Beiser, & Mawani, 2003). Others have used the terms pre-migration, peri-migration and post-migration (Fazel, 2015; Finklestein, & Solomon, 2009). For the purpose of this paper we use the terms pre-flight, flight and resettlement. We also go on to use the term preresettlement, to describe all stages prior to a refugee being hosted in another country, including pre-flight, flight and life in temporary shelters such as refugee camps. This maps on to the use of these terms by Williams (2010) in conceptualising research on refugee experiences prior to resettlement.
Throughout the process of becoming a refugee, the family is involved in actively responding to their changing environment. Each stage has associated stressors and trauma experiences. The pre-flight phase is the time when refugees are usually living in their home country and often experiencing war, persecution, and fear for their safety. Often, this is a time when they will be planning their escape, their surroundings may be chaotic, dangerous and marked by social upheaval and uncertainty (Rumbaut, 1991). Refugees may be faced with threats to themselves and their families and are likely to witness and be engaged in violence (Gonsalves, 1992; Lustig et al., 2004; Papadopoulos, 2001).

During the flight phase, refugees will have left their homes and will be in transit, often internally displaced and then in a refugee camp setting. Once the refugee has made the decision to leave his or her home country, the actual act of leaving may be very dangerous and stressful, with great uncertainty about the future (Fazel, & Stein, 2002). Preresettlement, refugees (i.e. those who have experienced pre-flight and flight) will have often experienced traumatic events such as witnessing violence, being tortured and imprisoned. In a study carried out in an African refugee settlement, Somali refugees had experienced an average of twelve separate traumatic event types and Rwandese refugees had experienced more than eight traumatic events (Onyut, Neuner, Schauer, Ertl, Odenwald, Schauer, & Elbert, 2004). One study found that the proportion of refugees who had been tortured varied from 5 to 30% depending on their ethnic origin and definition of torture (Burnett, & Peel, 2001; Montgomery, & Foldspang, 1994). In a clinical sample of multiple ethnicities, 37% of refugees reported incidents of torture, 37% reported feeling close to death and 35% reported a friend or family member had been killed (Kleijn, & Hovens, 2001).

Finally, resettlement describes refugees reaching a host country. Though refugees may be away from the immediate dangers they had faced during the pre-flight and flight phase, they may now face new challenges of adjusting to the new country, the belief systems, acculturation and new roles they will take up (Abe, Zane, & Chun, 1994; Papadopoulos, 2001). Resettlement trauma and stress is far less documented in the refugee literature, though can be highly traumatic (Fox, Cowell, & Montgomery, 1999). Refugees may experience violence, deprivation (Otto, Hinton, Korbly, Chea, Gershuny,
& Pollack, 2003) and day to day stressors such as social isolation which can be the strongest predictor of mental health problems (Ellis, MacDonald, Klunk-Gillis, Lincoln, Strunin, & Cabral, 2010; Miller, Weine, Ramic, Brkic, Bjedic, Smajkic, & Worthington, 2002).

The effect of war and trauma on the parent-child relationship

War significantly affects families at all stages of their refugee journey, leaving children at risk of both psychological distress and difficulties (Attanayake et al., 2009) and developmental problems (Diab et al., 2015; Tol et al., 2013). Research among war affected families in various countries has reported that in addition to trauma exposure, daily war stresses and poverty are highly disturbing to children (Cummings, Taylor, Merrilees, Goeke-Morey, Shirlow, & Cairns, 2013; Dubow, Huesmann, & Boxer, 2009). War and other organized violence can have a lasting impact on a community by an increase in family violence, substance abuse, and aggressive parenting (Catani, Jacob, Schauer, Kohila, Neuner, 2013; Olema, Catani, Ertl, Saile, & Neuner, 2014). For example in Northern Uganda, exposure to armed conflict and trauma was associated with family violence and substance use (Saile, Neuner, Ertl, Catani, 2013) and following war in Bosnia, maternal mental health predicted child adjustment (Smith, Perrin, Yule, Rabe-Hesketh, 2001). Parental PTSD is associated with an increase in self-reported aggressive parenting, indifference and neglect towards children (Stover, Hall, McMahon, & Easton, 2012 and a lower perceived relationship quality with children (Kilic, Kilic, & Aydin, 2011; Lauterbach, Bak, Reiland, Mason, Lute, & Earls, 2007). There are multiple negative effects associated with having a parent with PTSD such as an increase in children’s behaviour problems (Jordan, Marmar, Fairbank, Schlenger, Kulka, Hough, & Weiss, 1992; Lauterbach et al., 2007), depression (Harpaz-Rotem, Rosenheck, & Desai, 2009), anxiety and stress (Brand, Schechter, Hammen, Brocque, Brennan, & 2011) and trauma-related symptoms (Kilic et al., 2011). Altered family relationships after experiencing conflict pose continued threats to mental health and adjustment for both children and adults by creating chronic stress and may overload available coping resources (Miller, & Rasmussen, 2010). In parallel, Quota and colleagues (Quota, Punamäki, & Sarraj, 2008), reported that strong family relationships
predicted resilience among children exposed to political violence in Palestine. Little is known about the effect on family functioning or parental mental health on children who have been internally displaced (Reed et al., 2012) though research from war-affected and non-refugee populations indicates parental mental health is likely to be a central factor in children's psychological health (Panter-Brick, Eggerman, Gonzalez, & Safdar, 2009).

Good family relations are considered essential for children’s healthy development and especially during war conditions when they feel worried, threatened and at risk (Qouta et al., 2008). There is strong evidence that positive, secure and consistent parental relationships are essential to buffer trauma experiences in children during and after conflict (Thabet, Ibraheem, Shivram, Winter, & Vostanis, 2009). Children can be protected by family cohesion (Laor, Wolmer, & Cohen, 2001) and positive home environment as well as their mother’s perception of family (Zahr, 1996). One study reported that perceived parenting support had a moderating effect on the impact of exposure to traumatic events of war on children’s mental health, in addition to a negative correlation with exposure to traumatic events (Thabet et al., 2009). Previous research has highlighted a significant association between parents’ and children’s general psychopathology following war and political conflict (Qouta et al., 2008; Smith et al., 2001). Exposure to war trauma impacts on both parents’ and children’s mental health, whose emotional responses are inter-related (Thabet et al., 2008). In a study of caregiver-child mental health in conflict-ridden Afghanistan, the strength of caregiver-child associations was examined. The sample consisted of 681 caregiver dyads recruited via schools. Caregiver mental health was prospectively associated with measures of child mental health and for PTSD, caregiver mental health had a predictive impact comparable to the child experiencing one or two lifetime trauma events. A study investigating the relationship between mothers mental health and prevalence of depression and anxiety of young children (aged 4-6) after the war on Gaza, found a significant positive correlation between mothers mental health problems and depression and anxiety of their children (Thabet, Aziz, Abu-Khusah, & Vostanis, 2014). Often parents themselves experience mental disturbances and react to refugee stress with ineffective coping skills which can result in them being the perpetrator of physical
abuse to their children (IDMC, 2012; Paper 2 of thesis). There is great stress on primary caregivers in preresettlement as the demands of war and conflict, and their need to focus on survival, often leaves them unable to provide the usual support and care they are used to giving in more safe and stable circumstances (Ajdukovic, & Ajdukovic, 1993). Parents may be aware of how their parenting may have changed; in one study of mothers raising children in refugee camp in Uganda, mothers recognised that their roles as advisors, protectors and providers had been severely compromised (McElroy, Spittal, Atim, Tebere, & Muyinda 2012). Their life circumstances forced a focus on survival and interfered with their desire to socialise their children, leaving them worrying about their children’s future. Yet mothers displayed resilience and persistence in facing their challenges with their children, reporting that they advised their children even when they felt they weren’t listening. In another study, mothers living in refugee camps facing new emotional and behavioural challenges with their children made attempts to seek parenting advice from health professionals and teachers in their camps and described their frustration in the lack of support available (Paper 2 of this thesis).

**Ecological conceptualisation of the refugee journey**

With gathering evidence stressing both the negative impact war and trauma has on children and parents individually (Diab et al., 2015; Reed et al., 2012; Tol et al., 2011), as well as their relationship with each other (Panter-Brick et al., 2009; Reed et al., 2012), an examination of how the influence and significance of parenting on children may change at each stage of their refugee journey is valuable. Systematic understanding of both the journey of refugees and the factors that affect children at each stage may give clinicians and policy makers a better understanding of when and how best to target interventions. Here we draw on two adaptations of the original Brofenbrenner model to focus conceptualisation. The first, by Reed and colleagues (2012), provides an inclusive understanding of how children may be affected by their environment during their refugee journey. The second by Williams (2010), conceptualises the refugee parenting experience at each stage to resettlement.
The model by Reed and colleagues (Figure 1), as the original Bronfenbrenner model, depicts a child's experience by use of concentric circles, placing the developing child at the centre of the effects of different factors. In this model the focus is on the individual, family, community, and societal influences. What distinguishes this model from other ecological models is that it incorporates the stages of pre-flight, flight and resettlement (called premigration, migration and postmigration in this model), whereas often these would be represented in a separate model. This is the first model that bridges these two separate conceptual ideas, as the authors describe that overlap exists and some factors operate at several layers.

Figure 1. Reed et al., 2012 Model of Child Experiences During Displacement.
Accordingly, the influence that the parent has on the child changes at each stage. Prior to conflict and in the child’s original home, the child is influenced by not just the parent, but also the extended family and community. During the flight phase, it is common that families are split up and parents, often the mother, take the major parenting responsibility (Cairns & Dawes, 1996), therefore more value is placed on the parent-child relationship at this stage. Also, as this model posits, whether a child is displaced or not plays a significant factor in their development. Literature shows that children and adolescents, both who are internally displaced or not displaced, often experience more adverse events than children who leave a country as a refugee (Hasanovic, Sinanovic, & Pavlovic, 2005). In a study of internally displaced Bosnian children, higher rates of depression were found in those displaced than those who had not been displaced (Sujoldzic, Peternel, Klenovic, & Terzic, 2006). In another study, internally displaced Congolese adolescents had experienced more traumatic events than those non-displaced or those who had returned back, in addition to more daily stressors, and poor medical care (Mels, Derluyn, Broekaert, & Rosseel, 2010). The current model accounts for refugee and internally displaced children being a highly diverse group due the range of experiences associated with the different stages of migration they experience, and the need to understand the specific needs of children at each stage of their refugee journey.

While the role of the parent on the experience of the child during war and displacement is very important (Dybdahl, 2001), until recently, there was no ecological model that conceptualised and captured the refugee parent experience, and described how the environment of preresettlement impacts on refugee parents and primary caregivers’ experience. Williams (2010) found that research on the ecology of the parenting experience of refugees in preresettlement contexts was scarce (Williams, 2008, 2010). Though some researchers (Pine, & Drachman, 2005) had begun to explore the parenting experience of immigrant and refugee parents post resettlement, very little was still known about their experiences parenting their children preresettlement. In response, Williams developed an ecological model (Figure 2), offering insight and unpacking the parent or primary caregiver experiences and their interactions between community and society.
Figure 2. Williams, 2010 model of preresettlement parenting.

In this model the parent’s culture, religion and norms, their decision making in pre-flight and flight and how they use available resources around them, are all seen as significant factors. The refugee parenting experience is functioning within the context of pre-flight, flight and migration contexts and simultaneously influenced by multiple layers of ‘being’ in the world as a refugee parent. The model illustrates that as refugees pass through the different stages to resettlement, they are affected by different environmental contexts (Figure 2) that shape pre-existing values, ideas and norms. While the parent may have access to external support through their community and society before conflict, as they move through the phases to resettlement this may lessen, as families separate and health and other support systems no longer exist (Miller, & Rasco, 2004). Also, each environment is inter-reliant.
and integral to understanding the social development of refugee children within their family and social contexts. The model views the refugee family experience as a multi-layered process rather than static, affecting both the developing child and parent in preresettlement. The refugee family is affected by the stages of the model, (re)shaping pre-existing values, ideas and cultural norms in each stage they reach (Lustig et al., 2004; Splobodin, & de Jong, 2015; Sonderegger, Rombouts, Ocen, & McKeever, 2011).

Together these two models emphasize the need to recognise and understand the experiences and characteristics of each stage of resettlement as distinct and associated with its own risk and protective factors (Williams, 2010). This conceptual framework highlights both the significance of the influence of parental care in the experiences of displaced children at various stages in the family’s refugee journey, in addition to the factors that influence the experience of parents in caring for their children. Due to the elevated levels of stressors and challenges for parents and children, parenting during war can become very difficult (Reed et al., 2012; Slobodin & de Jong, 2015). However, by targeting parenting factors it may be possible to weaken the link between war and displacement and psychological difficulties in children (Diab et al., 2015; Tol et al., 2011). A recent review of interventions for children affected by war reported that the efficacy of interventions for war affected children in humanitarian settings is increasing but that programmes may not be sustainable without the addition of family support (Betancourt, Meyers-Ohki, Charrow, & Tol, 2013).

**Parent training**

There have been calls for parent training (sometimes referred to as parent education), in early detection and management of child mental health problems in post-war early recovery settings (Panter-Brick et al., 2014; Thabet, & Vostanis, 2015; Williams, 2010,). Parenting programmes offer a combination of parenting knowledge, skill building, competency enhancement and support (Cowan, Cowan, & Barry, 2001). They are designed to reduce presenting problems and prevent future difficulties thorough training, support or education (Smith, Perrin, Yule, & Rabe-Hesketh, 2002). There are several meta-analyses documenting the effectiveness of parenting interventions with
non-refugees, across a wide range of both parent and child outcomes (Barlow, Smailagic, Ferriter, Bennett, & Jones, 2010; Furlong, McGilloway, Bywater, Hutchings, Smith, & Donnelly, 2012; Zwi, Jones, Thorgaard, York, & Dennis, 2011). In addition to parenting programmes offered in group (Gardner, Burton, & Klimes, 2006; Scott, Spender, Dolan, Jacobs, & Aspland, 2001) and individual formats (Kaarensen, Ronning, Ulvund, & Dahl, 2006), programmes have also been successfully used through workbooks and telephone assisted services (Gallart, & Matthey, 2005), Internet-based (Sarkadi, & Bremberg, 2005) and TV-based approaches to prevention (Calam, Sanders, Miller, Sahnanni, & Carmont, 2008). Most of the research carried out on the effectiveness and applicability of parenting interventions with families affected by war has been carried out with resettled refugees residing in high-income countries (Kakuma et al., 2011; Keiling et al., 2011; Williams, 2010). However early recognition of trauma symptoms and psychosocial impairment is essential to ensuring optimal recovery for children (Barenbaum et al., 2004).

The literature reviewed so far in this paper has highlighted that refugee children and adults face struggle throughout their journey to resettlement, causing significant consequences to their mental health and family functioning. Changes in the family structure begin during the pre-flight phase, including a major shift from internal control to external control over decision-making processes (Williams, 2010). Research on refugee needs and psychosocial interventions has focused on those resettled in new countries (Fazel et al, 2012; Jordans et al., 2009, Punamaki et al., 2012). However, the struggles of prereSETTLEMENT and refugee camp life are significant. A report describing the consequences of displacement highlights that children living in refugee camps and prereSETTLEMENT settings are physically, emotionally and mentally vulnerable (IDMC, 2012). In addition, displacement poses great physical and psychosocial dangers leaving children more prone to abuse and exploitation in IDP settings (Masten, 2011). The mental health problems affecting children living in refugee camps include elevated symptoms of PTSD, depression, and anxiety (Barenbaum et al., 2004; Sagi-Schwartz, 2008). A qualitative study of Burmese refugees conducted in a refugee camp in Northwest Thailand demonstrated that children in the camps reported internalizing symptoms of depression, worry, sadness, and loneliness.
These symptoms related to chronic stressors in the camp setting, including violence, alcohol use, and child maltreatment (Meyer, Murray, Puffer, Larsen, & Bolton, 2013). Differences too in the physical set up of refugee camps also has an effect on children’s mental health outcomes, such that one study found that in small, unofficial camps, sleeplessness, depression and hopelessness were much higher than within official camps (Chan, & Kim, 2010).

**Aim**

Given that the challenges of parenting in preresettlement contexts are likely to be different at different stages, and that parenting skills interventions have been shown to be effective in many other contexts, such interventions are likely to be valuable at each stage in the refugee journey but may need to address different parenting needs and concerns. In response to calls for more evidence based psychosocial support for families during preresettlement (Williams, 2008; 2010), the present study aimed to systematically review the current literature to identify evidence based psychosocial interventions with a parenting component aimed at parents or primary caregivers displaced in preresettlement contexts by war or armed conflict. The aim was to identify what is currently being utilised at this specific stage to provide a better understanding of the best evidence available in order to better inform policymakers, practitioners and researchers.

**Method**

Using Preferred Reporting Items for Systematic Reviews and Meta-analyses criteria (www.prisma-statement.org), studies were identified at two stages. Stage one entailed searching published literature in evidence based databases (Global Health, Ovid medline, Embase, Psychinfo, Scopus, Web of Science). Results were limited to those that contained keywords within a matrix of relevant terminology identified in the study title or abstract. The following search terms were used: (mother* or father* or guardian* or parent*) and (child* or adolescent) and (refugee or internally displac* or externally displac* or IDP or camp) and (emotional or stress or psychological or anxiety or behavi* or conduct) and (intervention or training or programme or support).
Articles were included for full review if they adhered to the following criteria, a) publication involved a description of a treatment or intervention with a parent or caregiver component with children as primary or secondary beneficiaries, b) the population were displaced by conflict or war, c) the population was in a pre-resettlement context such as refugee camps or temporary housing, d) designed for parents with children up to age 16, e) published between 1990-February 2015, f) a qualitative or quantitative evaluation of a parent programme dealing with emotional or behavioural problems, g) have some outcome data and, h) English publication language. Articles were excluded if, a) the focus of the programme was solely physical outcome improvements, b) was not an evaluation study, c) was aimed at parents of children above the age of 16, d) focused on refugees in resettlement contexts, e) population was displaced by natural disasters.

At stage two searches of non-academic ‘grey’ literature were made in databases of international organisations (Google Scholar, WHOLIS, Medicine Sans Frontiers, UNBIS, UNICEF) for references to parent, caregiver or family programmes in refugee camps and preresettlement contexts. Related identified reviews and reports were hand searched at this stage. An initial search was carried out between July and September 2014 and then repeated in February 2015. Details of the electronic search strategy are provided in Figure 1.

Results

Stage 1: The searches of published evidence based literature resulted in a total of 844 publications; PsychINFO returned 103 articles, Pubmed 158, Embase 156, Global Health 11, Web of Science 156, Medline 133 and Scopus 127. Two hundred and seventy one articles were selected for full review; 270 were excluded for not meeting the study criteria, leaving two articles (Dybdahal, 2001; Morris, Jones, Berrino, Jordans, Okema, & Crow, 2012).
The first identified study to meet the inclusion criteria was a psychosocial intervention for internally displaced mothers and children in post war Bosnia and Herzegovina (Dybdahal, 2001). The primary aim of the intervention was to promote the development and well-being of young children through parental support, involvement and education. A randomised five month trial allowed the comparison of the short
term effects of the intervention for mother-child dyads (n=42) to a control group that received free medical care only (n=45). The intervention comprised of weekly sessions regarding trauma and dealing with stress reactions as well as promoting positive interactions and communications between mothers and children. The intervention had a small positive effect on mothers’ mental health, children’s weight gain and psychological functioning ($d=0.33-054$). Measurements were scales of functioning and psychological problems developed by the authors. Study limitations included a small intervention sample size, no fathers were involved and the possibility of contamination of treatment effects due to the living conditions of the participants. This study has been described in the literature as an exemplary and rare model of family and child support in post conflict settings (Betancourt, & Khan, 2008; Jordans et al., 2009).

The second identified study (Morris et al., 2007) was carried out in camps for internally displaced people in Northern Uganda. Participants were mothers with moderately or severely malnourished infants aged between 6 to 30 months. Mothers in the intervention group (n=132) were given a psychoeducation intervention covering early childhood development, stimulation and interaction and training, for aspects such as how to set limits and teach children good behaviours, alongside standard nutritional support. Weekly sessions took place over six weeks lasting between 90-120 minutes with an unspecified number of home visits. No effect for maternal knowledge about child development was found though mothers’ in the intervention group were more emotionally responsive (odds ratio: 2.97; 95% confidence interval: 0.71–5.23) and used more play materials (odds ratio: 2.16; 95% confidence interval: 1.22–3.10) than those in the control group. Mothers in the intervention group also found the intervention acceptable. Nine mothers from the intervention group initiated groups spontaneously in their own locations to assist other mothers, suggesting they may have found the intervention useful and acceptable. A major study limitation was that no randomisation and blinding of participant allocation took place.

Stage two: At stage two searches of non-academic ‘grey’ literature were made in databases of international organisations (Google Scholar, WHOLIS, Medicine Sans Frontiers, UNBIS, UNICEF) for references to parent, caregiver or family programmes in refugee camps and preresettlement contexts. Related identified reviews and reports
were hand searched at this stage against the original inclusion criteria. No additional studies were identified.

Discussion

Family cohesion is crucial for reducing the negative effects of war on child mental health (Chrisman, & Dougherty, 2014; Tol, et al., 2013). Poor family functioning is a significant risk factor for child PTS, increasing the impact of traumatic events (Berkowitz, Stover, & Marans, 2011; Trickey, Siddaway, Meiser-Stedman, Serpell, & Field, 2012). Parental stress reduces the capacity to maintain positive parenting strategies, contributing to maladaptive practices (IMC, 2013). The majority of research on evidence based interventions to support families affected by war has focused on those conducted with resettled refugees, with much less known about those in preresettlement contexts. However, each stage of a refugee’s journey carries its own risk and protective factors. Humanitarian agencies (IMC &UNICEF, 2014; UNICEF, 2013) and researchers (Betancourt et al., 2013; Williams, 2010) stress the urgent need for family-based mental health care in preresettlement contexts. The aim of this review was to identify peer reviewed intervention studies that have been carried out with parents in preresettlement contexts. A systematic review identified only two studies meeting criteria.

The lack of studies identified is not surprising given that several researchers have noted a lack of research on the potentially protective role of the parent or family in humanitarian conflict settings (Jordans et al., 2009; Panter-Brick, Grimon, & Eggerman, 2014; Thabet et al., 2009). The ‘family’ in political conflict literature often refers to the mother who most likely will have caregiver responsibility (Cairns, & Dawes, 1996). Attention on the parent in the conflict literature is often on their mental health and how this acts as a mediator of their children’s symptoms (Quota et al., 2008; Smith et al., 2001). Given that the first years of a child’s life are crucial for healthy physical, emotional and behavioural development (Thompson, 2001), in addition to the extent of war and armed conflict, this identified lack of published interventions at preresettlement for supporting parents in caring for their children is highly noteworthy for researchers, policy makers and aid agencies.
There is a general consensus that there is less representation of low and middle income countries in the mental health research literature (Helal, Ahmed, & Vostanis, 2011; Patel, & Sumathipala, 2001; Tol et al., 2013). Recent reviews have pointed to the lack of research on emergency-related mental health interventions in low- and middle income countries and complex emergencies (Barenbaum et al., 2004; Patel et al., 2007) despite an increasing body of research portraying the negative impact of political violence on child mental health and psychosocial well-being (Attanayake et al., 2009). While there is increasing research on the need for psychosocial interventions in complex emergencies (IASC, 2007), there is a gap between child mental health needs and availability of evidence-based interventions (Patel et al., 2007). The scarcity of high quality research on interventions to reduce adult and child trauma after conflict has also been pointed out by several researchers (Bonanno, Brewin, Kaniasty, & Greca, 2010; Hobfall, Watson, Bell, Bryant, Brymer, Friedman, & Ursano, 2007; Tol, Komproe, Jordans, Gross, Susanty, Macy, & de Jong, 2010). Though humanitarian agencies and researchers are becoming more aware of the need for research in preresettlement areas this still remains a major challenge.

The reasons for the lack of research in conflict settings may also hold true for the lack of parent specific evaluative work. For example, funding is often focused on the primary needs of food and shelter, often leaving little remaining. In addition, there is often a lack of skilled practitioners to meet the psychosocial needs of war-affected persons (de Jong, & Kleber, 2007; Medeiros, 2007). Access to conflict and preresettlement areas can be very restricted due to road closures, risk of violence, workplace safety factors and governmental and ethical restrictions. Also, the methodologies usually employed to carry out good evaluative trials could be unethical and impractical to carry out, such as randomization or wait list assignment (McDonald, 2009; Rimpela, 2000; Silove et al., 2005), therefore posing major methodological limitations (Jadad, 1998) and posing ethical challenges (El-Khani, Ulph, Redmond, & Calam, 2013).

Finally, the role of the family in the mental health protection and development of the war affected child has only gathered significant attention and momentum in the past decade (Patel, 2008; Slobodin, & de Jong, 2015). For example, humanitarian
organisations and researchers have recommended that psychological first aid be provided to communities and populations affected by armed conflict and integrated into their primary health care due to their extreme vulnerability (Patel et al., 2007; IASC, 2007). However, mental health infrastructure remains fragmented and there are very few empirical studies on appropriate psychosocial interventions to guide community practice (Patel et al., 2007). Though this is a challenge, an example of this has been demonstrated in the Philippines in which mental health services were offered in mobile clinics in shelters for internally displaced people. The results showed that brief psychotherapy sessions provided at primary level during emergencies can potentially improve symptoms of distress (Meuller, Cristofani, Rodriguez, Malaguiok, Gil, Grais, & Souza, 2011). This review was limited to identification of peer reviewed interventions that had been used with displaced families in post conflict, preresettlement contexts. This limitation was a deliberate strategy to explore this specific phase of migration as refugee experience is stage specific. It is highly likely that other studies would have been identified had displacement not been specified in the inclusion criteria, for example the research on families in on-going conflict zones such as Palestine. The conceptual ecological models of Reed and colleagues (Reed et al., 2012) depict that a child’s experience of displacement at any time will be a combination of their current stage in resettlement as well as the influence of their family. In parallel, the ecological model of preresettlement parenting by Williams (2010), also describes the parenting experience as being specific to the stage of resettlement in addition to other factors such as their culture, religion and norms. Therefore, parent and the child experiences are interlinked both between themselves and their phase of resettlement. According to these models, their experiences and thus their needs will be different at each stage of migration. Therefore the strength of this paper is the identification of the scarcity of evaluations of parent interventions at the specific stage of preresettlement displacement. Such information is valuable for policymakers and practitioners to identify how best to meet the needs of families at each stage of migration (Williams, 2008, 2010).

The field of parenting in post conflict settings would greatly benefit from a large scale, stage sensitive systematic review of all parenting interventions evaluated with families.
that have been affected by armed conflict at every stage of migration, from pre-flight to resettlement, including those not displaced and also those living in areas of ongoing conflicts to ensure no evaluations are excluded.

Conclusion

Armed conflicts continue to rage throughout the world displacing families and subsequently leaving more children at risk of developing mental health problems. Each stage of the refugee journey has different protective and risk factors, therefore an identification of evidence based effectiveness for interventions at each stage of the refugee journey is essential to meet refugee family needs. The efficacy of interventions for war affected children in humanitarian settings is increasing, but programmes may not be sustainable without the addition of family and community support (Betancourt et al., 2013). A systematic review of published interventions with displaced families identified only two studies with a parenting intervention component. We echo a growing call for action to place child mental health, especially in early recovery from conflict, in the global international agenda (Patel et al., 2007; Tol et al., 2011). Policymakers can do much to prevent long term psychological difficulties and distress if they can take action to prepare and respond, informed by the latest evidence and corresponding theory. The positive results from the two studies identified by this review give encouragement that parenting interventions could be valuable to families in prere-settlement contexts. There is a pressing need to investigate whether these findings can be extrapolated and used effectively in large-scale emergencies.
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PAPER 2- Parenting Challenges and Needs in Preresettlement Contexts
An exploration of parenting challenges and needs in preresettlement contexts

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Abstract

Background: Refugee children’s mental health through war, conflict and flight is strongly influenced by family environment and quality of relationships with parents and primary caregivers. Knowledge of parents’ support needs through displacement into preresettlement contexts is vital in designing interventions to improve outcomes for refugee children and families. This study investigated Syrian parents’ challenges, needs, and experiences of seeking parenting support in addition to the coping strategies they were using to care for their children.

Methods: Twenty-nine mothers and professional support workers in refugee camps and humanitarian contexts in Turkey and Syria participated in interviews or focus groups. Data were analysed using thematic analysis.

Findings: Data were structured into three themes; parenting challenges such as environmental, child specific and parent specific challenges; parents need and experience of parenting advice such as their experience of actively seeking support, the value they placed on discussing parenting issues and perceived barriers to accessing support; the coping strategies parents were using to care for their children, such as acceptance and normalisation, reaching out for and keeping mentally strong using faith.

Conclusion: Though parents struggled both physically and emotionally to support their children’s new needs, very soon after the immediate extreme stress of displacement, parents are very keen to access information on how best to parent their children. It may be possible to design and deliver interventions for parents in this context based on theoretical parenting principles and identified needs, to inform holistic interventions and culturally appropriate policy responses. There are clear ways such challenges could be addressed by parenting intervention which could reduce the impact of trauma experienced by children, the challenges they are still living with and will face in the future. This study is important for policy and humanitarian organisations working in preresettlement contexts.
Introduction

Worldwide, over 45 million people are refugees or displaced (United Nations High Commissioner for Refugees UNHCR, 2012). Most of those displaced are children, and the stress associated with war influences their psychological health and mental development (Panter-Brick, Grimon, & Eggerman, 2014; Thabet, Abed, & Vostanis, 2002). Families spend months and sometimes years in refugee camps following flight from their homes. The plight of such children and families has been highlighted by the Syrian crisis. Developing effective interventions to reduce refugee families’ suffering, throughout their journey to resettlement, is challenging (Williams, 2012), yet is a global mental health priority.

Refugees will have often lived through devastating experiences prior to fleeing their homes. In a study of 353 refugees in a Dutch clinic, 37% reported being close to death, 37% reported being tortured and 35% had experienced a friend or family member’s death (Kleijn, Hovens, & Rodenburg, 2001). Another study found 67% of refugees had been deprived of water and food, 67% reported being in a combat situation and 62% had felt they had been close to death (Cardozo, Vergara, Agani, & Gotway, 2000). It comes as no surprise than that research indicates an increased risk in psychological distress and psychopathology amongst refugee populations (Fazel, Wheeler, & Danesh, 2005).

Post Traumatic Stress Disorder (PTSD), is a form of psychiatric disorder that may develop after individuals have experienced or witnessed traumatic events, which are usually life-threatening or physical integrity-threatening. The classic symptoms of PTSD are avoidance and numbing symptoms, re-experiencing symptoms and physiological hyper arousal, decreased concentration, irritability and an over-activity to stimuli (DSM-IV, APA 2000). A systematic review of 20 studies showed that PTSD is approximately ten times more likely to be found among refugees than age-matched native populations (Fazel et al., 2005, Johnson, & Thompson, 2008). In a study by Marshall and colleagues (Marshall, Schell, Elliott, Berthold, & Chun, 2005), for example, symptoms of PTSD were found in 63% of refugees from Cambodia, 20 years after fleeing to the United States. In general a dose-response relationship is found between the number of traumatic experiences and the psychological stress refugees experience, such as a study reporting refugees with experience of over three trauma categories had an increased risk of mental health illnesses by eight times (Steel, Silove, Phan, & Bauman, 2002).

Research on the consequences of war and conflict on the mental health and development of children has greatly increased in the last decade (e.g. Betancourt, & Williams 2008; Panter-
Brick, Goodman, Tol, & Eggerman, 2011). The majority of children exposed to armed conflict show signs of mental health difficulties (Marwa, 2013; Ozer, & Oppdal, 2013). A systematic review of child mental health in on-going or post-war situations, has revealed elevated levels of PTSD (47%; seventeen studies), depression (43%; four studies), and anxiety (27%; three studies) (Attanayakey, McKay, Joffres, Singh, Burkle, & Mills, 2009). Other studies have shown that children exposed to war are also at high risk of developing various types of psychopathology (Pfefferbaum, 1997; Shaw, 2003; Thabet, Abed, & Vostanis, 2004). A systematic review of interventions to reduce PTSD and related symptoms, indicated a limited size and quality of evidence-base (Peltonen, & Punamaki, 2010), and researchers have called for a need to develop effective interventions to support children in this context (Betancourt, Souza, & Van Ommeren, 2011; Tol, Barbui, Galappatti, & Silove, 2011).

Research on the experience of trauma amongst refugees has been most commonly carried out utilising quantitative methodologies within the Western bio-medical model (Baird & Boyle, 2012; Khawaja, White, Schweitzer, & Greenslade, 2008; Schweitzer, Greenslade, & Kagee, 2007). This can be problematic as this model is unable to explain findings of moderately low levels of psychiatric symptomology such as a study with Cambodian residents living in a refugee camp, in which only 15 % of the residents suffered from PTSD (Mollica, Donelan, Tor, Lavelle, Elias, Frankel, & Blendon, 1993). Another study reported an even lower 3 % PTSD rates in a sample of refugees (Steel et al., 2002). Research with non-clinical communities suggests that refugees may be far more resilient than clinical studies represent (Bonanno, 2004) and that the majority successfully adapt to stressors and trauma (Khawaja et al., 2008). Some evidence confirms that extremely traumatic war exposure may present as immediately traumatic, but with a reduction in symptoms during the following 3 months to 1 year (Friedman, Stevens, & Morris, 2008; Thabet, & Vostanis, 2000).

Resilience is the capacity of an individual to return to normal functioning after severe trauma. The term is also used to refer to the absence of mental health and psychosocial problems despite severe hardships, in addition to the presence of developmental competences in adverse living conditions (Masten, 2007 and Werner and Smith, 1982). Fortunately there appears to be a number of coping strategies that protect refugees, contribute to their resilience and allow them to continue to function and recover meaningful productive lives. Coping refers to efforts to manage demands that are appraised as taxing (Lazarus, & Folkman, 1984). Coping behaviours and strategies have been traditionally categorised into three main categories; problem versus emotion focused, engagement versus disengagement, and primary
versus secondary control coping (Lazarus & Faulkman, 1984; Livneh, Livneh, Maron, & Kaplan, 1996).

Studies have examined the coping strategy utilised by refugees to promote positive adaptation at various stages in the refugee journey to resettlement (Goodman, 2004; Khawaja et al., 2008). A qualitative study with refugees from Sudan revealed that social support, religious beliefs and personal qualities were significant factors in coping (Schweitzer et al., 2006). Social support drawn from families and communities may act as a protective shield against the impact of traumatic experiences and current refugee challenges facing those displaced (McMichael, & Manderson, 2004). The use of religious practices and beliefs is commonly observed in studies of refugee coping as providing a number of coping strategies such as endurance (Peisker, & Tilbury, 2003) and a productive adaptation to life difficulties (Brune, Haasen, Krausz, Yagdiran, Bustos, & Eisenman, 2002). In addition, cognitive processes such as hope and aspirations for the future may increase resilience and aid overcoming trauma (Goodman, 2004; Beck, Rush, & Shaw, 979).

Systematic reviews have highlighted a focus on individual rather than family level evidence as a major limitation of the evidence base of child mental health in humanitarian contexts (Betancourt et al., 2013; Panter-Brick et al., 2014; Panter-Brick et al., 2011). However, the influence of family on war-affected children’s mental health is paramount (Quota, Punamaki, & Sarraj, 2008; Thabet, Ibraheem, Shivram, Winter, & Vostanis, 2009). Family environment represents a significant protective factor for child mental health outcomes (Borkowski, Landesman, & Bristol-Power, 2009; Panter-Brick et al., 2011). By targeting parenting factors it may be possible to weaken the link between the effects of displacement on the mental health of children (Diab, Peltonen, Qouta, Palosaari, & Punamäki, 2015; Tol et al., 2011). However, sparse literature exists investigating the parenting needs of refugee families (Reed, Fazel, Jones, Panter-Brick, & Stein 2012). Effective parenting may provide a ‘protective shield’ during difficulties, yet when parents themselves struggle, this may further complicate a child’s adaptation to war stressors (Elbedour, Ten Bensel, & Bastien, 1993). A parent who was previously warm and confident in their parenting may find the nature and quality of their interactions with their children dramatically altered by the challenges of living as a refugee (Betancourt, 2008).

Refugee parents experience a number of stages between parenting their children in their home country before flight, and finally being resettled in a new host country. This journey has been conceptualised by Williams (2010), who developed a four stage holistic ecological model
of refugee parenting; the family in its country of origin, preflight, flight and finally the family in resettlement contexts. At each stage parents are affected by multiple environmental contexts that reshape pre-existing values, ideas and cultural practices, creating new perceptions (Lustig, Kia-Keating, Knight, Geltman, Ellis, Kinzie, & Saxe 2004; Splobodin, & de Jong, 2015; Sonderegger, Rombouts, Ocen, & McKeever, 2011). According to this model, the parenting experience is functioning within the context of these four stages, while being simultaneously influenced by multiple layers of ‘being’ in the world as a refugee parent which includes the challenges they face. The refugee family experience is described as a multi-layered process rather than static, affecting both the developing child and parent in preresettlement.

Understandably, aid organisations working with refugee families during the flight and preresettlement phase typically focus on humanitarian relief such as food and shelter due to limited funding. However, changes in the family structure begin during the pre-flight phase (Williams, 2010), and since the parent’s role is so important to the child’s experience of refugee life, early context-specific parenting programmes could be extremely beneficial (Williams, 2012). There have been calls for parent education training in early detection and management of child mental health challenges in post war settings (Panter-Brick et al., 2014; Williams, 2010). Parenting education interventions provide parents with the knowledge and skills to promote positive and supportive relationships with their children. There are several meta-analyses documenting the effectiveness of parenting interventions across a wide range of non-refugee settings (Barlow, Smailagic, Ferriter, Bennett, & Jones, 2010; Furlong, McGilloway, Bywater, Hutchings, Smith, & Donnelly, 2012; Zwi, Jones, Thorgaard, York, & Dennis, 2011). However, research on the acceptability and effectiveness of such interventions with refugee families has focused on those resettled in high income countries, the needs of whom are different than those in preresettlement contexts (Kakuma, Minas, van Ginneken, Dal Poz, Desiraju, Morris, Saxena, & Scheffler, 2011; Keiling, Baker-Henningham, Belfer, Conti, Ertem, Omigbodun, & Rahman, 2011; Williams, 2010). An exemplary intervention with non-resettled refugee parents is an intervention that was conducted with displaced Bosnian mother-children dyads. The parents received psychosocial support and basic medical care or medical care only (Dybdahl, 2001). The intervention showed a positive effect on the mothers’ mental health and children’s psychological functioning and mental health also improved with reductions in anxiety levels, sadness and sleep problems. However, there is a need to investigate whether these findings could be replicated in large scale studies in refugee settings.
Research has indicated the benefits of early interventions with families after trauma (Dyregrov, 2002). With gathering evidence stressing both the negative impact war has on parents and children individually, and on their relationship with each other (Diab et al. 2015; Reed et al., 2012; Tol et al., 2011), an exploration of what challenges families are facing early on in their refugee journey is valuable to provide effective interventions.

For the purpose of this study, we use the example of Syria to investigate the parenting needs and challenges of refugee families in preresettlement contexts residing in refugee camps and shelters both in Syria and in Turkey. We also explore the perceived feasibility and value of intervention at this stage and what coping strategy parents are utilising in caring for their children. Over 7.6 million Syrians are now internally displaced (UNHCR, 2015), and over 4 million are externally displaced as refugees in neighbouring countries, such as Turkey, Lebanon and Jordan (UNICEF, 2013). Thousands have reached Europe, Asia and America. This presents an urgent need to understand, in context, the parenting challenges these families face and how best to support them. Without this ecological knowledge of the parenting experience in these preresettlement contexts, interventions aiming to meet the families’ specific needs may be non-feasible and ineffective. Therefore, this study aimed to explore the parenting needs and challenges of Syrian refugee families, their experiences with parenting support and how they were coping in preresettlement contexts.

Method

Study design

This study adopted a qualitative research approach as this provides rich explanatory data and has previously been used in refugee research (Creswell, Hanson, Clark & Morales, 2007). This study was conducted in two phases. Initially individual interviews provided privacy for participants to describe their experiences. Focus groups (FG) were then adopted when it became evident that parents were willing to talk with others experiencing similar challenges.

The setting

Four sites were accessed during data collection, two in Syria and two in Turkey. Three sites were refugee camps accepting newly displaced refugees, one site was a building housing refugees who had just arrived into Turkey.
Procedure

Ethical approval was granted by The University of Manchester research ethics committee (Ethical committee reference number 12102, 124110). Logistical support, including access to recruitment sites and safety checks, were provided by Generation Freedom of the NGO Watan. During phase one, parents were approached in refugee camp schools and handed study leaflets. Interested parents provided written consent and were interviewed the next day at the school.

The original ethical approval stipulated that a 24 hour window had to be maintained between potential participant’s receiving study participant information sheets and then consenting and taking part in the study. However, in phase one, it was difficult to recruit participants due to the practical challenge of gaining access to the same refugee camps the following day and locating the same families. During phase two an amendment was made to the original ethics application (El-Khani, Ulph, Redmond, & Calam, 2013) to allow for immediate consent and participation. FG’s were arranged and conducted later the same day inside parents’ tents. Interviews with professionals were conducted in an aid agency office.

Interview schedule

The interview schedule was designed by the main researcher (AE) with the assistance of a child and family psychologist (RC) and a qualitative expert (FU). It covered three areas: changes and challenges in the parenting experience; what coping strategy parents were using; and what, if any, challenges parents wanted support with. It was originally piloted using one-to-one interviews with two mothers, via Skype, who were residing in Gaza and had experienced the 2009 Israeli attacks. Following the pilot stage, the interview schedule was altered accordingly. The main changes was to a move to more direct questions and prompts as well as the addition of more Arabic terms for the word ‘parenting’.

Data analysis

Data were analysed using a mixed approach (Fereday, 2006) to thematic analysis (TA) (Braun, & Clarke, 2006). TA was chosen because of its ability to directly represent the descriptions of respondents’ viewpoints, experiences, beliefs and perceptions. An essentialist method was used which means we aimed to report the experiences, meanings and the reality of participants (Potter, & Wetherell, 1987). Initial inductive coding was carried out by researcher AE, that is with the aim of seeking a descriptive account of the data rather than an
interpretation and explanation of the discourse, allowing the themes to evolve from the data set rather than being theoretically driven. The research team reflected on identified codes to combine and rename these where appropriate. The team developed a revised code set that included the new and combined codes. Links between and within the themes were also examined. NVivo9 software was used to facilitate analysis. The research team reviewed the emerging themes and came to agreement on the final themes.

**Results**

Twenty nine participants took part in this study (n=29) comprising eight individual interviews and four focus group (19 mothers, range 5-6 per group) with mothers Participants’ ages varied from 22-45 years and cared for between 1-7 children. While some families had only recently arrived from Syria, others had been in the camps for up to eight months. Four were war widows, and two did not know if their husbands were alive. All participants were of the Muslim faith.

In addition, two interviews with professional aid workers (a local camp doctor and an on the ground director of an NGO) were conducted. In the planning stage of the study in the UK, while in discussions with Watan employees in Turkey, it became evident that their experiences and understanding of the refugee context would be very useful to this study. Because of the very unique and rapidly changing nature of the setting, these informants provided more information about the context and environment in which participants (the parents) were living. In line with exploratory qualitative approach, it was anticipated that diversity in the sample of parents and those working to support parents would not only give a rich data set of various issues and approaches (Peters, 2010) but also provide an additional lens to examine the challenges. The data from these two professional interviews were viewed as supplementary data to support the main data set of the parents.

Quotes are provided to illustrate themes, identified according to interview (I) or focus group (FG) number. Pseudonym initials are used for FG members when reporting data from more than one mother. Narratives were explored and three main themes were identified; parenting needs and challenges of Syrian refugee families, their experiences with parenting support and how they were coping in preresettlement contexts. Each theme, along with its sub-themes will be presented individually.
Theme one: Parenting challenges

Sub theme: Environmental challenges

Parents described how living conditions placed huge pressure on their ability to care for their children. They worried about their children’s health due to the extremely dirty camp conditions and lack of basic sanitization. This concern was further exacerbated by the lack of clothes and very limited supply of water in which to wash those clothes.

It’s hard though because of the dirt, and the illness they are catching, to just let them do what they want to do. FG(2)

They often contrasted their current situation with their lives in Syria where they were surrounded by familiar people. They were concerned about who their children where now exposed to and consequently their safety.

I don’t know who is round us, I don’t know, All God’s types of people are here, they can harm the children. I(2)

This led to conflict between children as some parents were reluctant to let children leave the tents as they perceived so much danger. Others were sympathetic to their children’s need to be allowed to play outside and tried to allow them, despite their fears.

Parents described their lives as chaotic and felt this was the main reason for many of the problems they had with their children.

It’s the chaos, this is what the root of the problem with our kids is. Life is so chaotic now. FG(1)

This chaos meant parents struggled with feelings of having very little control over their daily activities and their ability to influence and protect their children.

One mother described how in Syria she was a housewife and proud of her efficiency in caring for her family, but now she felt completely unable to control any aspect of her life and that of her family. Like several other participants, she highlighted the challenge of not knowing what to expect next, the inability to plan ahead and how this has changed her parenting priority.

We have no home. We can’t decide where we will live, I can’t decide what I will feed my kids. I don’t know what I will cook, as I don’t know what ingredients I will manage to get. I cannot control anything around me. We are living each second unaware of what’s coming next. You asked me what it’s like to be a mum now, well this is it, it’s like we are
not mums, we’re just keeping kids alive by feeding them and making sure they are alive and safe. FG(4)

The project manager of an NGO recognised the pressure parents were under and was very sympathetic. He reported how much the children relied on their parents and how little their parents could control in return.

_The parents are in charge of providing everything the children need, this is making them so stressed, extremely stressed, what a huge responsibility [...] to feel completely out of control of._ (Aid organiser)

One form of loss of control, was that while parents were being faced with new needs that their children were presenting, they lacked confidence in meeting these and supporting them, as they did not have any experience with such issues. Mothers felt that the external chaos they were experiencing as a family was aggravating both the physical and emotional reactions of their children to their experiences of war and current life.

*I’m not able to cheer him up or lift his spirits, I don’t know how. I’m angry and hurt myself and when I see him like that I get angry and do stupid things._ I(3)

**Sub-theme: Child specific challenges**

Parents reported an increase in inappropriate child behaviours as a core concern:

_But now they are ruder! They are spitting and hitting and shouting and using bad words._ I(8)

They reported their children’s play had become more violent and worried this reflected their exposure to war. Parents had strong commitments to their children’s future, and many felt the war had damaged the opportunities for these to be fulfilled, and saw the changes in their children as a reminder that things were no longer how they had planned.

_It’s not just that they are fighting more but the way they are fighting is very aggressive and scary. They seem so aware of how to hurt each other and of ideas like revenge and hate._ I(5)

_They have seen so much fighting and pain, it’s like their games are older than them. It’s all kill and murder, and bury and army sounds._ FG(4)

Parents worried that these new behaviours were not just temporary reactions to experiences, but would become characteristics into adulthood. The researcher’s field notes recorded that
while aggression and violence by the children to their own family or those around them was strongly discouraged and often punished by parents, parents encouraged and supported those adults who were returning back to their country of origin to fight back and defend them. Thus children were receiving mixed signals on the acceptability of violence.

In addition parents described children displaying a range of negative emotions such as anger and sadness, and perceived that these reflected children’s experiences of war and being a refugee. Parents found it very distressing seeing their children crying, feeling sad and unlike how they were previously. They reflected on how their children were before being displaced and how they wished they could see their children like that again.

She’s not like the other children, you feel she has a heavy load on her shoulders. Yes, she laughs and smiles and plays, but there is something inside her deep that is dark. She saw him [her father] dead and she cried over him to wake up. She remembers him at night, she cries his name. My insides cry with her. What can I tell her?  I(4)

Although mothers struggled to know how to support their children, they still felt they knew their children well and could identify subtle differences in their behaviour and personalities.

[Child’s name] is very angry and quiet. He doesn’t talk a lot but you can tell from his eyes. I(3)

Often children did not communicate their feelings, but parents were very aware of the changes in their mood and personalities. In particular, parents found their children’s lack of motivation and interest alarming.

[The children are] unmotivated for anything. They don’t seem to have the energy, but I know it’s not physical energy, it’s they just can’t be bothered. FG(4)

Parents described trauma symptoms, such as bed wetting, fear of loud noises and bright lights, and regressive behaviour: “They cry at night, they scream a lot while they are sleeping.” FG(4).

A camp doctor reported that parents had actively sought help from camp medical professionals when they had access to such services for a range of trauma symptoms.

You have sleep issues, wetting of the bed, loud noises make them jump, they are very anxious and many don’t like to leave the parent’s side, you know we call them anxiety issues. A few kids also display characteristics that are younger than them. (Camp doctor)

The doctor described actions such as thumb sucking, regressive behaviours and children becoming very dependent on their parents.
Another child specific challenge was that parents reported that communication with their children had changed: they often did not listen to their parents and talked to them in raised or more aggressive voices. Parents discussed in detail that they found this offensive and unacceptable.

*They shout a lot at me and each other. Before at home, I would just give them one look and they would lower their voice. Just a look. I didn’t need to say anything.* 2(2)

Parents blamed this change in communication on the influence of other children’s misbehaviours.

*They won’t listen any more. They copy each other, ‘Mama I’m not staying inside’ they say, they never used to speak like that. They would speak with a good voice. Now their voice is louder.* 1(1)

Families found this very challenging as they felt it was the root of many other difficulties and if they could improve family communication they felt it would help many other aspects of their new daily challenges.

*“...If they listen to us lots of things will be solved. They won’t get as dirty, as they won’t go to dirty places, they will sit and read with us. You know things that we tell them to do. But nothing is helping.* FG(2)

Mothers described their Syrian culture as placing a lot of emphasis on children respecting their parents and being obedient, hence, this type of misbehaviour was perceived as very challenging.

**Sub-theme: Parent specific challenges**

Parents sympathised with their children’s suffering. They were extremely worried about the impact of what their children had witnessed and that how they were currently living would have on their wellbeing and development.

*There is no doubt in our mind that this experience will leave a psychological or emotional effect on the children.* FG(1)

Children were seen as being entrusted by God and that parents would have to answer to God. This strongly motivated them to try to find support and to meet their children’s new needs. However, this belief also caused the families to feel they were failing their children, resulting in feelings of guilt. They struggled to manage these feelings as they felt they could not change their situation.
These are our kids, what do we have more precious? Just God protect them and us. FG(2)

The child is a responsibility and something from God to cherish and do our best with and they feel they aren’t able to. (Aid organiser)

Additionally, parents felt very guilty about some discipline techniques they were using with their children, such as hitting and threatening. They said they had not previously used these techniques often, but felt they now had no choice.

S: That’s why we end up smacking, as they don’t listen otherwise.

M: It’s the last think we resort to doing.

Interviewer: Do you find yourselves smacking a lot?

M: Yes, [...] it is true we cry as we feel heavy hearted doing it, but they don’t listen. How else can we protect them? FG 2(4)

Parents commonly described how they often felt that the only way their children would listen to them was by smacking them. Although they spoke openly, mothers looked shy and embarrassed when reporting this.

The parents described how, similarly to their children, they were now experiencing challenging emotions. They struggled to hold their families together while feeling stressed, angry and abandoned. Several mothers had been widowed and all had lost close family members and friends. During one interview when the researcher asked a crying mother if she would like to halt the interview she replied: “This is me always, my tears don’t dry”. I(5) Others expressed similar feelings of being overburdened and unable to cope with the daily challenges.

I’m an adult, 35 years old, I promise you when I hear strong winds and loud noises in the camps I get so scared. I feel like my body is exhausted and my head is aching. And I am an adult. FG(1)

Their negative feelings also affected how they were parenting their children, as described previously, with parents hitting their children, as these quotes from mothers illustrate.

S: I’m getting really angry.

Interviewer: Did you get really angry before in this way, when you were living in your home?

S: No, not at all.
Interviewer: And when you are angry what do you do?

S: I want to hit him and do hit. FG(2)

Mothers felt that if they themselves felt better and stronger, they would be able to care for their children more sensitively and calmly. They felt trapped by their mixed emotions and felt they were not caring for their children as they wanted to.

There were also changes in how parents communicated with their children. They felt their own communication was now filled with shouts and threats.

W: We tell them ‘don’t do this’ and ‘don’t do that’

S: First time, second time. Either shouting or threatening then hitting FG(1)

Mothers felt this was due to their own emotional challenges, but that such interaction was why their children were no longer obedient.

M: You keep telling them different things, depending on your mood, so ‘no don’t go out’ then ‘yes you can’ it’s no wonder they are not taking our words seriously.

A: I swear that’s true, they have become so hard headed and stubborn. Everyone is saying different things to them so they only want to listen to themselves now. FG(2)

Parents believed their moods contributed to giving mixed messages to children, which in turn contributed to the children’s negative communication styles. Parent’s struggled with feeling there was little they could do about this negative cycle of change in their children’s and their own communication.

Parents reported that although there were times they had the chance to engage in parenting behaviours they valued, such as introducing routines and telling stories to their children, they felt almost ‘stalled’ in a sense of not being able to reintroduce these into their relationship with their children.

Not because I don’t have time anymore, I can’t say I don’t have 30 minutes to sit and do it, it’s just something inside me, I don’t know. It’s like this thing I used to do before but I don’t do anymore, I don’t know why. FG(1)

I’m still in that mood now, I can’t drop it off. 1(1)

These feelings disabled parents and caused a lot of negative emotions. They felt frustrated that while they acknowledged and felt they should reintroduce past parenting habits they did
not feel able to. Parents did not understand why they felt this and hoped to be able to move on.

**Theme two: Parents’ need and experience with parenting advice**

**Sub-theme: Parents’ desire for parenting advice**

All mothers engaged passionately and eagerly in conversations about their parenting challenges, which led them on most occasions, without prompting by the researcher, to reveal high levels of interest in receiving parenting support and advice. Parents felt unsure and frustrated when dealing with new parenting challenges including emotional and behavioural changes in their children. Often this need to be better informed on how best to care for their children drove them to want and, where circumstances allowed, to seek parenting advice. Mothers felt they were trying their best to adapt, but were troubled with the worry that the ways they were currently meeting parenting challenges were not the most appropriate.

*There must be a way or direction to point the children, something to say to help their minds remove the images, to make them sleep [...] we don’t know how to help them be children. Someone must be able to give us the right advice or information of what to do. 1(3)*

A camp doctor echoed these fears and worries with dealing with new parenting challenges and thought parental advice was necessary for some in such conditions:

*We can appreciate from seeing around us the necessity of parents knowing how to raise these thousands of children, when everything they knew or were confident with, was dragged illegally from underneath them, leaving them in a black hole with no one to turn to (Camp doctor).*

Negative case analysis identified only one mother who stated she did not want external support:

*I should listen to my heart first as I am the one who has been a mother to these kids before and now, I think I was doing a good job. I know what things can make them good and polite and happy at least I can try to do things again. Someone else might say something that is not appropriate for me or my child. 2(4)*

This mother of a child with a mental disability had negative experiences with doctors, aid workers and teachers, who she had hoped would provide more assistance with her child’s condition.
Parents reported talking about and advising each other on parenting challenges. However, they did not feel this was enough, as they viewed themselves as collectively experiencing these new challenges and preferred professional support.

*We are so far away from doctors or people who can help us, we’re relying on each other, but we aren’t getting anything from each other as we are all the same.* 1(3)

Parents were making active attempts to access external parenting support from professionals. They discussed their worries with and sought advice mainly from teachers due to their accessibility. On some occasions parents had successfully received support from clinicians, though access was more challenging.

*I asked [teacher], I thought she will be a teacher she will have more knowledge. I know the teachers are more sensitive to these topics and experience them more with other children and parents.* 2(4)

Parents had varying preferences for models of delivery of parenting information. Some preferred the idea of receiving information in a written format such as a book, so that they might refer to it when they found the time available in their busy, chore-filled days. Others preferred this method because they could re-read information whenever they felt it was necessary, and share written information with friends and family. The majority of mothers preferred to attend face to face meetings with those offering advice:

*But it’s important that [the person delivering the advice] listens to me about my problems, just me you know, because my problem is different to your problem. Each one [of us] would like to ask different things.* 2(2)

Another mother preferred this as she could not read, others thought face-to-face group meetings would provide a chance to meet other parents and normalise the feelings and challenges they were experiencing, thus providing a coping strategy:

*I would like to sit together […] I’m new here […] I think others know each other but not me, so it would be good to meet with others. […] even to know others are having similar hard times, that it’s just not me.* 1(1)

Clearly there are severe constraints on delivery of parenting information in this complex setting. The project manager of an NGO placed emphasis on the importance of flexibility of delivery of any parenting programme to ensure successful reach to as many parents as possible.
Some projects arrive from well-wishers and donors, who want to do extravagant things, good things, but they simply won’t work, even if we had all the money in the world. But what we spoke about [providing parenting information to families] and how you sat with the mothers, you asked her what she wanted, yes this is it. A big important idea, but carried out simply on the ground here. (Project manager of NGO)

Flexibility in programme delivery emerged as important in not only allowing for adapting delivery when necessary, but to also accommodate other concerns that parents might experience, affecting their care for their children. One such concern that appeared was the emotional strain parents themselves were feeling and how this could affect how they supported their children. Several mothers spoke of how they too wanted advice on how they could help themselves manage their own fears and bad memories. One mother described the effect she believed her own feelings were having on her parenting technique:

*I’m not able to cheer him [son] up or lift his spirits, I don’t know how. I’m angry and hurt myself and when I see him like that I get angry and do stupid things.* 1(3)

Sub-theme: The value of discussing parenting issues

Parents described how receiving parenting advice from someone they viewed as a professional, such as a camp doctor, had been a positive, uplifting experience. Mothers spoke commonly of the low self-efficacy they felt in being capable of meeting their children’s new needs and their frustration at not being able to control their circumstances to change this for the better. Their interactions with professionals provided them with opportunities to improve their confidence with demonstrable effects on behaviour.

*I learnt something new, I did something for my kids. I sat with a professional and I had a meeting, he [refugee camp doctor] spoke to me like a real person not just a refugee mum […] I felt that I could do it. I felt like I’m going to do something.* 2(1)

The positive feelings parents reported experiencing, when discussing parenting issues with professionals, also seemed to extend to mothers simply taking part in the research. Being given an opportunity to discuss their parenting challenges apparently created positive effects. Parents described feeling ‘stalled’ in their parenting techniques and not being able to adjust to new parenting challenges required of them. Through taking part in the research they described feeling motivated to make more effort in meeting their children’s new emotional and behavioural needs.
Talking now and listening to myself I have so many things I want to change. I feel almost ready to change. Even just by myself. Others don’t know things are bad maybe and won’t feel like they could help. 2(4)

This mother highlights the importance of being given a chance to pause and think of her family’s needs. Very often in such challenging circumstances parents were not able to prioritise time to do this or reflect on what they could do to benefit themselves and families.

Another mother described how, in addition to frequent discussions with other parents about parenting issues and challenges, having the systematic, structured discussion facilitated by the researcher’s questions was very beneficial in motivating and making her feel more confident in her abilities to meet her family’s needs. A further reported positive effect of talking to the researcher was that the chance to discuss their parenting issues allowed them to reflect on how they had previously successfully met their family’s needs and the positive feeling associated with this. This allowed parents to regain confidence that they would be able to meet their current parenting challenges successfully. The following quote describes one mother’s emotional challenges and the significant positive shift she felt in herself after taking part in the research and observing “normality”:

Now I’m talking to you I’m thinking actually I do parent ok like you, and I think I’m ok, but the more I’ve watched you these last three days the more I have had a chance to remember what it’s like to be a normal mother and have a normal daughter. And the more I’m feeling like we will get better together.

I: You’re smiling as you say that, so was [the interview] a positive thing for you?

Definitely, just having a chance to think about how I am as a mother and remember how I was before, has made me feel better already and I found myself doing old habits with [daughter].1(4)

Sub-theme: Barriers to accessing support

Though many parents reported wanting advice on how to deal with their children’s emotional and behavioural problems, many perceived barriers stopped them seeking support. One mother described how previous negative experiences, involving aid workers visiting their refugee areas to deliver advice on various topics, had left them with little confidence that those who were trying to help them would be able to. One mother elaborated:
The problem is the experience we have had with them [people who come to give advice], they either come without a proper translator or they come and they just do men’s meeting which of course we are not part of. So nothing ever reaches us from what the talk was about. FG(1)

Such negative experiences of limited involvement or not being well prepared to meet community needs, had left others assuming that their parenting needs would not be met if they were to seek support externally. This had left some mothers feeling that while fellow mothers, like them, understood how they were struggling to cope with their children, support from professionals who might lack real understanding of what parents were experiencing and needed was the only alternative available.

In addition, parents also reported physical barriers due to the harsh nature of refugee life and its physical surroundings, hindering their ability to receive the advice they needed. One barrier was the practical difficulty of leaving their children to go and seek support, as their surroundings were too unsafe for their children to be left alone. Parents perceived the physical dangers of their refugee life so great that even when they had extended family or friends close to them they often still did not trust leaving their children out of their sight.

If I wasn’t so worried about what dangers my kids were in or what they would be getting up to in that hour, I would be there of course, but I think in that hour it is much better for me to just sit and gather my kids away from trouble and possible problems, like getting hurt or dirty. You can’t just leave them and go. FG(1)

Another concern was that they thought accessing such support might be expensive. This was very significant for families as many did not have an income or were living on their personal savings or humanitarian funds.

Parents also reported that the tough nature of refugee camp life produced many time consuming chores such as gathering water and hand washing clothes. Parents stated that these jobs left them with little time to do much else. They found themselves prioritising where and how to spend their time and this was rarely on accessing parenting support.

We are not free at all, we have so much to do. To leave your tent, children, family and all the responsibilities to cross over to the doctor to talk to for an hour, isn’t always an option. FG(1)

Finally, while recognising a significant need, the aid organisation director thought convincing aid organisations to invest, represented a considerable barrier, as they understandably prioritised basic needs such as food and shelter.
Of course there is a need [for parenting advice] but that is my opinion, others [organisations] will say they are not even getting the food they need and you want to tell them how to make them (the children) stop screaming at each other! (Project director of NGO)

Theme 3: Parent coping strategies

Sub-theme: Adaptation to a new norm.

Parents struggled to cope with the physical, emotional and behavioural changes they saw in their children. They were worried, saddened and stressed by not knowing how to help them. One coping strategy parents used was to accept the change in their child.

1(3) Now these things [that the children experienced and saw] kill even an adult, how then do we expect kids to not be affected?

Parents readily, and quite often suggested reasons why their children were acting in new and challenging ways.

1(7) I don’t blame them, they are mostly sad […] Their trust in life was broken, my husband says it’s not our fault, we didn’t do anything wrong. They used to have a good life and now it was dragged away from them and they don’t trust anything good happening *cries*

Parents spoke of great uncertainty for their future and felt that their situation was out of their control. They were coping by resigning themselves to accept that there was not much they could do to change the situation for themselves and children.

1(5) Really, the big difference is now it is wasted, no one listens or cares. Even me really I stopped exhausting myself, I asked myself last week ‘why are you doing this to yourself? They are older now, they are small men, stop hurting yourself by worrying and being stressed about them as really it’s not in my hand. I started to leave them to do what they want more.

This psychological acceptance that the mother describes, refers to a willingness to experience thoughts and feelings which are worrying and frightening without allowing them to determine her actions. Mothers’ parenting strategies changed once they allowed themselves to accept their situation, leading them to experience some psychological relief.

Parents’ acceptance and normalisation of changes in their children in light of what they had experienced was not a passive change. These changes were fuelled with a great deal of sympathy towards their children at what they had experienced, facilitating a change in
perception towards their children. Parents often described modifying their own behaviour with the acceptance they reached of the changes in their children. One mother says:

2(4) S: We are much more understanding,

I: How?

S: They cry a lot, they move slowly, they seem down. Usually I would get frustrated about this but now I know I shouldn’t get too angry as it’s not their fault they have been through pain, a lot of pain.

This change in perception by parents often expressed itself in adaptation in how they parented. They reported pushing themselves, even when they themselves were emotionally exhausted, to be more understanding and patient. 2(1) M: It’s hard for them and we have to be patient.

With so much physical environmental stress from their refugee camp life, in addition to their emotional stresses, it was a significant challenge for mothers to remain patient with their children.

2(4) It’s all about trying to be patient, but this is very hard. They hurt our hearts, we feel sorry for the children. We try our best to be patient. But it isn’t easy.

The most pertinent effect parents reported of this change in their perception, and the new understanding of their children some had tried to embrace, was in their disciplining of them. Participants reported being more forgiving and lenient with their children. They often compared how different their parenting experience was for them now, but also how they had to accept this was the right way to care for their children now.

2(2) A: We push slightly and then leave them slightly, we don’t want to put too much pressure on them

I: What do you mean you push slightly and leave slightly?

A: Like I might not let them out in the morning then later on I’ll say ok go now as I feel sorry for them.

Participants discussed how they would often consciously make an effort to change their viewpoint on their situation to help them deal with challenges within their families. In accepting their situation they allowed themselves to normalise both their situation and
changes in their children. This was not an easy thing for mothers to do, and often what they had to accept as normal was emotionally and practically overwhelming. One mother had fled to Turkey with her children once her husband had been captured by armed forces in Syria, she did not know is he had been killed and was told by many that he was most likely dead. She spoke of pushing herself to normalise her new situation, that is of being a single mother to four young children, in addition to working in a camp bakery to support her children. She says

2(4) You have to make new things ‘normal’ for your family. Social comparison emerged as a salient coping strategy utilised by participants to aid them in this. Parents discussed problems they were having with their children with other parents in the camps. Knowing that those around them were experiencing similar feelings and struggles helped parents to normalise their situation and feel more at ease.

2(4) K: *When I tell you and you tell me we will feel like we are all the same. Not that I am the one who should be feeling sorry for herself.*

Gratitude commonly arose from the social comparisons parents made. Parents reported often thinking of others less fortunate than themselves. Many of the participants often expressed their appreciation for the positive things that they still did have, such as their health, their children and their family.

1(3) *All praise be God, we have each other, we have our health, we are managing.*

Parents compared the condition their children were in physically and emotionally to others who they perceived as more tragically affected by the conflict. They reported this allowed them to feel they were in a fortunate position and to focus on the positive aspects of their situation, despite that which they had been through and were still experiencing.

1(6) *We are lucky, so many are worse than us. We are all together, most that are here are alone without their husband or missing their children,*

Mothers reported that thinking of others less fortunate to them reframed their view of their situation, conceding a positive outlook. This allowed them to normalise and feel better about their situation and also minimise the hardships they were experiencing. 1(7), *we made it here and we are not hurt, others are much worse.*

**Sub-theme: Reaching out for support**

Participants stated that social support provided them with not only the chance to normalise their experiences and feelings, but also to reach out and find solutions for new problems they
were facing. They spent time together, often in between daily tasks, discussing their difficulties both with their children and with other aspects of their life and how they could improve their situation.

A: *We stand with each other, she will tell me an idea and she will tell another one and I’ll think of what to do.*

One mother described that traditionally pre-conflict, Syrian women would rely on the female elders in their family, such as mothers and grandmothers, for parenting advice, but that they felt this traditional support network was no longer effective to meet their new needs. One mother says:

2(2)A: *They [our parents] raised them [their children] in easier circumstances, not like now. They won’t benefit us as much as talking to a friend or neighbour who may have been here a few months more than ourselves.*

Though participants did not necessarily have their more senior female relatives close by to them in the camps, this mother highlighted the great significance they placed on their new neighbours and friends.

There were limits to the significance parents placed on social support though, some parents reported not listening to the advice of other parents around them in the camps, and felt it was not useful. They conveyed feeling that their past traumas and current difficulties needed to be addressed with more professional help and that though they participated in giving and accepting advice, this was not really a sufficient help for them. One participant said:

1(3) *We’re relying on each other but we aren’t getting anything from each other, as we are all the same.*

This mother had been living in a refugee camp for over 6 months unaware of whether her husband was alive or had been killed in Syria. Her four children, all under the age of ten, were displaying severe trauma symptoms. She indicated that though she felt that she needed more professional help for herself and children, she still accepted support from others as this was the only support she has access too.

In addition to receiving advice, mothers were actively seeking out comfort and help from each other. Participants conveyed being very reliant on other adults in the camps and were highly effective at seeking out available sources of assistance. By drawing out support from those around them, mothers found their situation less weighty and frightening. The opportunity of
being listened appeared very significant to these participants and drove the process of reflection.

2(2) M: Generally all we have is each other, we advise each other and we complain and let all our problems out to each other

Though reaching out for support did not necessarily change their situation, but being listened to was highly important. Mothers cherished their new friendships and often bonded with women much older or younger than them. One mother described social support as a significant reciprocal process of emotional support, she says: 2(2) If I get sad you will lift my spirits and I will lift yours

By reaching out they were able not only to acquire support for themselves but also build a bond with another parent. Participants described that these new relationships they had formed may not have been assisting them physically or easing their difficulties, but provided empathy and shared experiences, all of which these participants deemed very important.

Sub-theme: keeping mentally strong using faith

One of the most commonly reported ways parents were dealing with their stressors was using religious coping. Parents readily described their need to remain mentally strong for themselves and their children. They were aware how mentally challenging their struggles were and spoke comfortably about how they tried to keep strong. A commonly identified coping strategy was the use of religion. Parents proudly reported that religion and its associated practices positively influenced their well-being on an individual level and as a parent. With acceptance of their situation and its accompanying difficulties for them and to their children, participants surrendered their sense of control and responsibility to God, noting a sense of relief. One mother says:

2(2) S: I Just sit and read the Quran (holy book), that always soothes me.

They described that by praying they were provided with comfort, believing that God would listen and answer their prayers. Parents reported using faith to cope with moments or times when they felt especially overwhelmed by challenges with their children, or were upset or stressed.

SF: I spend longer in prostration now when I pray and feel so much closer to God, as if he can feel me and hear my prayers.
They reported that during times of difficulty they would turn to their faith which often involved participation in a number of religious activities such as praying or reading the Quran, their holy book. These activities were important facets of participants coping strategies. God played a variety of roles for participants, including providing a sense of meaning, control and understanding. They had an immense trust in God which was contrasted with their distrust in other forms of support, as one mother says: 2(2) SF: What else is going to help us but almighty God?

Participants’ religious practices also provided them with an opportunity to be reminded of their trust in God. They reported that their holy book, the Quran, was a source of guidance on how to react and cope during their difficulties.

1(3) I find myself reading Quran (holy book) and it calms us all and it gives up hope that Allah will not leave us, we will have our relief, if not now in the next life.

In addition, participants’ faith had a direct effect on their parenting. They used their Islamic faith as a productive framework, providing them with a positive motivator to better their situation and the way they cared for their children. They reported a sense of hope and motivation for their situation generally and their children particularly. They described that the trust they placed in God was not a passive trust but one that, according to their faith, was providing them with encouragement to strive to improve all aspects of their situation, including how they cared for their children as the following quote illustrates:

2(4) K: God will protect us, but HE has told us to do all we can to look after ourselves. We do our part and put our trust in God. Fear of what is around us is always what makes us sensible. Not to go out alone, make sure children are with us at all times.

Parents reported their faith as guiding them to view their children as trusts from God, to be cherished and cared for. They found comfort in this and often spoke about this topic with softened voices. They believed that they will be questioned by God on whether they did their best towards their children.

2(4) A: These are our kids, what do we have more precious? Just God protect them and us, these are our trusts from God

This religious belief was noted by a camp doctor as pushing parents to try their best with their children. He says:
Because the parents are strong, yes, they are going through hard times and the children are getting out of control but the parents are doing their best. They feel the responsibility in front of God. These are their kids! Each person is doing their best, whatever best is and how useful it actually is and how good for the child it is, is a different story.

Parents spoke of praying and making supplications to God for both guidance and strength to do the right thing for their children. One mother says:

1(2) pray to Allah to make me do the right thing to help them [our children] now.

Participants’ trust in God extended to the belief that they would be rewarded for the hardships they had experienced and were still facing, which they perceived as allowing them to cope with their difficult circumstances. Participants often stressed the importance of this belief to them as a coping strategy. They reported talking with their partners and children about this trust in God, as the following quote highlights:

1(2) I tell them [the children] Allah will give us relief, we will have our reward, if not now in the next life.

Their religious beliefs allowed them to imagine and actively focus on the future, which they envisioned as being a much better place for them to raise their children. They frequently described their aspirations for the future as centering on their parenting motivations to give their children a better and safer life. They drew strength in viewing their time in the camps as a short period that they would be leaving soon for a much brighter future. Another major desire for all participants was to go back to Syria and rebuild their previous lives.

1(3) But we are ok, thank God, we love each other and we tell each other that we will be able to raise our children in a free Syria. God willing it will all change.

The influence of participants’ religious faith was evident when reflecting on their hopes for the future. Their faith guided them to feel optimistic, and paramount to this was their trust in God to fulfil their dreams.

1(6) When the regime [government] falls will be the best day, we are waiting for that, Allah will reward us soon.

Another participant echoes feeling of hope for the future: 2(4) MU: When we go back, God willing, we will be able to restore how we used to be. I know it. I pray this is just a short period that will pass.
Participants believed God had a plan for them and that by believing in Him and being hopeful their situation would improve. This component of parents coping highlighted participants’ strength, resilience and determination.

**Discussion**

Scant literature describes the parenting needs and challenges faced by refugee families during war and while still in a preresettlement stage. At a time when the role of the parent or primary caregiver is highly significant (Dimitry, 2011; Toll et al., 2011), little is known about how families may best be supported (William, 2010). This study identified three main themes; parenting needs and challenges of Syrian refugee families, their experiences with parenting support and how they were coping in preresettlement contexts. Each theme, along with its sub-themes will be discussed individually.

Theme one identified the three main factors that contributed to the parenting challenges of refugee families. Firstly, environmental stresses such as the perceived chaos of refugee camp life and child safety concerns were a significant challenge to refugee parenting. This finding fits with the ecological model proposed and utilised by Williams (2008) that proposes that environmental factors play a very significant role along all stages of the refugee experience. Our findings add to this by highlighting which specific environmental factors caused the most stress in the preresettlement stage and the effect these have on parenting, such as the use of more physical discipline techniques and impaired familial communication. Previous research has highlighted that basic needs and safety concerns can be more strongly correlated with measures of distress than war related events in refugee populations (Rasmussen et al., 2010). This research goes further by illustrating the major effect daily environmental stresses have on the parenting experience of refugee families.

Secondly, parents were challenged by changes in their children’s behaviour and emotions, which they attributed to the events their children had experienced. While our findings echo previous research that has identified such presentations in children affected by conflict (Dimitry, 2011; Chimienti, Nasr, & Khalifeh, 1989; Thabet & Vostanis, 2004), it demonstrated the impact of such behavioural and emotional changes on the caregivers of these children, identifying the important stressors that further diminish their sense of being a competent parent. This study also identified a downward spiral, with changes in parents’ reactions to their environment and changes in their children’s behaviour and emotions affecting their feelings of competence in parenting and in turn actual parenting behaviour. The children reacted
negatively to their parent’s lack of confidence, so parents’ feelings of competence decreased further, while children’s behavioural problems increased.

Thirdly, similarly to their children, parents experienced stress and emotional challenges which they perceived as negatively affecting how they parented their children. Parents spoke of their experiences of violence and fear and how these memories affected their daily functioning. Overwhelmed with worries and fear for their children’s safety, they lacked confidence that they could care for their children in this new environment. Previous research with refugees in camp settings, has also shown altered parenting care, as parents focus more on physical daily needs (McElroy, Muyinda, Atim, Spittal, & Backman, 2012). However, this current study demonstrates more specifically what these changes are, identifying that parents were adopting the use of negative discipline techniques such as shouting and hitting their children. At a time when it was crucial that children followed their parents’ instructions for their own safety, parents felt they were non-compliant and that physical strategies were necessary.

Research has indicated high levels of child maltreatment evident in refugee populations (Lustig et al., 2004), and this study contributes one reason why this might be occurring. Parenting interventions are effective public health approaches to reduce child maltreatment (Chen, & Chan, 2015), and could be a useful model to adopt in preresettlement contexts.

Theme two identified that displaced parents residing in refugee camps made clear their need for support with emotional and behavioural changes in their children, and with their parenting. They were motivated to understand how best to parent in this context and make active attempts to acquire information, despite very limited resources available. Parents were keen to receive parenting advice and thought this would improve their children’s welfare demonstrates the feasibility and value of exploring the needs of refugees in preresettlement contexts.

Parents represent a critical protective factor in the displaced child’s environment. While recent research (Marwa, 2013; Tol et al., 2013) has highlighted the necessity of parent support for refugee families, this study indicates how much parents appreciate the value of parenting support and that they want to be better informed. A recent systematic review of the mental health of Syrian refugees, emphasises the critical need for culturally appropriate psychosocial and community-based support (Quosh, Eloul, & Ajlani, 2013). Parents and aid workers emphasised parenting information as a major need, indicating that parenting interventions would be well received and appreciated. As the number of people requiring help is so large, providing individual help to families is not possible, yet this study suggests written advice
would be valued, and group settings could be well received if child safety concerns are addressed. Context-sensitive psychosocial interventions focusing on increasing parent competency and addressing parent and child difficulties could prove efficacious (Williams, 2012).

Theme three identified what strategies parents used to cope in preresettlement contexts. To the best of our knowledge, this is the first study to explore coping strategies in Syrian parents living in refugee camps and refugee housing. This is highly important to understand in the relatively recent Syrian crisis, as how parents manage challenges and uncertainties in refugee contexts effects both their own mental health and that of their children (Garbarino, & Kostelny, 1996; Smith, Perrin, Yule, & Rabe-Hesketh, 2001). The three sub-themes of 1) adaptation to a new norm 2) reaching out for support and 3) maintaining mental health using faith, offered a unique insight in better understanding the coping strategies parents use to remain resilient and to care for their children. These sub-themes and actions are consistent with characteristics that have been identified as buffers to the development of psychological disturbance. While this study had not sought to explore connections between different strategies, exploration presented faith as a clear common element between them, often facilitating other coping strategies. For this reason discussions about the influence of faith will be made for all sub-three themes.

The first sub-theme involved the psychological strategies parents engaged in to cognitively reframe their situation. Parents had been through highly challenging and traumatic circumstances prior to reaching the camps. They were very open about the emotional difficulties they faced in trying to accept the new reality of what their life had become. Several mothers were now widows, two had lost children, most had witnessed extreme violence or torture and now they were faced with the difficulties and uncertainty of refugee camp life. Parents described how they had started to accept their situation, this included the changes in themselves, those they experienced with their children, and their environment. They described different psychological ways they reacted before feeling acceptance at their situation, initially feeling overwhelmed, angry and confused as to how to deal with the changes they were facing, to a more positive and hopeful acceptance that they must adapt to meet their new difficulties. This progressive move parents made to acceptance is highly important as PTSD symptom severity has been associated with lower acceptance of emotional experiences after differing traumatic exposure circumstances (Tull, Barrett, McMillan, & Roemer, 2007). An important finding was that as parents started to accept the changes they saw in their children, they began to adapt their parenting techniques to meet their new needs. They described
putting a lot of thought in these changes that resulted in a conscious decision to become more sympathetic and patient with them. Park and colleagues (Park et al., 1996) argue that ‘acceptance coping’ is one of the most relevant coping strategies in relation to trauma recovery. Likewise, Zoellner and Maercker (2006) suggest that the ability to accept situations that cannot be altered is crucial for post traumatic growth. Of course, as this paper highlighted, parents very often react to stress poorly and may use maladaptive parenting techniques such as hitting and shouting.

Another cognitive reframing tool parents were using to cope with current challenges and acceptance was to normalise their situation. They did this by both minimalizing the severity of what they had and were still experiencing, in addition to resigning themselves to whatever the future held. This is consistent with previous studies in which refugees described resigning themselves (Basoglu, Mineka, Paker, Aker, Livanou, & Gok, 1997; Khawaja et al., 2008) to what they were experiencing and felt it was not in their control to change. Normalisation was greatly aided by social comparisons that participants were making, in which they compared themselves with other mothers who were worse off. Research has shown that individuals who engage in downwards comparisons may feel less distressed about themselves (Todd, & Worell, 2000). Participants in this study compared their children with those of others, who were severely injured or had troubling emotional and behavioural difficulties. They recounted stories to each other of such families and children and were quick to follow with saying prayers and thanks to God for not being in such a position.

The second coping strategy identified, which has also been previously shown to be important in dealing with stress and trauma, is that of the use of social dimensions (Faulkman, & Moskowitz, 2004; Gorst-Unsworth, & Goldenberg, 1998). Social coping involves using available external social support networks to access support. With this, mothers in this study were able to enjoy both social and material support. Feelings of belonging were increased and also practical help became available such as support with childcare or chores. This was similar to other findings that showed by accessing such networks, refugee mothers tended to feel less sadness, depression and anxiety and an enhanced belonging to their new community (McMichael, & Manderson, 2004).

Social support also allowed mothers to access help and engage with others in an active and problem solving way rather than respond passively to events. In a meta-analysis investigating the relationship between coping styles and health outcomes, problem-focused strategies were more positively associated with better mental health outcomes (Penny, Tomaka, & Wiebe,
Problem solving was highly important to participants in this study, as they described facing many new, confusing and challenging problems with their children. The connections they made with each other allowed them the space and time to discuss, normalise and think through how best to meet their new challenges.

Social coping also involves individual factors such as social support seeking or the ability to bring in support, as we found prominent in our sample of mothers. Often within war settings, individuals lose significant social networks which may leave them feeling low and even depressed and more likely to develop PTSD (Ozer, Best, Lipsey, & Weiss, 2003). In this study, participants were actively seeking to bolster social networks with new neighbours or other mothers a further distance away in camps. They also made efforts to seek support from teachers and camp workers for advice, though these were often futile. Being able to utilise social support is a very adaptive and important coping strategy as it is widely viewed as a protective factor against the development of psychopathology following trauma (Brewin, Andrews, & Valentin, 2000). However, mothers often wanted more external support than that which they were receiving from each other. One described engaging in social activities, conversations and asking advice from other mothers, but only because this was the only support available to her. She felt that if other, more professional help was available, she expected that she would not rely so much on social support from other mothers.

The third coping strategy was the strength and comfort they found in their faith. Finding strength in religion was based on the positive appraisals mothers made of their circumstances: participants believed they were still alive because God had protected them and their children, and would continue to protect them. This parallels previous research on faith, such as a meta-analysis of 49 studies in which the relationship between religious coping and psychological adjustment to stress was examined (Ano, & Vasconceles, 2005). The results indicated that positive and negative forms of religious coping are related to positive and negative psychological adjustment to stress, respectively. Much literature on coping has focused on the positive impact of faith and spirituality on mental health (e.g Mattis, 2002).

The fact that religious coping primarily involves thoughts of placing one’s trust in God, should not be misunderstood as helplessness, rather as a passive form of empowerment for individuals (Mattis, 2002). Consistent with previous finding with refugees (Brune et al., 2002; Khawaja et al., 2008), participants maintained religious practices to alleviate their stress and felt better by doing so. They engaged in their faith by surrendering themselves to God, undertaking religious activities and asking God for strength and patience.
All participants were of the Islamic faith, a religion in which believers are encouraged to follow the teachings of the Quran, the holy book. As parents described, children have a very elevated position in Islam, and the Quran states that parents will be judged by God on how much effort they placed in caring for their children. Parents’ described this as a motivator to make an effort to spend time with their children and be more patient even when they felt overwhelmed with their own emotions. A camp doctor supported this view, describing parents as doing their best with their children as God had instructed them to. Parents felt a heightened sense of responsibility toward their children which parallels previous work with women after trauma (Srivastava, 2005).

Consistent with previous findings (Brune et al., 2002), refugees described their belief that their fate was in the hands of God and that, by maintaining their faith in him, their situation would improve. Focusing on the future and having wishes and aspirations for what one will go on to achieve, has been reported to help refugees endure severe circumstance (Peisker, & Tilbury, 2003). When explored further, participant goals were almost all to do with having a better future for their children in which they would be safe and have an education. Similar to other findings, participants in this study adopted a positive cognitive style of focusing on the future (Goodman, 2004). This allowed them along with their families collectively to create dreams and wishes and maintain a sense of purpose in life. This collaborative religious coping, in which individuals involve their families and those around them has been found to be a much more positive coping strategy then more individual self-directed coping in which one would rely on themselves to manage a stressor (Salama, Morris, Armistead, Koenig, Demas, Ferdon, & Bachanas, 2013).

As mentioned previously, this study had not sought to explore connections between different strategies but that exploration presented faith as a clear common element between them. Faith, as a combination of both beliefs and the physical practices parents undertook, had a significant effect on their lives which seemed to facilitate their other coping strategies. Thus, though other coping strategies were utilized independently of faith, it was common on deeper examination to find these based on religious beliefs. For example, acceptance as a psychological strategy, was based on participant’s belief that God had a plan for them that they must accept. Social support was also embedded in faith, as participants’ religious beliefs greatly encouraged social cohesion and reciprocal social support, thus by engaging in social support they believed they would be rewarded by God.
Faith gave parents feelings of independence; they didn’t have to rely on other people or organisations, they had felt let down by others, but believed God would always be there for them. Having a religious background and growing up in religious societies, they perceived religious coping as a ‘relatively compelling’ and available resource (Pagament, 1997), which was principal to them and connected with their other coping strategies.

**Strengths and limitations**

The main researcher was of Syrian origin, which provided a number of advantages such as conducting the research in Arabic with the Syrian dialect, having a good understanding of participants’ culture and traditions and being sensitive to their beliefs. Despite both physical and time restraints in accessing camps and meeting with families, much effort was put into carrying out repeat visits and spending time with families outside the research process to get an understanding of their day to day experiences of living in refugee camps and buildings. The qualitative methodology allowed in depth exploration of mothers views and both interviews and focus groups were utilised to enhance rigour, relevance and validity of results. In addition the sample size was similar to that used by other studies with participants in preresettlement context (Khawaja et al., 2008; Pavlish, 2007) and there was variation in factors including mothers’ age, marital status, number of children and length of displacement.

The study has several limitations, as expected when conducting research in conditions such as refugee camps (El-Khani, Fiona, Redmond, & Calam, 2013; Ford, Mills, Zachariah, & Upshur 2009). Several participants originally expressed unease about being audiotaped, an important tool in qualitative narrative research (Wengraf, 2001; Pavlish, 2007). Participant confidentiality was explained to interested parents and all expressed reassurance that they were happy to then be audiotaped. Nevertheless, we cannot be certain parents did not withhold information from the researcher due to being audiotaped. It may not be possible to make generalisations based on this sample, as the contextual nature of narrations are that they reflect an understanding of a certain time, place and circumstances (Pavlish, 2007). However, given that the identified themes, such as the coping strategies identified in this study, reflect those in previous research within other preresettlement contexts (Khawaja et al., 2008; Pavlish, 2007), it seems that the results may be applicable should this study be repeated with a larger sample.

Finally, no measures of participant’s trauma levels and experiences were used, so we cannot differentiate between the challenges, needs and coping strategies experienced by those more traumatised than others.
**Conclusion**

This study identified the parenting challenges of recently displaced families and a willingness and need for refugee parents to be supported in the parenting of their children. Despite the difficulties parents had faced and were still experiencing, they were motivated to better parent their children and were eager for parenting information, but were faced with both physical and psychological barriers. Parents were adopting coping strategies that allowed them to cope with their challenging circumstances. Focusing on the parenting experience, contributes to the aim of better understanding how to reduce children’s psychological trauma. The majority of the research with refugees has focused on their needs during the resettlement period in a new host country, but with many families spending significant amounts of time (sometimes years) in refugee camps, support must be provided early in the refugee journey. Providing parenting interventions for families in refugee camps could offer a way to help parents better support their children and parent them effectively thus reducing the impact of the trauma, their current challenges and those they face in the future. This need must be recognised in policies and practices to protect the mental health of children and families at this prere resettlement stage of their refugee journey.
PAPER 3 – Feasibility Study
Daily bread: A novel vehicle for dissemination and evaluation of psychological “first aid” for families exposed to armed conflict in Syria

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Abstract

Background: The risks to the mental health of children and families exposed to armed conflict in Syria are of such magnitude that research into identifying how best to deliver psychological “first aid” is urgently required. This study tested the feasibility of a novel approach to large-scale distribution of information and data collection.

Methods: Routine daily humanitarian deliveries of bread by a bakery run by Khayr Charity Foundation, a humanitarian assistance arm of NGO Watan, were used to distribute parenting information leaflets and questionnaires to adults looking after children in conflict zones inside Syria. Study materials and a detailed research protocol were emailed to an assigned project worker in Turkey. Leaflets and questionnaires requesting feedback were printed, transported alongside supplies to a bakery in Syria, then packed with flatbreads in transparent bags. Three thousand bread packs were distributed by volunteers, supervised by a field officer, from three distribution points to which questionnaires were returned, then taken to Turkey and despatched to the UK.

Findings: Notwithstanding border delays, 3000 leaflets and questionnaires were successfully distributed over two days. Questionnaire return over five days yielded 1784 responses, a return rate of 59·5%. Overall ratings of the usefulness of the leaflet were 1060(59·5%) “quite a lot” and 339(19·0%) “a great deal”. A multi-stage content analysis process was used to code 400 respondent open text comments. Four main themes emerged; positive comments about the leaflet, suggestions for modifications, descriptions of children’s needs and the value respondents placed on faith.

Interpretation: Findings indicate the willingness of NGO staff and volunteers to assist research, the remarkable willingness of caregivers to respond via questionnaires, and the value of brief advice, despite challenging conditions. It demonstrates the scope for using existing humanitarian supply routes both to distribute information and to receive feedback directly from recipients even in high risk settings.
Background

The Syrian crisis has brought to the forefront the enormous challenges that families face in the context of war and displacement. To date, over seven million people are internally displaced; at least half of those internally and externally displaced are children. In immediate humanitarian crises, the focus is on shelter, food and essential medical care. However, loss and adversity, disruption and adaptation to new environments pose additional significant risks to mental health. Building resilience and optimising mental health is fundamental to longer term adjustment, and reducing emotional suffering and promoting mental health is therefore a major global health challenge.

A systematic review shows that key protective factors for refugee children include settling in a stable context with social support, parental support and family cohesion, perceived support from friends and good experiences in school. A review of preventive interventions for children exposed to armed conflict, including refugees, noted the paucity of high quality research on interventions in these contexts and the need for “psychological first aid” to be embedded into programmes in primary health and education. The scale of the Syrian crisis makes plain the impossibility of providing individual interventions for all families at risk of mental health difficulties. Given the scale of the problem, one priority for delivery of psychosocial interventions in this context is to identify ways of providing information at the population level as part of a public health model, and evaluating these.

Families represent the front line of defence for children’s mental health. Promoting preventive approaches which provide information tailored to the community and context to help families provide warm, supportive parenting is one means of offering a relatively low cost method for strengthening support for children. However, building the evidence base for helpful interventions in highly risky settings requires a feasible means of obtaining data.

Our pilot work on parenting in Turkey and Syria, including focus groups and questionnaires with parents in refugee camps and interviews with NGO staff in the field, revealed that very soon after the immediate extreme stress of displacement,
parents were very keen to access information on how best to parent their children in this new context. They were willing to complete brief questionnaires and to participate in focus groups, where they talked constructively about their needs. Parents made plain their need for information on how best to care for their children in this context. Working with a non-governmental organisation (NGO), Watan, we identified a potential means of rapid distribution of information and data collection. Watan suggested that we could distribute printed material rapidly to very large numbers of identified families in need alongside their routine distribution of bread via their humanitarian assistance charity, Khayr Charity Foundation, and obtain data on parent and carer views through this means. We tested the feasibility of the bread wrapper approach; firstly, to distribute information to families (either internally displaced persons (IDPs) or existing inhabitants) living inside Syria and secondly, to obtain completed questionnaires from families via the same bakery distribution routes. The questionnaires enabled parent feedback on the perceived usefulness of information provided.

**Methods**

Routine daily delivery of bread from a bakery in Syria run by Khayr was used to distribute parenting information leaflets (Appendix G) and questionnaires (H) to parents and other caregivers living with children in a conflict zone in northern Syria close to the Turkish border. At the time, families in the area surrounding the bakery comprised 60% IDPs and 40% existing inhabitants. For many of the IDPs this was often their second and sometimes third relocation point since fleeing their homes. Every individual listed as living within 10 km of the bakery received bread routinely regardless of whether they were an IDP or existing resident. Bread distribution was carried out daily by approximately 200 volunteers using frequently updated lists for streets and blocks of housing which included parent/caregiver status and needs, and thus households with children could be identified, allowing distribution of study materials to appropriate recipients.
A local project worker was identified by Watan to manage the study from Turkey. Study materials which included a very detailed, specific research protocol (Appendix D), a data collection record form (Appendix E), a bakery collection record form (Appendix F), were emailed to the project worker in Turkey, where parenting information leaflets and questionnaires were printed and subsequently transported alongside bakery supplies to the bakery in Syria. A field officer led the study from the bakery inside Syria and co-ordinated volunteers who assisted in packing and distributing materials there. The bakery was 130 km from the Bab al-Hawa Border Crossing, an international border crossing between Syria and Turkey. At the bakery, the field officer completed Bakery Collection Record forms. Questionnaires, numbered and colour coded to enable data tracking across different distribution points, plus pens, were packed inside transparent plastic bags containing the daily provision of flatbreads (Appendix I). Three thousand bags of bread enclosing study materials were distributed to families listed as including an adult caregiver of a child or children from three of the bakery’s surrounding distribution points. These were located within three km of the bakery to the north and east. The field officer and volunteers then supervised the return of questionnaires into boxes at the distribution points and then to the bakery over a period of five days.

Questionnaires were taken back to Turkey over five days where they were photocopied to prevent data loss and despatched ten days later to the UK. Photocopies held in Turkey were destroyed confidentially following receipt of the original questionnaires in the UK. All stages of the study were photographed to verify activity. “WhatsApp”©, which allows photographs to be shared, and, when available, email and “Skype” © were used to monitor the progress of the study (Appendix I). Free text comments written onto questionnaires were translated by the lead author who is bilingual English/Arabic.

Leaflets (Appendix G) comprised two sides of A4 with four sections: 1) what caregivers might be experiencing, 2) what children might be experiencing, 3) how caregivers can help themselves and 4) how caregivers can help their children (including safety,
providing warmth and support, giving praise, spending time together and talking; encouraging play and maintaining routine). Questionnaires covered whether, and how long, families had been displaced, basic demographics, who caregivers talked to about parenting concerns, and then asked specific questions about the leaflet, including an overall rating, and ratings of each of the four sections of the leaflet on a four point scale, ‘not at all’ useful to ‘a great deal’. Space for comments was provided. All materials were translated into Arabic with back translation to ensure fidelity.

Approval was obtained from The University of Manchester’s Research Ethics Committee (Ethical committee reference number 13285) and the protocol was developed with risk assessment and reviewed by Watan and Khayr.

**Results**

Parenting information leaflets and questionnaires were successfully distributed over two days to 3000 parents and caregivers in total, 1500 from the first bread distribution point, (A), 1000 from the second (B) and 500 from the third (C). The field officer and volunteers were able to distribute packs and obtain completed questionnaires with no adverse events. The return rate overall was 1784, 59.5%, comprising 740 (49.3%) for location A, 690 (69%), location B, and 354 (71%) for location C. In addition, four hundred respondents wrote comments on the questionnaire.

Table 1 shows the sample characteristics of the respondents; 1271 (71.3%) were internally displaced and 429 (27.6%) existing residents, (missing data 20 (1.1%).
Table 1

Sample Characteristics of Respondent Comments

<table>
<thead>
<tr>
<th>Sample characteristics</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1307</td>
<td>73.3</td>
</tr>
<tr>
<td>Female</td>
<td>452</td>
<td>25.4</td>
</tr>
<tr>
<td>Missing</td>
<td>24</td>
<td>1.3</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>5</td>
<td>0.3</td>
</tr>
<tr>
<td>1-4</td>
<td>1010</td>
<td>56.6</td>
</tr>
<tr>
<td>5-8</td>
<td>714</td>
<td>40.0</td>
</tr>
<tr>
<td>9-12</td>
<td>32</td>
<td>1.8</td>
</tr>
<tr>
<td>Missing</td>
<td>22</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Internally displaced</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1271</td>
<td>71.3</td>
</tr>
<tr>
<td>No</td>
<td>492</td>
<td>27.6</td>
</tr>
<tr>
<td>Missing</td>
<td>20</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Length of time in current location (for displaced families)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;3 months</td>
<td>373</td>
<td>29.3</td>
</tr>
<tr>
<td>3-6 months</td>
<td>404</td>
<td>31.8</td>
</tr>
<tr>
<td>6-12 months</td>
<td>199</td>
<td>15.7</td>
</tr>
<tr>
<td>&gt;12 months</td>
<td>278</td>
<td>21.9</td>
</tr>
<tr>
<td>Missing</td>
<td>17</td>
<td>1.3</td>
</tr>
</tbody>
</table>

The majority of respondents reported seeking parenting support (1719, 96.4%) (Table 2).

Table 2

Who Caregivers Seek Parenting Support From

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Support sought for parenting issues</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1719</td>
<td>96.4</td>
</tr>
<tr>
<td>No</td>
<td>60</td>
<td>3.4</td>
</tr>
<tr>
<td>Missing</td>
<td>4</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Who caregivers seek parenting support from</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>676</td>
<td>39.3</td>
</tr>
<tr>
<td>Grandparent</td>
<td>331</td>
<td>19.3</td>
</tr>
<tr>
<td>Sibling</td>
<td>441</td>
<td>25.7</td>
</tr>
<tr>
<td>Aunt</td>
<td>210</td>
<td>12.2</td>
</tr>
<tr>
<td>Uncle</td>
<td>150</td>
<td>8.7</td>
</tr>
<tr>
<td>Cousin</td>
<td>160</td>
<td>9.3</td>
</tr>
<tr>
<td>Friend</td>
<td>579</td>
<td>33.7</td>
</tr>
<tr>
<td>Neighbour</td>
<td>373</td>
<td>21.7</td>
</tr>
<tr>
<td>Religious leader</td>
<td>398</td>
<td>23.2</td>
</tr>
<tr>
<td>School teacher</td>
<td>307</td>
<td>17.9</td>
</tr>
<tr>
<td>Charity worker</td>
<td>297</td>
<td>17.3</td>
</tr>
<tr>
<td>Health worker</td>
<td>450</td>
<td>26.2</td>
</tr>
</tbody>
</table>
Overall, the majority of families, both IDPs and existing residents rated the usefulness of the leaflet (Figure 1) as ‘quite a lot’ (IDPs: 774 (60.9%), existing residents, 274 (55.7%)) or ‘a great deal’ (IDPs:262 (20.6%), existing, 75 (15.2%)).

Figure 1. Overall usefulness of leaflet.

T-tests indicated a significant difference on all five usefulness questions between IDPs and existing residents, with IDPs giving higher ratings (Table 3).

Table 3
Means for Usefulness of the Advice on the Leaflet, IDPs and Existing Residents

<table>
<thead>
<tr>
<th></th>
<th>Internally displaced</th>
<th></th>
<th>Existing 492(27.9)</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Overall usefulness</td>
<td>1.99</td>
<td>0.71</td>
<td>1.78</td>
<td>0.81</td>
</tr>
<tr>
<td>What might you be experiencing</td>
<td>2.08</td>
<td>0.76</td>
<td>1.86</td>
<td>0.88</td>
</tr>
<tr>
<td>What can you do to help yourself</td>
<td>1.96</td>
<td>0.81</td>
<td>1.84</td>
<td>0.87</td>
</tr>
<tr>
<td>What might your child be experiencing</td>
<td>2.09</td>
<td>0.77</td>
<td>1.93</td>
<td>0.88</td>
</tr>
<tr>
<td>What can you do to help your child</td>
<td>2.10</td>
<td>0.79</td>
<td>1.95</td>
<td>0.88</td>
</tr>
</tbody>
</table>

Note. *p<0.05, **p<0.01, ***p<0.001.

Scale: 0 (not at all) to 3 (a great deal)
Respondent comments were coded using a multi-stage content analysis process. Four main themes emerged; positive comments about the leaflet, suggestions for modifications, a description of their children’s needs and the value respondents placed on their faith (Table 4). Nineteen comments were coded twice into two separate themes.

The highest numbers of comments were in the positive comment theme. Respondents praised the content of the leaflet for usefulness and clarity. One caregiver wrote “I have been waiting for something useful like this after not finding anyone to answer my questions”. Another wrote “This is great if we follow it accordingly. It has relaxed us and shown us what to do. We can reduce anxiety and fears in our children and make them feel safer”. Messages described increased positivity, motivation and caregiver self-confidence on receiving the leaflet.

Caregivers left comments suggesting what modifications they felt needed making to the leaflet. They suggested they wanted more detailed information on emotional difficulties such as anxiety and dealing with bereavement. One caregiver wrote “I wish there was more attention and details on how to deal with fear; our children are really suffering from this”.

Caregivers described both children’s physical needs (such as clothing, medicine and food) and psychological needs. One caregiver wrote ‘The children are complaining a lot now of physical problems and the main reasons for this is the stress they are facing from how fearful they are during these really challenging times’. High levels of fear, bedwetting and anxiety were the most common psychological needs reported. Finally, caregivers’ comments contained references and supplications to god such as ‘We turn to god for support’. Some comments were only prayers or reference to god while others ended with a religious supplication.
Table 4

*Frequency of Comments Coded in Themes (n=400)*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme 1: Positive comments</td>
<td>289</td>
<td>68.97</td>
</tr>
<tr>
<td>Theme 2: Modifications suggested</td>
<td>67</td>
<td>15.99</td>
</tr>
<tr>
<td>Theme 3: Needs</td>
<td>36</td>
<td>8.59</td>
</tr>
<tr>
<td>Theme 4: Faith</td>
<td>16</td>
<td>3.82</td>
</tr>
<tr>
<td>Excluded</td>
<td>11</td>
<td>2.63</td>
</tr>
</tbody>
</table>

**Discussion**

This study demonstrates the feasibility of a means of both distributing information and receiving responses which fitted readily into existing humanitarian frameworks. The efficiency with which the NGO distributed 3000 leaflets and questionnaires in two days and the very high return rate of 59.5% from families exemplifies the potential that this approach offers for rapid dissemination of information to families and for families to give feedback. To our knowledge this is the first time this approach has been used. We received photographic reports via “WhatsApp”© on the progress of the study from the printing of materials in Turkey, through their wait for several days in the bread supply trucks on the Syrian border, their distribution packed into the supplies of bread for each family, to their return. Via Skype ©, we heard of the cheers of people queuing at the bakery distribution points when parents dropped off completed questionnaires. While we do not have exact data on the literacy rates of families who were involved in the study, we were informed by our field officer that these were high. Often if one member of the family was illiterate there was another member in the family who could read and write. We received a photo of a child completing the questionnaire on behalf of his mother who could not read or write (Appendix I), a valuable observation for planning the framing and presentation of future resources.
We were open minded over how valuable caregivers in this context would find the leaflet, but were pleased to find that 81.5% of IDP caregivers rated its overall usefulness as either ‘quite a lot’ or ‘a great deal’. In addition, of the five items caregivers were asked to rate, three were rated as ‘quite a lot’ or more. These results indicate the potential for brief written material to assist families in better caring for their children in the challenging environment. The comments left by caregivers further supported the usefulness of the leaflet, with 69% of the 400 comments being positive. Several comments expressed thoughts and ideas that were not mentioned in the leaflet such as ‘giving yourself a chance to relax emotionally is very important so that you can take control of your actions and encourage good behaviours in your children’. It is possible that the leaflet may have prompted parents to think and reflect on their parenting and what strategies they could adopt to better care for their children. Similar findings were found in our previous exploratory work with Syrian refugees; simply taking part in conversations about parenting challenges led parents to reflect on how they could improve and adapt the approaches they were using with their children (Paper 2 & 3 of thesis). Parents wrote very useful and detailed comments too on what modifications they felt were necessary to improve the leaflet. Not only is this information very important for future replication and dissemination; it also provided further insight into what key difficulties caregivers were struggling with.

Of paramount concern was the safety of all staff and families. Detailed protocols were designed to cover anticipated risks. Tragically, one bakery we had planned to work with was bombed before the study commenced. The area was deemed too dangerous for UK researchers to travel to, and the study was therefore run remotely by local staff already in place and well versed in management of day-to-day security. We were conscious of the risks posed if materials were not acceptable, and of the security of the data itself. At the NGO’s request, the parenting information leaflets and questionnaires carried no identifying information regarding their source. Returned questionnaires were photocopied as quickly as possible following collection and crossing the border to Turkey and kept separately in case of loss of the original versions during transport to the UK. In presenting the data, actual locations remain confidential. Since this study has been completed, heavy air strikes in the area mean many of the existing families
have now left for Turkey and new families have arrived from other parts of Syria, highlighting the struggle and often constant movement refugees experience in search of safety and the need for support to be accessed wherever they are.

The field officer highlighted to us the significance of the relationship and trust we had built with the NGO Watan and its advantages for the study. We had worked closely with Watan over the past two years on background exploratory research; therefore they trusted our team’s expertise and research motivation and were eager to support this study. Likewise, we trusted their capability to follow our ethical requirements and execute the study professionally. On the ground, the families engaged in the study and returned questionnaires as they were distributed from a source they trusted. With such vast numbers of bread packs being delivered daily, many of those involved in bread distribution were members of the local community who were volunteering their time. We had no indications that families were concerned that their confidentiality would be compromised. These cycles of trust were paramount.

The demonstration, on a large scale, of the feasibility of this effective, family-specific communication and research channel helps to establish a basis for the further development and testing of materials to provide psychological support to families which can act as the base layer of a public health approach in a complex, changing context, where very little psychological assistance is available. Peltonen and Punamaki identify “new generation” preventive interventions which start from recognition of strengths and vulnerabilities of specific groups and work to enhance existing protective mechanisms and elements that promote healing and resilience, attending to culturally salient, appreciated, traditional ways of addressing distress. The development and evaluation of culturally appropriate and evidence-based materials, which can rapidly be made widely available for distribution, is essential.

Testing the effectiveness of materials for use in this context, including both impact on individual families and the transmission of information and sharing of support within wider communities is essential. The methodology we describe provides a means of providing families with very rapid access to information, and researchers with a novel
means of collecting data in the field under difficult conditions. Given the scale of the humanitarian problem, this approach has the capacity to assist many thousands of people.

**Acknowledgements**

This research was supported by a grant awarded by The University of Manchester’s ESRC Transformative Research Prize Committee. We are immensely grateful to Watan and Khayr Charity Foundation, our project worker, our field officer, the bakery workers and all the volunteers for their creativity, assistance, and inspiration, and offer our heartfelt thanks to all the families who returned questionnaires.
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SECTION IV - GENERAL DISCUSSION
Summary and discussion of findings

The studies presented within this thesis have aimed to identify aspects of both the parenting needs of refugee families in preresettlement contexts and the feasibility of meeting such needs. The present project offers a range of empirical accounts, including both qualitative and quantitative studies of parenting needs and experiences. The introductory literature drew on conceptual frameworks offered by ecological models in which each stage of a refugee’s journey carries its own risk and protective factors (Bronfrenbrenner, 1979; Reed, Fazel, Jones, Panter-Brick, & Stein, 2012; Williams, 2010). These models highlight that the quality of the parent-child relationship becomes even more salient as the family experiences conflict and is displaced. Humanitarian agencies and researchers stress the urgent need for family-based mental health care in preresettlement contexts. The systematic literature review (Paper 1), revealed a gap in the research on evidence based parenting interventions utilised in preresettlement contexts. Several factors that may have led to this finding were identified. Firstly, there is a general lack of research in low and middle income countries including those experiencing conflict. Secondly, in post-conflict settings, unsurprisingly, funding is often prioritised for primary needs such as food and shelter, with psychosocial needs being addressed as more secondary. Thirdly, access to conflict and preresettlement areas can be very restricted for practical reasons such as road closures, risk of violence, workplace safety factors and governmental and ethical restrictions, limiting the scope for intervention and evaluation. Fourthly, the methodologies usually employed to conduct good evaluative trials could be unethical and impractical to carry out in the field, such as randomization or wait list assignment. Fifthly, there may be a lack of reporting of existing parenting components in interventions directed to children who have been affected by war. Finally, the role and importance of the family for the mental health, protection, and development of the war affected child, has only gathered significant attention and momentum in the past decade.

In the context of a lack of identified evidence based research on parenting needs and interventions supporting families in preresettlement contexts, a qualitative study were designed to develop and expand the knowledge base describing parenting
preresettlement. The research was conducted with Syrian refugee families, as the Syrian crisis is the biggest refugee crisis of the past decade and researchers and humanitarian agencies have called for cultural and need specific interventions to support this population (IMC & UNICEF, 2013; Quosh, Eloul, & Ajlani, 2013).

The first theme in paper two, revealed that parenting in preresettlement contexts was affected by several significant and context-specific challenges. The first was the environmental challenges of raising children in refugee contexts, such as a lack of routine, fear for their safety and physically dirty surroundings. Another challenge was child specific challenges, such as an increase in negative behaviours and emotions and symptoms of trauma. Also, parent specific challenges which included maladaptive parenting techniques and emotional difficulties. Parents reported the ways in which these challenges impacted on their perceived ability to support their children and how they struggled to support their children’s new needs. Identifying these challenges and incorporating support for them could be significant in providing need-specific parenting interventions.

The second theme in paper two, identified parents’ specific needs and experiences in relation to potential parenting interventions in this context. This identified that despite the highly challenging circumstances that they had experienced and were still living through, parents had a strong desire for parenting advice and they valued discussion about parenting issues. They were actively seeking parenting support but were faced with both physical and perceived barriers to accessing such support, which left them frustrated and unsure of how to deal with their new challenges. They described what they wanted support with and how they felt it was best for them to receive such support.

The last theme in paper two explored the coping strategies parents utilised when caring for their children in preresettlement contexts. Parents were using coping strategies such as acceptance, normalisation and gratitude to adapt to their new environment, in addition to reaching out for support, which helped them to problem solve and gain support. They also described keeping mentally strong using their faith to soothe their pain and to motivate themselves to parent well. The identification of
these themes is significant as they may be translated into strategies to provide appropriate psychosocial interventions in such settings.

The results of this paper identified two key discussion points. The first was the identification that the daily environmental challenges of living in refugee contexts were significantly affecting parents’ ability to care for their children, both physically and psychologically. Though previous research has highlighted that basic needs and safety concerns can be more strongly correlated with measures of distress than war related events in refugee populations (Rasmussen et al., 2010; Miller, & Rasmussen 2010), these findings go further by illustrating the major effect daily environmental stresses have on the parenting experiences of refugee families. Finding ways to address physical problems that are causing distress to parents in camp environments may be an essential starting point for any intervention to support parents in providing the care that their children need. Without the explorations of parents’ struggles and needs, such as those which this study has identified, interventions risk being inapplicable to real life refugee contexts. Also, by addressing daily physical challenges, it may be easier to identify those parents with more significant psychological needs for referral to more specialised therapies. This does not suggest that practical challenges in refugee contexts should be addressed by mental health professionals, but that there is a need for mental health professionals and local services to identify ways of working in partnership to provide a more holistic package of care for families.

The second point for discussion is that this study identified that parents were experiencing major psychological struggles themselves. Parents described feeling they needed help for themselves, to support them with the negative and difficult emotions they were experiencing, which they perceived as a barrier to providing their children with the care they felt they needed. Parenting interventions often focus heavily on training the parent to provide better care for their children, with less attention placed on parents own mental health (Chen, & Chan, 2015). Taking into consideration the results of this study, and that previous studies have identified an association between the levels of caregiver mental health and their children’s mental health (Betancourt et al., 2015), there is an identified need for parenting interventions to include, early on,
significant components which focus on helping parents to cope with their own emotional experience.

In response to the identification that families were eager, very early on in their preresettlement journey, to access support on how best to parent their children, a feasibility study was carried out to test distributing parenting information and feedback questionnaires to families affected by conflict in Syria. Leaflets and questionnaires were successfully distributed and caregivers responded remarkably with a feedback return rate of almost 60%. Also, overall ratings of the usefulness of the leaflet were 59.5% as “quite a lot” and 19.0% as “a great deal”. In addition caregivers also engaged with the feedback questionnaires further, leaving comments in which they stated the usefulness of the leaflets, suggested modifications and described their children’s needs and how they required help for these needs. The findings of this study indicated the willingness of NGO staff and volunteers to assist research, the willingness of caregivers to respond via questionnaires, and the value of brief advice, despite challenging conditions. Also, it demonstrates the scope for using existing humanitarian supply routes both to distribute information and to receive feedback directly from recipients even in high risk settings.

Strengths of the Research
Each paper presents its own discussion on strengths and limitations. However, this section will highlight those that are most likely to influence the strength of the conclusions drawn from the findings outlined above. Firstly, the systematic review conducted in paper one, is notable for its advancement of the literature on parenting in preresettlement contexts. Previous to this study, no systematic reviews have looked at this specific stage in the refugee journey to identify parenting interventions. Thus, it was difficult to draw firm conclusions on the evidence of both the availability and effectiveness of parenting support at this stage. Review conclusions were strengthened with the use of the PRISMA statement, which guided the search, allowing for a coherent, replicable and transparent strategy.

In addition, the systematic review was limited to identification of peer reviewed interventions that had been used with displaced families in post conflict,
preresettlement contexts. Though it is highly likely that this limitation may have resulted in the omission of studies that did have a parenting component but were not displaced, this limitation was a deliberate strategy to explore the specific needs of families that are both at a preresettlement stage after conflict, and displaced. This strategy was theoretically driven by the previously highlighted ecological models (Reed et al., 2012; William, 2010), that depicted that the significance of identifying the needs of refugees at each stage of their journey, included the need to take into account if individuals had been displaced or not.

Paper2, adopted a qualitative approach, which has commonly been recognised as suitable for exploring refugee experiences (Khawaja, White, Schweitzer, & Greenslade, 2008; Nakamanya, Siu, Lassman, Seeley, & Tann, 2014). This approach allowed an in-depth exploration of parent’s views rather than researchers’ preconceptions (Camic, Rhodes, & Yardley, 2003). Several methods were used to enhance rigour and relevance of results, such as combining focus groups and interviews.

Also, interviews and focus groups were carried out by the researcher, who is a native English and Arabic speaker and of Syrian background. Her in-depth understanding of the Syrian culture and language allowed her to be accepted by the refugee communities in which the research was conducted, and reduced the risk of miscommunication (Guerin, Guerin, Diiriye, & Yates, 2004), also giving her a deeper understanding of the participants’ narratives.

Another strength is that the research studies were carried out in collaboration with an NGO working inside Syria and Turkey. This increased the likelihood for future research and implementation. It is generally accepted that it is a major struggle to ensure health care research findings are actually used (Grimshaw, Eccles, Lavis, Hill, & Squire, 2012). Therefore building early collaborations with those who are receiving and using international funding for aid projects and have logistical connections is very valuable. In parallel, to increase the likelihood of future implementation and research with local partners, this research had a major strength in that it involved testing the feasibility of a cost effective approach to delivering information to families. This illustrated to our
partner NGO the further possibility of such research with other humanitarian
distributions chains they may be involved in.

Limitations of the Research
It is important to recognise the limitations of the presented research. Firstly, the
sample size of paper two was modest. This was mainly due to the significant
challenges of data collection in this setting, such as accessing refugee camps and
locating appropriate spaces to conduct the interviews and focus groups. However, the
sample captured variation: mothers varied in age, and numbers and ages of their
children. Also, some mothers were living with their husbands while others were
widows or did not know their husbands’ whereabouts. In addition the levels of trauma
mothers had experienced varied as well as the length of time they had been displaced.

Another limitation to the qualitative study was the absence of fathers in the sample.
This is a common limitation in parenting studies, but proved far more challenging in
refugee camp settings. During the daytime, males were commonly outside the central
refugee camp areas to which the researcher had access, and male dominated areas
were considered unsafe for the female researcher to enter. However, in this context,
mothers undertook the majority of the parenting responsibilities and fathers, when
present, had a much smaller role. Generally, fathers are far less represented in
research than mothers (Phares & Compas, 1992), in addition, it has been noted that in
the world of political violence, the word ‘family’ often refers to the ‘mother’, who
often undertakes most of the parental duties (Cairns & Dawes, 1996). Fathers were
however included in the consultation groups that were carried out in Manchester with
refugee parents, allowing the researcher to gain an insight into father’s experiences in
refugee contexts. Nevertheless, alternative methods, perhaps including male
researchers, should be explored to gather father experiences in real field conditions.

The presented research was carried out with Syrian refugees. Reflecting again on the
previously presented ecological models (Reed et al., 2012; Williams, 2010), refugees
are affected by their culture and beliefs along every stage of resettlement including
pre-flight. Therefore Syrian refugees may be distinctive in their culture and needs,
leading to the results presented in this thesis not being generalizable to all refugees

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that are affected by conflict. These studies can be considered as ground work for understanding refugee family needs in preresettlement.

**Researcher Reflexivity**

This section provides the researcher’s personal reflections and is therefore written in the first person.

Reflexivity is central to qualitative methods because the researcher becomes the main analysis tool within the process. As Charmaz states, the ‘theory depends on the researcher’s view; it does not and cannot stand outside it’ (p. 130, 2006). Given the highly interpretive nature of qualitative analysis and the inevitable influence of the researcher on the analysis, reflexivity is essential throughout to protect against the researcher biasing the interpretations to a point where these lose value.

From very early on I was aware of how, as the main researcher, my previous experiences in the field of parenting research and interventions, in addition to Syrian culture, might influence the research and interpretations made. This research was after all initiated by my desire to understand how Syrian parents affected by the conflict could be supported in caring for their children. Both my parents are originally from Syria, and though I was born and raised in London, I have grown up with a deep connection to my heritage. Watching the news of the humanitarian crisis in Syria unfold led me to questions about how I could utilise my skills as a researcher to try to bring benefit to Syrian families.

The first phase of reflexivity began in the very early stages of the research during which the studies were being prepared. This entailed a lot of self-reflection to identify potential biases. These included my status as being originally from Syria, being a mother to two young children, being trained on a parenting programme, being a humanitarian activist and the fact that I was conducting research for the purpose of obtaining an academic qualification. Once identified, the next stage involved analytical reflection, during which I reflected on the ways the various potential biases I identified could influence not only how I conducted the research, but also how I analysed the data. Once I was mindful of my potential biases, keeping them separate was an active, ongoing process throughout the studies.
In preparation for my field trip to conduct research with refugees in camps, I wondered if parents would view my lack of experience in living through war as making me less able to understand their needs and challenges. I also worried that they would feel this way as I had never lived in Syria but only in the UK. I also examined my previous parent training and reflected on how this would influence both the data collection and analysis of the data. Although I recognised that my training could be very useful in providing knowledge and facilitating the analysis, I also tried to keep mindful of the need to remain open to alternative explanations.

During the interviews and focus groups, my primary role was as a researcher, and allowing myself to connect to participants as a fellow Syrian mother helped with engagement and rapport. My in-depth understanding of the Syrian culture and language allowed me to be accepted by the refugee communities amongst whom the research was conducted, and reduced the risk of miscommunication. Because of the political sensitivity, it was important that I disclosed my personal views on the war and allowed them to understand that, like the majority of the families in refugee camps, I too held an anti-government political stance. Without this declaration of political position, the NGO that facilitated the research informed me, that families might not have opened up or have been willing to talk to me, as those who are not opposed to the government yet are present in refugee settlements are often viewed as governmental spies.

I realised during the study pilot that I was able to connect with the participants as we shared similar beliefs and cultural norms. Therefore, during data collection in Syria and Turkey, I tried to adopt a ‘beginners mind’ so that I would not be in a position of assumed knowledge. I did this by asking participants to clarify, elaborate and give examples during our meetings.

At times during the interviews and focus groups, I would struggle with the stories that the families described, namely those that involved deaths and torture. I had the opportunity to call or email my supervisory team after each meeting to debrief and gain emotional support but I did not feel the need to do this, rather I allowed the time after the meetings with families to reflect and process what I had heard. This often left me with an incredible sense of motivation and strength, because, rather than feeling
sorry for these families as I felt I was expected to, I found myself in awe of how they managed to stay positive and continue functioning in their day to day lives.

During the analysis stage of both papers two and three of this thesis I worked very closely with my supervisory team to ensure that my high involvement and familiarity with the data collection would not bias the results. I used the supervisory team to check my findings and discuss the processes and influences which underpinned my interpretations through the study. Many sessions were spent critically analysing my analysis decisions and recoding until the research team felt the final analysis was a true reflection of the data.

Despite the challenges of this research, the research process has provided many opportunities to develop skills and knowledge which will inform my future research and practice. Reflexivity was beneficial in ensuring a high standard of work, allowing me to stand back and look at the research as a whole. This process has allowed me a greatly increased understanding of the importance of implementing and evaluating novel applications of existing evidence-based approaches within a humanitarian setting. Finally, the research has provided an opportunity to increase my knowledge of the parenting experience and a privileged insight into the challenges and needs of parents and children in this context.

**Impact of research**

The partnership that the research team, led by the main researcher, has built with the NGO Watan, through the journey of the research presented here, has been significant and fruitful. The team have built mutual respect and appreciation for the skills that both sides have brought to this research, acknowledging that one could not have functioned in this research capacity without the other. The NGO has engaged in the research and appreciated the significance of identifying parenting needs before implementing interventions with families. Watan have informed the research team, that since 2013, they have included ‘Working to meet parents’ needs’ as one of their organisational aims. In addition, this aim has been included in an MOU between themselves and an international organisation that provides funds for projects that Watan implements with Syrian refugee children in Turkey. Watan has since approached the research team with the aim of continuing the collaboration, and joint
submissions for funding to trial a parenting programme that has been adapted for Syrian refugee families, using the results of this research, has been made.

The significance of this research, and the results that have been identified, have been recognised both nationally and internationally. In 2014, the research team secured an R2HC fund (£9,980) to develop parenting materials based on the findings from the qualitative studies presented in this thesis. This also allowed for running consultation groups in Manchester with newly arrived Syrian refugee parents, who reviewed the materials and discussed their experiences and opinions on what may be acceptable for families living in Syria and in refugee contexts. Also in 2014, on the basis of the research presented here, the research team secured an ESRC Seed Funding grant (£2,975), to conduct the feasibility research study that is presented in Paper 3. In early 2015, the research team won a Wellcome Trust Institutional Strategic Support Fund for public engagement award (£5000), which enabled the research team to hold an exhibition that opened for the general public in Manchester, to provide a visual and experiential presentation of the work that this thesis has reported. This fund also included the production of a film that depicted the parenting experiences of Syrian families in Syria, their journey to the UK, and their experiences parenting their children in the UK. This public engagement activity allowed academics, professionals and the general public, to come together and discuss the need for more sensitivity and appreciation of the significant needs refugee families have both in prereSETTlement areas, and when they are resettled in the UK, and for the need for interventions for families along their journey to resettlement. Also, an R2HC fund (£10,000), has very recently (August, 2015) been awarded to the research team to carry out a pilot study of an adapted parenting intervention with Syrian refugee families living in Turkey.

In addition, the researcher has been invited to speak internationally about her research in conferences in the USA, Australia and Holland, as well as several UK conferences. She has also been invited to various media presentations such as appearing as a guest on ‘Women’s Hour’ and on BBC Radio 4. These activities have been valuable in drawing attention to the research findings and gaining funding to continue the research.
Recommendations for future research

Besides the recommendations for future research considered in each individual paper, drawing the results together to provide recommendations for how to take this research forward is very important. Firstly, it would be valuable to carry out a large scale investigation of preresettlement parenting needs in the Syrian refugee context. The Syrian refugees’ preresettlement journey is a recent phenomenon, which within the last year has escalated, as more families are crossing into Europe in staggering numbers. Families may be in transit while they stop in various countries, until they reach a final settlement country. Along each stage they will have different needs and face varying risks. Our research has indicated that very soon after the immediate effects of displacement, families are eager to access parenting information. Understanding the needs of these families at every stage of their preresettlement journey will be key to the delivery of stage specific interventions.

Secondly, drawing on the success reported in this thesis in distributing parenting information and receiving feedback questionnaires in conflict zones, via the use of existing humanitarian aid supplies (bread delivery), it would be valuable to explore the use of other humanitarian chain routes. The researcher noted that families in refugee settings routinely receive essential supplies, such as baby milk and nappies, in addition to sanitary products for females. The distribution process of these items could be used to carry out a multi-site, large scale exploration of parenting information delivery. Providing examples of cost-effective ways of reaching families with information in preresettlement contexts may be valuable in encouraging funding organisations and NGO’s to prioritise parenting needs. In addition, exploring models of various cost-effective delivery formats that could be utilised in response to specific local needs and field conditions would be valuable, such as group discussions, written information or multi session interventions.

Thirdly, drawing on the lack of evidence based evaluations of interventions highlighted in this thesis (Paper 1), a large scale RCT of a parenting intervention adapted specifically for Syrian refugees in preresettlement contexts would be very valuable in expanding the knowledge base and informing acceptability and effectiveness of interventions in this context.
Conclusion
The aim of the work presented in this thesis was to explore the needs of preresettlement Syrian refugees living in refugee contexts and the feasibility to meet these needs. An initial systematic review established a paucity of evaluations of evidence-based interventions at this stage of the refugee journey. A qualitative study with displaced parents in refugee camps and settings revealed that parents were faced with environmental, child specific, and parent specific challenges that resulted in them struggling to care for their children. However, despite the difficulties parents had faced and were still experiencing, they were motivated to better parent their children and were eager for parenting information, but were faced with both physical and psychological barriers. The methodology employed in this study has the potential to be used in other preresettlement contexts for guiding implementation work. A feasibility study revealed it was possible to reach large numbers of families inside a conflict zone and receive feedback questionnaires, illustrating that families are eager, very early on, to engage in parenting support. Finally, this research has identified a willingness and need for refugee parents to be supported in the parenting of their children, and a lack of access to such support. This need must be recognised in policies and practices to protect the mental health of children and families at this preresettlement stage of their refugee journey. Policymakers can do much to prevent long term psychological difficulties and distress if they can take action to prepare and respond, informed by the latest evidence and corresponding theory.
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APPENDIX A

PARTICIPANT INFORMATION SHEET (ENGLISH VERSION)
AN EXPLORATION OF PARENTING NEEDS IN WAR AND REFUGEE SITUATIONS

Participant Information Sheet

You are invited to take part in a research study which aims to explore the parenting needs of mothers and fathers during war situations and refugee situations. This study is part of a PhD in Psychology at the University of Manchester in the United Kingdom. Please read the following information before you decide if you would like to take part in this study. Thank you for reading this.

Who will conduct the research?

The research will be conducted by Aala El-Khani a PhD student at the University of Manchester who will be visiting your camps. This researcher is not a medical provider and cannot provide any help, advice or services but is keen to hear your views of your parenting needs during war.

Title of the Research

An exploration of parenting needs in war and refugee situations

What is the aim of the research?

This study wants to find out what parents find challenging with regard to parenting their children at the time of war and when they have been displaced from their homes, and what has helped. This study aims to identify how parents may be assisted in parenting effectively in difficult circumstances. It also wants to find out what ways parents believe they can best access help during these times.

Why have I been chosen?

You have been chosen because you are a parent of a child aged between 4-10 years old.

What would I be asked to do if I took part?

If you agree to take part, you will be invited to take part in an interview with the researcher in one of the educational tents in your camp or camp school. The interview will last approximately 40-50 minutes.

What happens to the data collected?

The data collected will be analysed and then stored safely for a period of 4 years.

How is confidentiality maintained?

The information that you provide will not be shared with anyone outside the research team. Your interview will be identified with a number rather than with your actual
name. If you accept to take part in an interview, what you say will be audio-recorded. However, your name and any other personal information will not be included in transcriptions. All paper and digital data will be stored securely in University premises. At the end of the study, the information will be anonymised and audio records will be deleted once they have been transcribed.

What happens if I do not want to take part or if I change my mind?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to provide verbal consent. If you decide to take part you are still free to withdraw at any time during the interview without giving a reason and without detriment to yourself.

What is the duration of the research?

The interview will last approximately 40-50 minutes.

Where will the research be conducted?

The research will take place in one of the educational tents in your camp at a time appropriate for you.

Will the outcomes of the research be published?

Yes. They will be published in journal articles and in conference presentations.

Contact for further information

Please approach the researcher (who gave you this information sheet) tomorrow, who will be in the same place you met her today.
AN EXPLORATION OF PARENTING NEEDS IN WAR AND REFUGEE SITUATIONS

CONSENT FORM

I will read the following consent form to you, if you agree to each statement I say please say Yes, or No if you do not.

1. I confirm that I have read/had read to me, the Information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily

2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason

3. I understand that the researcher is not a therapist and will not be able to provide me with any help after the study is complete

4. I understand that the interviews will be audio recorded

5. I agree to the use of anonymous quotes

6. I agree to take part in this project

__________________________________________  ____________________________
Name of participant                                              Date

__________________________________________  ____________________________
Name of person taking consent                                         Date and                     Signature
APPENDIX C

INTERVIEW SCHEDULE (ENGLISH VERSION)
Interview and focus group outline of questions

What was your biggest challenge in parenting your child during the war?
What made it difficult to parent during the war?
What would you have liked help with at the time of war with regard to parenting your child/children?
Has the way you parent since the beginning of war until now changes?
If so, how?
Now that you are in this refugee camp, what is your experience of parenting your child?
What has made it harder/easier?
How do you feel you are coping?
What do you do when you are feeling worried/stressed/upset about your child?
Would you like any help with parenting your child now?
If yes, what would you like help with now with regard to parenting your child as a refugee?
What kind of help regarding parenting your child could you have been realistically provided to you at that time you were in Syria?
What kind of help regarding parenting your child do you think you can be realistically provided to you now?
During the time when you were in Syria how did you find out about what was happening outside?
Now you are here, how do you access information about what is happening outside?
How often do you hear this/see this?
APPENDIX D

DATA COLLECTION PROTOCOL
DATA COLLECTION PROTOCOL

AT THE OFFICE – BEFORE DISTRIBUTION TO BAKERIES

1. PRINT THE LEAFLETS AND QUESTIONNAIRES AND RECORD FORMS

Every family will be given two documents with their bread by staff at the bakeries:

1) A caregiver information leaflet titled:

“Information for adults looking after a child or children through conflict and displacement”

2) A questionnaire

Print or photocopy the number of parenting information leaflets and questionnaires required for each bakery.

Print both documents double-sided (i.e., back-to-back) on A4 paper so that each document comprises only 1 A4 page. Print on different coloured paper for each bakery as follows:

Bakery 1: Blue paper
Bakery 2: Pink paper
Bakery 3: Yellow paper

Also print 1 copy of the provided Data Collection Record Form and 1 copy for each bakery of the Bakery Record Form. Print these documents double-sided on A4 paper and print the Bakery Record Forms on coloured paper as described above.

2. ADD IDENTIFICATION NUMBERS TO THE QUESTIONNAIRES

After the questionnaires have been printed, write identification (ID) numbers on them using the instructions below.

In the top right hand corner of the questionnaire is a series of boxes where the participant identification number should be written as shown below.

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<th>Participant ID:</th>
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The first digit of each ID number represents the bakery where the questionnaire will be distributed from.
For questionnaires being distributed from Bakery 1, place a 1 in the first box.

| Participant ID: | 1   |   |   |

For questionnaires being distributed from Bakery 2, place a 2 in the first box.

| Participant ID: | 2   |   |   |

For questionnaires being distributed from Bakery 3, place a 3 in the first box.

| Participant ID: | 3   |   |   |

Individual ID numbers should be written after the first digit (i.e., after the bakery number), starting with 001 and continuing up until the number of families that the questionnaires will be delivered to.

For example, for Bakery 1:

| Participant ID: | 1   | 0 | 0 | 1 |
| Participant ID: | 1   | 0 | 0 | 2 |

For example, for Bakery 2:

| Participant ID: | 2   | 0 | 0 | 1 |
| Participant ID: | 2   | 0 | 0 | 2 |

For example, for Bakery 3:

| Participant ID: | 3   | 0 | 0 | 1 |
| Participant ID: | 3   | 0 | 0 | 2 |

3. STAPLE THE LEAFLETS AND QUESTIONNAIRES TOGETHER

After ID numbers have been added to all the questionnaires, staple the parenting information leaflets to the questionnaires making sure that the parenting information leaflets are on top of the questionnaires.

4. PUT THE LEAFLETS AND QUESTIONNAIRES INTO BATCHES

Put the leaflets and questionnaires for each bakery into batches of 50 and place an elastic band around each batch. Ensure that all leaflets and questionnaires for Bakery 1 are batched together, that all questionnaires and leaflets for Bakery 2 are batched together and so on.
5. PUT THE LEAFLETS AND QUESTIONNAIRES INTO BOXES

Place the batches of leaflets and questionnaires into boxes. As this is being done, count how many have been put in each box. On each box, write in large letters the number and location of the bakery where they are going to be transported to and the number of leaflets and questionnaires that are inside the box.

6. RECORD THE NUMBER OF LEAFLETS AND QUESTIONNAIRES IN THE BOXES

Record on the Data Collection Record Form, separately for each bakery, the number of leaflets and questionnaires that are in the boxes.

7. RECORD THE NUMBER OF BOXES TO BE SENT TO EACH BAKERY

Record on the Data Collection Record Form, separately for each bakery, the number of boxes of leaflets and questionnaires that will be sent to each bakery.

8. PLACE A BAKERY RECORD FORM ON THE TOP OF THE LEAFLETS AND QUESTIONNAIRES IN AT LEAST ONE BOX FOR EACH BAKERY

Write the number of leaflets and questionnaires that each bakery is being provided with, the number of boxes that the leaflets and questionnaires have been put in and place the form in at least one of the boxes for each bakery so that each bakery will have their own form to use.

9. SEAL THE BOXES

Check that the number of leaflets and questionnaires in each box has been counted, the number of leaflets and questionnaires has been written on the boxes and that the correct bakery number has been written on the boxes and that in at least one of the boxes for each bakery a Bakery Record Form has been included. Also check that on the Bakery Record Form the number of leaflets and questionnaires and boxes for the bakeries has been recorded. Then seal the boxes and place somewhere ready for collection and transportation to the bakeries.

10. RECORD THE DATE THE LEAFLETS AND QUESTIONNAIRES ARE COLLECTED FROM THE OFFICE FOR TRANSPORTATION TO THE BAKERIES

Record on the Data Collection Record Form, and separately for each bakery, the date that the leaflets and questionnaires were collected for transportation to the bakeries.

11. RECORD THE DATE THE LEAFLETS AND QUESTIONNAIRES WERE DELIVERED TO THE BAKERIES

Record on the provided Data Collection Form, and separately for each bakery, the date the boxes of leaflets and questionnaires were delivered to the bakeries.
WHAT SHOULD BE DISTRIBUTED TO EACH FAMILY WITH THEIR BREAD?

Inside the boxes transported from the office in Hatay to the bakery is a *Bakery Record Form* and leaflets and questionnaires (printed on coloured paper) that are to be distributed to each family that collects their bread supply from the bakery. Each family should be given the following.

1) A caregiver information leaflet (1 page)
   The title of the leaflet is:
   “Information for adults looking after a child or children through conflict and displacement”

2) A questionnaire (1 page).

The leaflet and questionnaires have been stapled together with the leaflet on top.

WHAT ARE FAMILIES TOLD IN THE LEAFLET AND QUESTIONNAIRE?

The leaflet is for families to keep as it provides adult caregivers information on ways to support their children they are caring for during conflict and displacement.

The questionnaire asks caregivers of children to provide basic information about themselves and about how useful they have found the information in the leaflet.

Caregivers are given the option to complete and return the questionnaire. Please note that caregivers do not have to complete and return the questionnaires. It is up to caregivers to decide whether or not they would like to complete and return the questionnaires. Caregivers will be asked to return the questionnaires to the bakery.

The questionnaire provides the following instructions to parents.

“Hello, we are a group of researchers in the United Kingdom wanting to understand how to help Syrian people who are looking after children. We are interested in knowing whether it is possible to use bread wrappers to send information to children’s caregivers. We would also like to know if you think the information we have given you is useful.

It is entirely up to you whether you wish to complete this form. The important thing is that we need the form to be filled in by an adult who is looking after a child or children.

If you are willing to fill in the questionnaire please return it to the place where you collected your bread from. You do not have to complete this form, so please be assured that if you do not want to return it, this will not affect whether you receive bread or any other supplies now or in the future.

We are not asking for your name or any other details that could identify you or your family personally and we will not contact you in any way. The information we collect about you and
your family will be stored confidentially through encryption – this means that only members of the research team will have access to the information.”

INSTRUCTIONS ON WHAT TO DO

1. RECORD THE NUMBER OF BOXES OF LEAFLETS AND QUESTIONNAIRES DELIVERED TO THE BAKERY USING THE BAKERY RECORD FORM

Record the number of boxes of leaflets and questionnaires delivered to the bakery on the Bakery Record Form which can be found on top of the leaflets and questionnaires in one of the boxes.

KEEP THE BOXES TO USE THEM TO RETURN CAREGIVERS’ COMPLETED QUESTIONNAIRES BACK TO THE OFFICE IN.

2. PREPARE THE LEAFLETS AND QUESTIONNAIRES FOR DISTRIBUTION

If bread is usually distributed from the bakery wrapped in paper, place one set of papers (i.e., 1 leaflet and 1 questionnaire) inside the wrapper of each portion of bread before it is distributed to each family.

If the bread is not usually wrapped in paper, make space in the bakery to put the papers at the counter in a place where it is easy to reach them so that when the bread is handed out to families one set of papers can be handed to each family at the same time.

3. DISTRIBUTE THE LEAFLETS AND QUESTIONNAIRES TO FAMILIES WITH THEIR PORTION OF BREAD

Distribute the leaflets and questionnaires to families either by handing them to families if they are not wrapped inside paper with the bread or by simply handing the bread to families as usual if they have been wrapped inside bread wrappers.

4. RECORD THE DATE(S) THE LEAFLETS AND QUESTIONNAIRES WERE DISTRIBUTED

Record on the Bakery Record Form the date(s) the leaflets and questionnaires were distributed.

5. RECORD THE NUMBER OF LEAFLETS AND QUESTIONNAIRES THAT WERE DISTRIBUTED

Record on the Bakery Record Form the number leaflets and questionnaires that were distributed or if it’s easier the number of leaflets and questionnaires that are remaining (i.e. that weren’t distributed).

6. COLLECT THE QUESTIONNAIRES CAREGIVERS HAVE COMPLETED AND RETURNED
Collect the questionnaires that caregivers return to the bakery and place them face down in the boxes in which they were delivered.

7. COUNT AND RECORD THE NUMBER OF QUESTIONNAIRES CAREGIVERS HAVE COMPLETED AND RETURNED

Before the questionnaires are collected from the bakery and transported back to the office in Hatay, count the number of questionnaires that caregivers have completed and returned and record this number on the Bakery Record Form.

8. COUNT AND RECORD THE NUMBER OF BOXES OF QUESTIONNAIRES BEING SENT BACK TO THE OFFICE IN HATAY

Count the number of boxes of questionnaires to be collected and transported back to the office in Hatay and record this number on the Bakery Record Form.

9. RECORD THE DATE THE BOXES OF QUESTIONNAIRES ARE COLLECTED AND TRANSPORTED BACK TO THE OFFICE IN HATAY

Record on the Bakery Record Form the date the boxes of questionnaires are collected and transported back to the office in Hatay.

10. PLACE THE BAKERY RECORD FORM IN ONE BOX AND SEAL ALL BOXES

Place the Bakery Record Form on top of the completed questionnaires in one of the boxes being collected and then seal all boxes and place ready for collection.
1. COUNT THE QUESTIONNAIRES

Take the questionnaires out of the boxes returned to the office from the bakeries.

Inside one of the boxes returned from each of the bakeries should be the Bakery Record Form which will have on it the number of completed questionnaires returned by caregivers to the bakeries. Update the Data Collection Record Form with the information that has been provided on the Bakery Record Forms by staff at the bakeries if this has not already been updated through communicating with the bakeries whilst the leaflets and questionnaires were distributed).

Recount the number of completed questionnaires returned from each bakery and write the number on the Bakery Record Form and Data Collection Record Form.

2. PUT THE QUESTIONNAIRES IN BATCHES

Put the questionnaires in batches of 50 (or less if fewer than 50 are received) and place an elastic band around each batch. Make sure that questionnaires from Bakery 1 are batched together; questionnaires from Bakery 2 are batched together and so on.

3. PUT THE QUESTIONNAIRES IN ENVELOPES OR A BOX

Depending on the number of questionnaires returned by caregivers, place the questionnaires in envelopes or a box and place with them the Bakery Record Forms and Data Collection Form. A photocopy of these forms can be retained in the office for records.

4. SEND THE QUESTIONNAIRES TO THE UK

Send the questionnaires back to the UK using DHL and the address provided below.

Professor Rachel Calam  
School of Psychological Sciences  
Second Floor, Zochonis Building  
Brunswick Street  
Manchester  
M13 9PT  
UNITED KINGDOM

Email Aala El-Khani (Aala.El-khani@postgrad.manchester.ac.uk), Kim Cartwright (Kim.Cartwright@manchester.ac.uk), or Rachel Calam (Rachel.Calam@manchester.ac.uk) with the tracking number.

On the day that the questionnaires are collected by DHL and before sealing the envelopes or box, record on the Data Collection Record Form the date that they are being sent to the UK and the number of envelopes or boxes used to send them and make sure the Data Collection Form is put in the envelope(s) or box before being sealed and collected.
APPENDIX E

DATA COLLECTION RECORD FORM
## DATA COLLECTION RECORD FORM

TO BE KEPT AT THE OFFICE IN HATAY AND SENT BACK WITH QUESTIONNAIRES TO THE UK.

### NUMBER OF LEAFLETS AND QUESTIONNAIRES TO BE DELIVERED TO BAKERIES

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<th>Bakery</th>
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APPENDIX F
BAKERY RECORD FORM
BAKERY RECORD FORM

This section is to be completed by staff at WATAN’s office in Hatay.

NUMBER OF BOXES OF LEAFLETS AND QUESTIONNAIRES BEING TRANSPORTED TO BAKERY (COUNT AT OFFICE BEFORE COLLECTED AND TRANSPORTED TO BAKERY)

NUMBER OF LEAFLETS AND QUESTIONNAIRES BEING TRANSPORTED TO BAKERY (COUNT AT OFFICE BEFORE COLLECTED AND TRANSPORTED TO BAKERY)

DATE BOXES COLLECTED FOR TRANSPORTATION TO BAKERY

This section is to be completed by staff at the bakery.

DATE BOXES DELIVERED TO BAKERY

NUMBER OF BOXES DELIVERED TO BAKERY

NUMBER OF LEAFLETS AND QUESTIONNAIRES INSIDE BOXES DELIVERED TO BAKERY (COUNT AT BAKERY UPON DELIVERY)

DATE(S) LEAFLETS AND QUESTIONNAIRES DISTRIBUTED TO FAMILIES

NUMBER OF LEAFLETS AND QUESTIONNAIRES DISTRIBUTED TO FAMILIES (COUNT AT BAKERY AFTER BEING DISTRIBUTED TO FAMILIES)

OR

NUMBER OF LEAFLETS AND QUESTIONNAIRES REMAINING (I.E., NOT DISTRIBUTED TO FAMILIES)
NUMBER OF QUESTIONNAIRES RETURNED BY CAREGIVERS TO BAKERY *(COUNT AT BAKERY BEFORE BEING PLACED IN BOXES AND COLLECTED FOR RETURN TO OFFICE)*

NUMBER OF BOXES OF QUESTIONNAIRES BEING SENT BACK TO OFFICE

DATE BOXES COLLECTED FROM BAKERY FOR TRANSPORTATION BACK TO OFFICE

This section is to be completed by staff at WATAN's office in Hatay.

DATE BOXES DELIVERED TO OFFICE

NUMBER OF BOXES OF QUESTIONNAIRES RETURNED TO OFFICE *(COUNT AT OFFICE)*

NUMBER OF QUESTIONNAIRES IN BOXES RETURNED TO OFFICE *(COUNT AT OFFICE)*
APPENDIX G

PARENTING LEAFLET
INFORMATION FOR ADULTS LOOKING AFTER A CHILD OR CHILDREN THROUGH CONFLICT AND DISPLACEMENT

ABOUT YOU

What might you be experiencing?

- You may become more irritable than usual and your mood may change back and forth dramatically. You may be especially anxious or nervous or depressed.
- You may have repeated and vivid memories of your experiences. These flashbacks may lead to physical reactions such as rapid heartbeat or sweating.
- You may find it difficult to concentrate or make decisions, or become more easily confused. Your sleep and eating patterns may also be disrupted.

All of these things may affect how you get on with the child or children you are looking after.

What can you do to help yourself?

- Recognise that this is a challenging time but one that you can work to manage. You have tackled other hardships at other times in your life.
- Recognise that you are a unique person. Use the skills and resources that you have.
- Allow yourself and your children to mourn any losses you may have experienced.
- Try to be patient with changes in how you are feeling.
- Try and keep hopeful and a positive outlook. This will help your children have hope for the future.
- Support each other and take help from friends, relatives, community and religious leaders.
- Look after yourself as much as possible and try to rest when you can.
- As much as you can, try to establish or re-establish routines, such as regular bed times.
- Try to keep yourself occupied with regular chores or with work or activities with others around you.
- Maintain any religious activities you do.

ABOUT YOUR CHILD

What might your child be experiencing?

How children react to stressful experiences can vary depending on a variety of things, for example their age, but here are some common ways children react:

- Physical complaints such as headache, stomach ache, fever, cough, lack of appetite.
- Being fearful and anxious.
- Difficulty sleeping, nightmares, night terrors, shouting or screaming.
- Older children may go back to bedwetting, clinging to their parents, frequent crying, thumb-sucking, being afraid to be left alone.
- Becoming unusually active or aggressive or the opposite shy, quiet, withdrawn and sad.
- Difficulty concentrating.

It is important to remember that it is NORMAL for children to show stress reactions or problem behaviours after frightening and distressing experiences.

What can you do to help your child?
SAFETY

- Strive to keep your family together at all times.
- Try hard not to be separated from your children for long periods of time.
- Ensure your children know their name, and where you are staying and how to get help if they are separated from you.
- If you are going to a distribution site either keep your children close by at all times or leave them at home in the care of a responsible and trusted relative or adult.
- If your children do go along with you arrange in advance somewhere you can meet if you become separated. Ensure this is somewhere the child will know and feel comfortable.
- If your child goes out to play tell them to let you know where they are going and when they will be back.

PROVIDING WARMTH AND SUPPORT

- Promise that you will do everything you can to care for and protect them.
- Try to be affectionate with your child by often giving them hugs or holding their hand.
- Try to tell them often that you love them. Being caring and telling your children that you love them will reassure them.

GIVING PRAISE

- Look for opportunities to praise your child when they have done something good, however small it may seem.
- Try to be patient with your child and not to criticise them for changes in their behaviour, such as clinging to you or frequently seeking reassurance.
- Encourage your child to help, and praise and thank them when they do. Children cope better and recover sooner when they help others.

SPENDING TIME TOGETHER AND TALKING

- Pay attention to your child. Spend a few moments with them whenever you can.
- Take time to listen to them and try to understand what they have experienced. Ask how they feel about their experiences and which experiences are most stressful and difficult to adjust to.
- Do not promise your children things you cannot provide.
- Be open and try to give children accurate information about what is happening.

ENCOURAGING PLAY

- Encourage your child to play with you, their siblings or other children. Play is important in helping children work through past and current stress and experiences and to prepare for the future. It helps maintain some normality in their lives.

MAINTAINING A ROUTINE

- Try to maintain everyday routines, such as bedtimes, as much as you can.
- Encourage children to do school work (reading, maths, writing), even if there are no schools.
APPENDIX H

FEEDBACK QUESTIONNAIRE
Hello, we are a group of researchers interested in knowing whether it is possible to use bread wrappers to send information to children’s caregivers. We would also like to know if you think the information we have given you is useful.

It is entirely up to you whether you wish to complete this form. The important thing is that we need the form to be filled in by an adult who is looking after a child or children.

If you are willing to fill in the questionnaire please return it to the place where you collected your bread from. You do not have to complete this form, so please be assured that if you do not want to return it, this will not affect whether you receive bread or any other supplies now or in the future.

We are not asking for your name or any other details that could identify you or your family personally and we will not contact you in any way. The information we collect about you and your family will be stored confidentially through encryption – this means that only members of the research team will have access to the information.

We would like to ask you some questions about you and your family. For each question, please circle one answer e.g., unless other instructions are given.

1. What is your gender? Male Female

2. How many children are you looking after and what are their ages?

Please complete the boxes below with the ages of each of the children.

<table>
<thead>
<tr>
<th>Child 1</th>
<th>Child 2</th>
<th>Child 3</th>
<th>Child 4</th>
<th>Child 5</th>
<th>Child 6</th>
<th>Child 7</th>
<th>Child 8</th>
</tr>
</thead>
</table>

3. Have you been displaced to where you are living now? Yes No

4. How long have you been living where you live now?

<table>
<thead>
<tr>
<th>Less than 3 months</th>
<th>3-6 months</th>
<th>6-12 months</th>
<th>12 months or more</th>
</tr>
</thead>
</table>

5. People looking after children often have concerns. When you are worried about the children you are looking after, who do you talk to? Please circle as many answers as you wish.

<table>
<thead>
<tr>
<th>Parent</th>
<th>Brother or Sister</th>
<th>Grandparent</th>
<th>Aunt/Uncle</th>
</tr>
</thead>
</table>

Participant ID: [Redacted]
We would like to ask you some questions about the leaflet. Please circle ONE answer for each question.

6. Overall, how useful do you think the information in the leaflet is?

<table>
<thead>
<tr>
<th>Not at All</th>
<th>Only little</th>
<th>Quite a lot</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Looking at each section of the leaflet:

7. How useful do you think the information is on “What might you be experiencing?”?

<table>
<thead>
<tr>
<th>Not at All</th>
<th>Only little</th>
<th>Quite a lot</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

8. How useful do you think the information is on “What can you do to help yourself?”?

<table>
<thead>
<tr>
<th>Not at All</th>
<th>Only little</th>
<th>Quite a lot</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

9. How useful do you think the information is on “What might your child be experiencing”?

<table>
<thead>
<tr>
<th>Not at All</th>
<th>Only little</th>
<th>Quite a lot</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

10. How useful do you think the information is on “What can you do to help your child”?

<table>
<thead>
<tr>
<th>Not at All</th>
<th>Only little</th>
<th>Quite a lot</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

11. Do you have any comments about the leaflet?

The leaflet and pencil are for you to keep whether or not you complete the questionnaire.
APPENDIX I

PHOTOGRAPHS OF FEASIBILITY STUDY
The following are a collection of photos sent by our collaborating NGO, verifying the study activities

1- The study materials on the Turkish side of the Turkey-Syria border
2- The study materials inside Syrian
3- The bakery in which the bread wrappers were packed
4- The bread wrappers ready for distribution
5- A father holding a study bread wrapper
6- An illiterate mother is helped by her son to read and fill out the feedback questionnaires