



The relationship between trauma centrality, self-efficacy, posttraumatic stress and psychiatric co-morbidity among Syrian refugees: Is gender a moderator?



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ABSTRACT

This study examined the inter-relationship between trauma centrality, self-efficacy, posttraumatic stress disorder (PTSD) and psychiatric co-morbidity among a group of Syrian refugees living in Turkey, and whether gender would moderate the mediational effect of self-efficacy on the impact of trauma centrality on distress. Seven hundred and ninety-two Syrian refugees completed the Harvard Trauma Questionnaire, General Health Questionnaire-28, Centrality of Event Scale and Generalized Self-Efficacy Scale. The results showed that 52% met the cutoff for PTSD. Trauma centrality was positively correlated with PTSD, psychiatric co-morbidity and self-efficacy. Self-efficacy was negatively correlated with PTSD only. Gender did not moderate the mediational effect of self-efficacy on the path between trauma centrality and distress outcomes. To conclude, following exposure to traumatic events, more than half reported PTSD. Perception of the future and identity construction was affected. Signs of psychological distress were evident, alongside resilience, regardless of gender.

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1. Introduction

This study examined the psychological effects of the Syrian war, a global crisis which has created over 4 million refugees and left 8 million internally displaced (Jefee-Bahloul et al., 2015; Khalil, 2013; Nassan et al., 2015; Refugees, 2015). A prevalence rate of 33.5% has been estimated for posttraumatic stress disorder (PTSD) (Alpak et al., 2015), but risk factors associated with PTSD and psychiatric co-morbidity have been neglected in research despite being an important key for medical professionals and policy makers from international humanitarian organizations when providing psychological intervention.

Trauma centrality and self-efficacy are potential risk factors affecting PTSD. According to the trauma centrality hypothesis (Berntsen and Rubin, 2006a), vivid personal memories validate thoughts and behaviour and act as personal reference points from which meaning is attributed to existing beliefs, feelings, experiences and future expectations. Memories of traumatic events are particularly accessible, forming personal reference points

(Berntsen, 2001; Porter and Birt, 2001; Reviere and Bakeman, 2001; Rubin et al., 2004). The continual media coverage of the ongoing war and their refugee status were constant reminders for these refugees of their war experience, keeping traumatic memories vivid and stimulating reference points. Highly accessible trauma memories lead to overestimation of the frequency of traumatic events, a likelihood of re-traumatization and thereby unnecessary hypervigilance and avoidance behaviour. The link between memories and traumatization echoes further the dual representation model arguing that psychological and physiological states can be affected through accessing trauma material in different memory systems (Brewin et al., 1996).

Traumatic memories consist of highly stressful episodes which can shatter world assumptions (Janoff-Bulman, 1992) leading to oversimplification of life situation, i.e. different aspects of life explained in terms of traumatic experiences and contradictory experiences dismissed (Berntsen and Rubin, 2006a; Linde, 1993; Robinson, 1996). Consequently, outlook on life changes, life course is redirected and turning points become a causal agent in one's life story (Pillemer, 1998, 2003).

Life stories define who we are and how we understand ourselves (Fitzgerald, 1988). When traumatic memories become

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turning points, they affect self-definition and become central components of personal identity and an integral feature of their sense of self, leading to a traumatized self across situations (Berntsen and Rubin, 2006a). This traumatized self is characterized by profound changes and reconfigurations of the inner world (psychological processes, sense of well-being, beliefs and values) (Wilson, 2006). Trauma centrality is interwoven with a traumatized self and, hardly surprisingly, associated with elevated PTSD and psychiatric co-morbidity (Bernard et al., 2015; Berntsen and Rubin, 2006b; Boals and Schuettler, 2011; Brown et al., 2010; Lancaster et al., 2011; Ogle et al., 2014, 2016; Schuettler and Boals, 2011).

Trauma centrality affects self-efficacy. The theory of post-traumatic self suggests that trauma changes the self-structure by reducing the self-regulatory, goal-directing capacity (Wilson, 2006) leading to a feeling of powerlessness (Brewin, 2003) and to social cognitive theory's diminished "agentic" model of adaptation (Bandura, 1997; Benight and Bandura, 2004b). The capacity to adapt to distressing events is reduced, influencing PTSD severity and recovery. In short, trauma reduces self-efficacy (Bandura, 1997; Benight and Bandura, 2004a; Brown et al., 2015; Brown et al., 2016; Brown and Ryan, 2004; Wehmeyer et al., 2009), elevating PTSD and psychiatric co-morbidity. This inverse relationship between trauma and self-efficacy has been demonstrated in literature among victims of different kinds e.g. (Benight et al., 2008; Benight and Harper, 2002; Flatten et al., 2008; Hirschel and Schulenberg, 2009; Hoelterhoff and Chung, 2013; Hyre et al., 2008; Weisenberg et al., 1991).

Self-efficacy, then, acts as a mediator. To social cognitive theorists, this mediational effect is expected since people do not react merely to the effect of the trauma but to continuing adaptational strains caused by the trauma (Benight and Bandura, 2004a). This mediational effect has been supported in literature e.g. (Benight and Bandura, 2004a; Bosmans et al., 2013; Cieslak et al., 2008; Lambert et al., 2013; Luszczynska et al., 2009a; Samuelson et al., 2016; Smith et al., 2015).

This mediating effect of self-efficacy is linked to gender. Women are more likely to construct a negative event as central to their identity with ensuing mental health issues (Boals, 2010). Women coping with trauma reported lower levels of self-efficacy (Solomon et al., 2005). The same finding was established among Chinese adolescents in dealing with stressful life events (MA and Xu, 2006). Women have been found to exhibit reduced resilience, a facet of self-efficacy, as trauma centrality increases (Wolfe and Ray, 2015). In other words, gender can moderate mediational effects.

The theoretical framework amounts to the hypothesized model depicted in Fig. 1 for the current investigation. We hypothesized that 1) a higher level of trauma centrality would be associated with higher levels of PTSD and psychiatric co-morbidity, and 2) a higher level of self-efficacy would be associated with lower levels of distress outcomes, and 3) gender would moderate the mediational effects of self-efficacy on the path between trauma centrality and distress outcomes. To the best of our knowledge, no studies have investigated this model among Syrian refugees.

2. Methods

2.1. Participants

Seven hundred and ninety-two ($F = 417$, $M = 375$) Syrian refugees resettled in Turkey participated in the research. Just over half (51%) were recruited from a camp and the rest from the community. On average, they were 28 years old (mean = 28.27, $SD = 11.77$); most were either married (48%) or single (43%). Four percent had not received education but the majority had completed secondary school education (74%) and the rest a university education. They

had left Syria almost two years ago (mean = 22.64 in months, $SD = 10.11$) and, at the time of the study, had been living in Turkey for approximately 18 months (mean = 18.30 in months, $SD = 8.85$). Two percent escaped to Turkey alone; over half (59%) left with immediate family members.

2.2. Procedure

The staff from a non-profit humanitarian organization situated in a town inside Turkey near the border with Syria took us to an area where refugees had been housed in temporary accommodation. The purpose of the research was explained and upon consent, participants were asked to complete questionnaires (see the measures section). Data were simultaneously collected from a refugee camp nearby. Relief workers distributed questionnaires when providing practical help. The purpose of the research was explained with an information sheet and consent sought. Refugees were informed of the anonymity of information collected and their right to withdraw from the study at any time without giving a reason. Approximately 900 refugees were approached generating a response rate of 88%. The inclusion criteria were: (1) 18+ in age and (2) of Syrian refugee status. All questionnaires were back translated with the help of two Arabic native speakers highly proficient in English, who independently translated the questionnaires, one from English to Arabic and the other from Arabic back to English. They and the first author then compared the back-translated English version with the original and found no discrepancies. Ethical approval for the study was granted by the Ethics Committee at Zayed University in the United Arab Emirates.

2.3. Measures

A demographic page collected information on age, gender, educational level, marital status, time since leaving Syria, duration of stay in Turkey and whether escape to Turkey happened alone or with family members. It also recorded information on the extent of loss on leaving Syria (1 = nothing to 5 = everything), the extent of anger in response to events, feeling a general sense of danger presently and feeling safe in present accommodation (1 = not at all to 8 = extremely).

The Harvard Trauma Questionnaire (Mollica et al., 1992) measures the experience of traumatic events since the war started in Syria. These events included witnessing extremely distressing events (e.g. execution), exposure to combat situations (e.g. explosions), murder, and violent death or kidnapping of family members or friends. Based on the overall experience of events, PTSD symptoms were measured in 16 items (1 = not at all to 4 = all the time) based on the DSM-IV diagnostic criteria. The DSM-5 version was not available at the time of the study. A probable PTSD diagnosis was achieved if refugees reported at least one intrusion, three avoidance and two hypervigilance symptoms. An item was endorsed if the score was ≥ 3 . The summation of the 16 items generated a total score. The α for the total score ranged from 0.87 to 0.90 depending on the sample (Mollica et al., 1992). The current sample produced an excellent Cronbach's α total score of 0.90.

The General Health Questionnaire-28 (Goldberg and Hillier, 1979) estimates the extent to which refugees report psychiatric co-morbidity at interview using the rating scale 1 = better than usual to 4 = much worse than usual. Co-morbidity refers to general psychological symptoms (somatic problems, anxiety, social dysfunction and depression) which are often associated with PTSD symptoms (Keane et al., 2007). Increased total score is indicative of increased global dysfunction. Test-retest reliability coefficients for the total score range from 0.78 to 0.95 (Goldberg and Bridges, 1987). The current sample produced an excellent Cronbach's α

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