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The protective effects of social support and family functioning on parenting stress among Hispanic/Latino/a American immigrant parents with traumatic life experiences: A mediation analysis

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Abstract

Despite high rates of traumatic experiences reported among Hispanic/Latino/a immigrants in the U.S., the effect of post-traumatic stress on parenting stress among Hispanic/Latino/a immigrant parents with young children has been overlooked. The present study tested the direct and indirect relationships of self-reported maternal post-traumatic stress symptoms on parenting stress, and the mediating role of protective factors among Hispanic/Latino/a mothers with young children. Baseline data collected from mothers participating in a community-based child-parent dyadic intervention were analyzed. Measures included the post-traumatic stress disorder (PTSD) Checklist, the Protective Factors Survey, and the Parenting Stress Index-Short Form (PSI). The sample included 80 mothers with a child between ages 0–6 years. About 75% of these mothers were migrants from Central America. A multivariate regression analysis showed that maternal post-traumatic stress symptoms predicted higher levels of PSI, and two protective factors (social support and family functioning/resilience) fully mediated the relationship between maternal post-traumatic stress symptoms and PSI. Higher social support and family functioning/resiliency may have protective effects on Hispanic/Latino/a mothers with post-traumatic stress, leading to lower levels of stress related to parenting. Findings underscore the importance of interventions that enhance access to social support and promote family functioning/resilience for Hispanic/Latino/a immigrant mothers with trauma histories to cope better with parenting stress.

Keywords

family functioning; Hispanic/Latino/a immigrant parents; parenting stress; post-traumatic stress; social support; trauma

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CONFLICT OF INTEREST STATEMENT

Mihoko Maru, Ruth Paris, and Meital Simhi declare that they have no conflict of interest.

1 | INTRODUCTION

Parenting stress is a negative emotional response arising from attempts to adjust to the requirements and expectations of parenthood (Deater-Deckard, 2004). Child developmental models offer that parenting stress is a function of child and parent characteristics (e.g., temperament), challenges of being a parent, and interactions between the parent and the child (Abidin, 1995). High levels of parenting stress have been associated with negative outcomes in parent-child relationships among parents with young children, including harsh parenting and dysfunctional parent-child relationships (Chung et al., 2020; Moe et al., 2018). Parenting stress, if unaddressed, potentially has devastating consequences for child development including adverse neurodevelopment, less favorable physical health, increased risk of behavioral, emotional, and cognitive problems, and attention disorders (Barroso et al., 2016; Glover, 2014; Kleinhaus et al., 2013; Thakar et al., 2013).

A small number of studies, drawn predominantly from Caucasian samples, have identified parental trauma history as a predictor of parenting stress among parents of infants and young children (Ammerman et al., 2013; Chemtob et al., 2013; Moe et al., 2018; Sprang et al., 2013). Parental trauma exposure can lead to poor parental mental health including depression, anxiety, and post-traumatic stress disorder (PTSD) (Christie et al., 2019; Ornelas & Perreira, 2011; Perreira & Ornelas, 2013; Valdez et al., 2015) which can further impact parental functioning, including parenting stress (Ammerman et al., 2013). Maternal trauma exposure is also associated with compromised maternal-infant attachment, and negative parenting attitudes, such as perceiving the child to be difficult to manage, and higher risk for dysfunctional parent-child relationships (Enlow et al., 2014; Sprang et al., 2013; van Ee et al., 2012).

Given that communities of color, including Hispanic/Latino/a immigrants, experience high trauma exposure (Perreira & Ornelas, 2013), they are put at risk for poor mental health and psychological distress (e.g., Sangalang et al., 2019). Many of these immigrants are also parents and thus, the intergenerational effects of trauma on parenting stress are highly concerning for this population (Fortuna et al., 2019). Similar to what has been found in Caucasian samples, parenting stress among Hispanic/Latino/a mothers with young children have been linked to harsh parenting (Mortensen & Barnett, 2015) and poor infant development due to maternal depression (Huang et al., 2014).

The lack of access to culturally competent early childhood programs and child welfare services for Hispanic/Latino/a families with young children (e.g., Child Welfare Information Gateway, 2016; Smith, 2020) have prevented Hispanic/Latino/a immigrant families from receiving adequate support, underscoring the need for more empirical research. To that end, further examination of familial factors such as social support, parent-child attachment, and family functioning, that could potentially explain the association between trauma symptoms and parenting stress is warranted. Understanding the role of these familial factors on parenting stress for Hispanic/Latino/a immigrant parents who have traumatic life histories would inform the development of much needed family programs.

1.1 | Exposure to trauma and mental health among Hispanic/Latino/a immigrant parents

Latin American adults migrating to the U.S. from high-conflict and violence areas are likely to have been exposed to traumatic events in their home countries (Valdez et al., 2015). For example, immigrants from Guatemala, Honduras, and El Salvador leave home to escape violence, starvation, impoverished living conditions, human rights violations, insecurity, poverty, drug cartel infiltration, forced child recruitment into gangs, and extortion (Sawyer & Márquez, 2017; Valdez et al., 2015). In addition, many migrants are subject to physical and sexual abuse, rape, human trafficking, dismemberment, and possibility of death during the migration process (Valdez et al., 2015).

Cumulative traumatic experiences place migrants at imminent risk of poor mental health (Valdez et al., 2015; Vogt, 2013) including PTSD (Perreira & Ornelas, 2013) and depression (Ornelas & Perreira, 2011). Immigrant parents are also faced with additional challenges post-migration, including acculturation, social isolation, and caring for a child and other family members in a new environment (Fortuna et al., 2019; Valdez et al., 2015), further exacerbating their mental health. Currently, a majority (93%) of Hispanic/Latino/a children in the U.S. are U.S.-born, with approximately a quarter living with at least one parent who is an unauthorized immigrant (National Research Center on Hispanic Children & Families, 2021). Unauthorized immigrant parents and their young children are constantly faced with stress, anxiety, and fear of family separation due to their uncertain legal status (Clarke et al., 2017). Such extremely challenging circumstances have detrimental effects on parental functioning (LaBrenz et al., 2020). As Fortuna and colleagues (2019) argue, caregiver-infant well-being can be threatened by a myriad of pre- and post-migration traumatic life events including gender-based violence, discrimination, and poverty, which negatively impact Hispanic/Latino/a mothers' ability to care for their children and other parenting behaviors. Indeed, a small number of studies with Hispanic/Latino/a mothers have demonstrated associations between maternal trauma histories and low parenting competence including parental resilience, concrete support, and social support (LaBrenz et al., 2020) and infant bonding (Lara-Cinisomo et al., 2018).

1.2 | Parental and familial protective factors of parenting stress

Most research on the predictors of parenting stress has focused on the risk factors that contribute to high parenting stress such as parental mental health (Fernandes et al., 2012; Kwako et al., 2010; Xu et al., 2018; Skreden et al., 2012) and poor family functioning (Pisula & Porbowicz-Dörsmann, 2017; Mikolajczak et al., 2018). The roles of protective parental and familial factors on parenting stress, on the other hand, have received less attention but are important to consider for interventions that aim to lower parenting stress. A small number of studies have demonstrated that mothers with secure attachment style and/or better reflective functioning, or those with higher level and quality of early parent-child or parental bonding experience lower parenting stress (de Cock et al., 2017; Howard, 2010; Nijssens et al., 2018). Other research also suggests that social support and instrumental support help reduce parenting stress (Sampson et al., 2015; Schellinger et al., 2020). For example, Solem et al. (2011) tested parents' personal coping resources and found that perceived social support and sense of coherence predicted lower parenting stress. Family functioning or family competence is another factor that is associated with parenting stress.

Families with higher levels of functioning or more competence measured in such domains as relationships, cohesion, conflict, adaptability, organization, and quality of communication and expressiveness (Beavers & Hampson, 1990; Lewandowski et al., 2010) also report lower parenting stress (Gleeson et al., 2016).

To date, research is limited with regards to protective factors of parenting stress among Hispanic/Latino/a immigrant parents with young children. Cardoso and Thompson (2010) found that perceived social support from family and friends, but not partners, was related to lower levels of parenting stress among Mexican American mothers. Popp et al. (2019) supported these findings through a study with young adult Mexican-origin parents reporting that maternal support helps increase parenting satisfaction, which in turn lowers parenting stress. Similar results were also found in a study of foreign-born and nativeborn Hispanic and non-Hispanic Black mothers who were interviewed at 1-year postpartum (Driver & Amin, 2019). Bailey and colleagues studied the cultural applicability of protective factors in preventing child maltreatment and among Spanish-speaking families which highlighted the role of family functioning (Bailey et al., 2015). However, its effect on parenting stress specifically has not been studied.

1.3 | Present study

Existing research has established that parental trauma influences parenting stress via poor parental mental health such as anxiety and depression. Exposure to traumatic life experiences also negatively impact factors that can lead to parenting stress such as family functioning (Sangalang et al., 2017; Sexton et al., 2015), parental attachment styles (Moe et al., 2018), and parental reflective functioning (Milligan et al., 2021). Given the multiple factors that contribute to parenting stress, there is reason to further investigate the pathways that underlie the relationship between parental trauma and parenting stress, and the role of parental and familial factors that could potentially mediate or explain the effects of trauma on parenting stress. To date, there is one study that found an association between parent's childhood trauma and parenting stress which was mediated by social support among first-time mothers with infant children (Ammerman et al., 2013).

Given the high prevalence of trauma exposure among Hispanic/Latino/a immigrants, it is important to understand the complex direct and indirect effects of trauma on their mental health. In particular, unpacking the effects of trauma on parental mental health has crucial implications on the development and safety of young children, yet there remain significant gaps in our understanding among Hispanic/Latino/a immigrant families. The goals of this study were to examine the association between maternal post-traumatic stress symptoms and parenting stress, and to test the mediating effects of parental/familial factors thought to be protective of negative parent-child relationships among a sample of Hispanic/Latino/a immigrant mother-child dyads. Based on existing literature (e.g., Ammerman et al., 2013; Bailey et al., 2015; LaBrenz et al., 2020), we hypothesized that (1) mothers' post-traumatic stress symptoms would have a positive association with parenting stress and (2) the relationship between parental post-traumatic symptoms and parenting stress would be mediated by family functioning, social support, concrete support, and attachment.

2 | METHODS

Data used for analysis were collected as part of an evaluation study conducted within a community agency located in a low-middle-income suburban area of a city in the northeastern U.S. The agency provides a range of parenting and family services for families with young children birth to six. Data were collected at baseline from parent-child dyads who received Child-Parent Psychotherapy (CPP), a trauma-responsive attachment-focused therapeutic intervention that helps strengthen parent-young child relationships for families who have had experiences of trauma (Lieberman, Ghosh Ippen, & Van Horn, 2015).

2.1 | Procedures

All parents and children who enrolled in dyadic treatment with a CPP clinician between April 2017 and June 2021 were invited to participate in the evaluation study. The following were inclusion criteria for participation in the evaluation: (1) parent and child between birth and 6 years of age and (2) parent able to provide knowing consent to participate in the evaluation. Of the evaluation measures, this study utilized self-report questionnaire packets including demographic questions and standardized measures of parenting experience and capacity and trauma which were collected via in-person or remote (telephone or video conferencing platform) individual interviews with the parent by agency staff trained in measures administration by the evaluation team. Remote data collection began in April 2020 in response to the COVID-19 pandemic to ensure the health and safety of participants, clinicians, and evaluation staff. The evaluation measures were collected as part of the assessment process at the beginning, before participants began the CPP intervention. Agency interviewers obtained informed consent before measures were administered. Consent forms and measures were available in both English and Spanish and interviews were conducted in participants' language of preference. All research materials and procedures were reviewed and approved by the University Institutional Review Board. Data were entered, cleaned, and analyzed by the evaluation team. The overall total sample of the evaluation study included Hispanic/Latino/a and non-Hispanic/Latino/a participants and two male participants. For the purposes of this study, we created a dataset with a subset of the main dataset selecting individuals who identified as a Hispanic/Latino/a ($n = 83$) female caregiver.

2.2 | Measures

The mothers' post-traumatic stress symptoms were measured using the PTSD Checklist (PCL-5; Weathers et al., 2013), a 20-item self-report measure that assesses the symptoms of PTSD according to the DSM-5. Total scores ranging from 0 to 80 were generated for each participant by summing the scores for each item (e.g., "In the past month, how much have you been bothered by repeated, disturbing, and unwanted memories of the stressful experience?"). Responses are given on a 5-point Likert scale ranging from *not at all* (0), *a little bit* (1), *moderately* (2), *quite a bit* (3), and *extremely* (4). Based on the number of items with a response of 2 or greater endorsed in each criteria, practitioners are able to assess whether the respondent is at risk for PTSD. The internal consistency of the PCL measured with Cronbach's alpha using the study data was .90. A separate 30-item self-report measure called the Life Stressor Checklist-Revised (LSC-R; Wolfe et al., 1997), was also used for descriptive purposes to understand the type of traumatic experiences the mothers have had.

The LSC-R items are scored as 1 (yes) or 0 (no) and if endorsed, and the age of the incident is recorded. The “yes” responses on the first 27 items are tallied to create a total score. The LSC-R has good criterion validity and test-retest reliability (Wolfe & Kimerling, 1997). Frequencies were generated for all positively endorsed items.

The Protective Factors Survey (PFS; Counts et al., 2010), originally designed for use with parents receiving child maltreatment prevention services, was used to measure family protective factors in four areas: family functioning/resiliency (e.g., “In my family, we talk about problems”), social emotional support (e.g., “I have others who will listen when I need to talk about my problems”), concrete support (e.g., “I would have no idea where to turn if my family needed food or housing”), and nurturing and attachment (e.g., “My child and I are very close to each other.”). Responses are given on a 7-point scale and the mean score is generated for each subscale; a higher score represents higher level of protective factors. Cronbach alphas for each of the subscales were .62 (nurturing and attachment), .79 (concrete support), .79 (social support), and .89 (family functioning/resiliency). The measure has also been validated with a Hispanic/Latino/a sample of families (Conrad-Hiebner et al., 2015).

The main outcome of interest was calculated using the Parenting Stress Index-Short Form (PSI-SF; Abidin, 1995). PSI-SF measures the degree of stress in the parent-child relationship to promote the early classification of children at risk for development of behavioral or emotional distress (Loyd & Abidin, 1985). PSI-SF includes 36 items, each item rated from *strongly disagree* (1) to *strongly agree* (5) (e.g., “I often have the feeling that I cannot handle things very well”, “I feel trapped by my responsibilities as a parent”), and three subscales (parenting distress; parent-child dysfunctional interaction; difficult child). The sum of all items is used to calculate total stress score, ranging from 36 to 180. A higher score indicates greater level of parenting stress, and those with total stress raw score of 90 or higher are considered at clinically significant levels of stress. The PSI total score had high internal consistency (Cronbach’s alpha = .90).

2.3 | Statistical analysis

Three individuals did not have any items of the PFS completed, and therefore were excluded from analysis, making the final total sample size $n = 80$. All analyses were conducted using SAS OnDemand for Academics software. Descriptive statistics were generated for all demographic items and variables used in the regression models. We first ran Pearson correlations to examine bivariate associations between variables. We then ran simple regression models testing the association between the outcome (PSI) and maternal post-traumatic stress symptoms (PCL) as the main predictor. No control variables were included for a few reasons. We considered including number of children, household income, and age of the parent as control variables given their potential relationship with our outcome of interest (e.g., Conger et al., 2002, 2010; Krieg, 2007; Oyarzún-Farías et al., 2021). None of these variables were correlated with the outcome variable. Other demographic variables (e.g., housing status, child’s age) were considered by running a correlation analysis, however, they also did not correlate with the outcome. Thus, we decided not to include these variables in the models. To test whether PFS factors would mediate the association between PCL and PSI, we ran multivariate models using PROC CAUSALMED testing each PFS

variable one at a time. The significance of the indirect effects was tested using bootstrapping procedures ($n = 5000$). A Monte Carlo power analysis was conducted using Schoemann et al's (2017) web-based tool MCpowrMed which suggested that the sample size provided sufficient power (.93) for simple mediation analyses.

3 | RESULTS

3.1 | Sample characteristics

Baseline sample characteristics are presented in Table 1. A majority of the 80 mothers identified as migrants from Central America (76.3%), almost all mothers had stable housing, a little over half reported that they were never married, and two-thirds reported having more than one child. The mean age of the parents was 30.1 ($SD = 6.5$) years, while the mean dyad child's age was 32.3 ($SD = 21.2$) months. Twenty-nine percent reported having been involved with child welfare previously. About half of the mothers had less than a high-school education (12th grade in the U.S.). Forty-six percent of the parents reported that they were employed either part-time or full-time during the 6 months prior to baseline. Eighty percent of those who reported their annual household income earned less than \$25,000. The top five most frequently reported events on the LSC-R included: Someone close died suddenly or unexpectedly (71.3%), serious money problems (67.5%), been emotionally abused or neglected (67.1%), abused, physically attacked, harshly punished by someone they know (56.3%), and having to leave where they were living and move to another location because they could not pay for basic needs, or felt unsafe (55%).

Table 2 lists the mean values of the main outcome PSI ($M = 82.6$, $SD = 20.3$, $Min = 45$, $Max = 152$, 32.5% scored in the "high risk" range and 27.5% scored in the "at risk" range), and predictors, PCL ($M = 26.0$, $SD = 14.5$, $Min = 0$, $Max = 60$, 40% scored in the "at risk for PTSD" range) and PFS. In terms of the protective factors, the nurturing and attachment subscale had the highest mean score ($M = 6.2$, $SD = .9$), while the scores for other three subscales (FFR, SS, and CS) were in the middle to upper middle range.

3.2 | Bivariate analysis

Pearson's correlation results showed a positive association between the outcome (PSI) and maternal post-traumatic stress symptoms ($r = .27$), which was consistent with our first hypothesis. Higher post-traumatic stress experienced by mothers was associated with higher parenting stress. On the other hand, three of the protective factors were negatively correlated with PSI, suggesting that higher levels of family functioning/resiliency ($r = -.55$), social support ($r = -.46$), and nurturing and attachment ($r = -.65$) are associated with lower parenting stress. Maternal post-traumatic stress symptoms also correlated negatively with family functioning/resiliency ($r = -.33$) and social support ($r = -.40$; See Table 2 for the full correlation table).

3.3 | Multivariate regression and mediation analyses

Further analyses using linear regression demonstrated that higher post-traumatic stress symptoms experienced by the mother was related to a higher score on the PSI ($B = .37$, $SE = .15$, $p = .02$, $R^2 = .07$, $df = 1, 78$, $F = 5.93$). Table 3 presents the results of the five

models run separately. PCL remained a significant predictor for one of the models after the protective factor variable was entered into the model (Model 2 with Concrete Support as a predictor). In models 3, 4, and 5, however, PCL was no longer significant after the potential mediating variables were added. Since PFS-NA and PFS-CS were not correlated with PCL, and thus did not meet the assumptions for the causal steps approach of mediation analysis (Baron & Kenny, 1986), they were not examined for further analysis. The causal steps approach to assessing mediation requires that (1) there is a significant relationship between the independent (IV) and dependent (DV) variables and between the IV and mediating variable (MV), (2) the MV is significantly associated with the DV in the presence of the IV, and (3) the association between the IV and DV becomes non-significant or the coefficient is smaller in absolute value in the presence of the MV (Baron & Kenny, 1986; MacKinnon et al., 2007). Mediation analyses were conducted for models 3 (SS) and 4 (FFR) given that the association between PCL and PSI changed possibly due to the effect of the third variable. The significant correlation seen between PCL with each of the two potential mediators also satisfied the criteria to test for mediation. Results of the PROC CAUSALMED with bootstrapping partially supported our second hypothesis. Both PFS-SS (indirect effect = .236, $p < .01$; 95% CI = .09, .47) and PFS-FFR (indirect effect = .243, $p < .01$, 95% CI = .09, .47) fully mediated the relationship between PCL and PSI. These results suggest that there are indirect effects of social support and family functioning/resiliency which explain the association between the mothers' post-traumatic stress symptoms and parenting stress (See Figures 1 and 2).

4 | DISCUSSION

Experiences of traumatic and distressful events can have lasting mental health consequences. Among Hispanic/Latino/a immigrant parents, the migration process can cause significant distress which contributes to negative mental health outcomes both for themselves and their children (Ornelas & Perreira, 2011). When coping with the psychological distress that often accompanies trauma, these parents may be compromised in their ability to effectively function in their parenting roles, especially in positive and nurturing caregiving practices (Christie et al., 2019). Traumatic adversities often impose strain on the parent and may inflict harmful intergenerational effects on multiple childhood outcomes (Cerdeña et al., 2021).

As seen in previous studies of non-Hispanic/Latino/a parents (e.g., Ammerman et al., 2013; Chemtob et al., 2013), we found that post-traumatic stress symptoms were associated positively with parenting stress for the Hispanic/Latino/a immigrant mothers of young children in our sample (hypothesis 1). This finding is important given the salience of parenting stress and the often concomitant dysfunctional parent-child relationships which impact young children's healthy growth and development (Lamb & Lewis, 2005) including their mental health (Hattangadi et al., 2020). Additional bivariate analysis also demonstrated that maternal post-traumatic stress symptoms were negatively correlated with the protective factors of family functioning/resiliency and social support. Our findings aligned with existing literature supporting the sequelae of post-traumatic symptoms on parental and familial protective factors, which served as the basis of our mediation analysis. Experiences of forced displacement have been found to negatively impact aspects of healthy family

functioning including communication and family cohesion among another immigrant population, Southeast Asian American mothers with school-age children (Sangalang et al., 2017). While there is evidence that demonstrates the benefits of social support on post-traumatic stress symptoms among mothers (e.g., Pinto et al., 2019), the inverse relationship has been less examined. Our results indicated that mothers with high post-traumatic stress symptoms reported low perceived social support. Immigrant mothers with post-traumatic stress symptoms may be less able to access or to expand their social network due to barriers that result from comorbid mental health conditions like depression and/or anxiety, preventing them from establishing supportive relationships with others. Other systemic issues such as linguistic and cultural barriers and discrimination also contribute to acculturative stress among Hispanic/Latino/a immigrants (Lueck & Wilson, 2011) which can exacerbate mental health difficulties and thus, result in increased social isolation (Elmer & Stadtfeld, 2020).

Our mediation analysis showed that family functioning/resiliency and social support indirectly affected the relationship between post-traumatic stress symptoms and parenting stress (hypothesis 2). The model suggested that mothers who reported high post-traumatic stress symptoms also reported low levels of social support and family functioning/resiliency, which in turn, was associated with their high parenting stress. Two protective factors, concrete support and nurturing and attachment, did not significantly correlate with maternal post-traumatic stress symptoms, nor were mediators of post-traumatic stress symptoms on parenting stress. This was a surprising finding given that PFS had been tested and validated with Hispanic/Latino/a parents (Bailey et al., 2015). The literature is, however, limited on these two constructs for this population. More data is needed to establish the applicability of these constructs for Hispanic/Latino/a immigrant families with young children as well as for mothers with trauma histories.

4.1 | Limitations

This study used a convenience clinical sample drawn from a community-based family services agency offering programming to families who at the time of recruitment were seeking or referred for services. This may exclude those who are unable to access such services due to resources or lack of information, creating some degree of selection bias. The study instruments collected were all self-report measures, and thus based solely on the perception of the participant parent. Operationalizing concepts such as social support which are “social resources that person perceives to be available...” (Gottlieb & Bergen, 2010, p. 512), could be enhanced using multiple instruments that measure different dimensions of social capital (structural, cognitive, relational; Nahapiet & Goshal, 1998). Parenting stress of non-biological mothers or female caregivers may present differently compared to biological mothers of this population, and future studies are needed to explore any differences. Finally, the type of data used for the mediation analysis was cross-sectional, and therefore, no temporal relationship could be established between the independent, mediator, and dependent variables. However, our data showed that on 13 of the 27 LSC-R items, at least half of the participants responded that the traumatic event happened to them before the age of eighteen. Furthermore, post-traumatic stress symptoms, which include avoidance, anxiety, irritability, anger, and shame, among others, tend to lead to social withdrawal and

isolation including disconnecting from family (e.g., King et al., 2006). On the other hand, there is no strong evidence that suggests that the inverse relationship—protective factors or parenting stress leading to post-traumatic stress—is likely. These reasons supported the conceptual model (i.e., the impact of post-traumatic symptoms on parenting stress via protective factors) we tested using cross-sectional data. A regression analysis was also used for the mediation analysis with no control variables adjusting for possible confounders due to a low sample size. Different analytical methods such as path analysis or structural equation model that accounts of measurement error and a larger sample size may lead to more robust findings.

4.2 | Clinical implications and further research

Our findings have important implications for interventions. For Hispanic/Latino/a mothers, social support and optimal family functioning have the potential to mitigate the impact of parental trauma on parenting stress that could potentially be harmful to the child. Having strong social support and the ability to benefit from the support could have protective effects on their parenting stress for Hispanic/Latino/a mothers with post-traumatic stress symptoms. Brown et al. (2021) presented similar results on how social support mediated the impact of violence exposure and trauma symptoms on another aspect of parenting—parenting competence—among a racially diverse sample of mothers in the U.S. with substance use disorders and PTSD. Aspects of family functioning such as communication, family dynamics, and problem-solving skills, could be improved through family-focused interventions and may allow mothers to better manage parenting stress. The centrality of family, also known as familism or *familismo* (e.g., Sabogal et al., 1987), remains crucial for Hispanic/Latino/a immigrant families in the U.S., which further emphasizes the value of strong family functioning and social support. Hispanic/Latino/a immigrant parents with trauma histories could benefit from interventions that target improving these life domains.

The Diversity-Informed Infant Mental Health Tenets (St. John et al., 2013) offer a paradigm for practice rooted in equity and social justice for professionals working with infants, children, and families. Of relevance for Hispanic/Latino/a immigrant families, the principles of diversity-informed practice encourage examination of how interventions are shaped by all the people involved, practitioner and recipient, as well as the sociopolitical and historical context. The tenets encourage clinicians to listen closely to the young children and families with whom they are working and encourage them to draw on familiar resources and supports as well as offering additional ones. Furthermore, they highlight the importance of offering services in the native language of immigrant children and parents as primary language is linked with identity and coping.

The findings suggest that addressing unique post-immigration challenges (e.g., acculturation process) and how they affect the family system may prove beneficial to Hispanic/Latino/a mothers with trauma histories. Interventions like CPP can be an ideal culturally responsive approach for Hispanic/Latino/a immigrants given the emphasis on trauma symptoms and how they may manifest in relationships between parents and young children. CPP directly addresses the psychological needs of children who have experienced significant life stressors along with those of their parents using a family-based dyadic approach, which is respectful

of the strong family values within Hispanic/Latino/a culture. The clinician can address a family's concrete needs including assistance with legal matters, education, and bilingual services, among others, which are often among the challenges faced by new immigrants. CPP clinicians focus on trauma within broader family relationships and aim to improve family communication, cohesion, and resiliency—the qualities that served to protect the mothers in this study from the negative sequelae of trauma symptoms. This type of multi-faceted assistance can improve family functioning and is often experienced as social support while simultaneously directly addressing post-traumatic stress symptoms. Circle of Security (Hoffman et al., 2006), an attachment-based group intervention for caregivers of young children is another program that has been adapted for Spanish-speaking families. This program not only promotes secure attachment between the parent/caregiver and the child but also provides a space to foster social support among families.

The present study assessed the four protective factors of the PFS, but future studies could also explore other factors that may be culturally relevant to the Hispanic/Latino/a population such as acculturation, enculturation (retention of traditional values and practices), experiences of migration and the grief associated with losing familiar home cultures and contexts, and transborder family relationships. Utilization of a trauma measure that includes common experiences for immigrants (pre-, during, post-migration) may also yield findings that help enhance interventions. Ultimately, further studies should build on the few that are available (Lieberman, Van Horn, & Ghosh Ippen, 2005; Lieberman, Ghosh Ippen, & Van Horn, 2006) to test interventions for young Hispanic/Latino/a children and their families that offer parenting and social support, build on protective factors such as family resilience, and address trauma and acculturation.

5 | CONCLUSION

This study offers us lessons regarding how social support and family resilience can mitigate the impact of trauma symptoms on parenting stress in one particular community of Hispanic/Latino/a immigrant families. The findings provide empirical support to guide evidence-based interventions for families. Programs that aim to address the psychological needs of individual parents and young children should do so while also attending to broader social and family matters. Infant mental health interventions, such as CPP, offer the possibility of addressing both the micro and mezzo needs of traumatized young children and their families.

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DATA AVAILABILITY STATEMENT

Deidentified data that support the findings of this study are available from the corresponding author upon reasonable request. The data are not publicly available due to privacy or ethical restrictions.

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KEY FINDINGS

- In a community sample of 80 Hispanic/Latina/o mothers with young children (child mean age = 32 months), higher maternal post-traumatic stress symptoms were associated with higher parenting stress.
- Social support and family functioning mediated the relationship between post-traumatic stress symptoms and parenting stress.
- Results suggest that interventions that improve social support and family functioning may mitigate the effect of traumatic symptoms on parenting stress for Hispanic/Latina/o mothers with young children.

STATEMENT OF RELEVANCE

Many immigrants from Latin America to the U.S. are exposed to traumatic experiences pre-, during, and post-migration, which greatly impact families. The present study adds to the limited knowledge base pertaining to Hispanic/Latino/a immigrant mothers with infant and preschool children who may be considered at-risk due to maternal post-traumatic stress. The study highlights the importance of providing trauma-responsive support to lower maternal parenting stress and its impact on children’s development and mental health.

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STATEMENT OF DIVERSITY AND ANTI-RACIST SCHOLARSHIP

This study addresses critical issues of disparity that impact the Hispanic/Latino/a community in the U.S. who have limited access to a variety of mental health and social services due to a lack of programming that are linguistically, culturally, and trauma responsive. The study was designed and implemented through a partnership with a community agency that provides bicultural/bilingual services by staff who themselves have lived experiences as immigrants. The authors of the present manuscript are trained in social work, a field that promotes social equity through the application of social justice and systems-oriented frameworks in both academic and/or practice settings.

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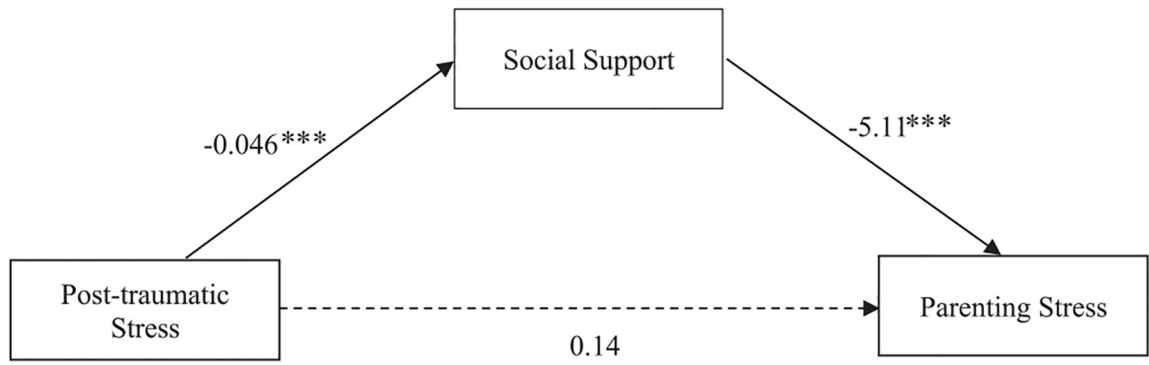


FIGURE 1. Unstandardized regression coefficients for the relationship between parental trauma and parenting stress as mediated by social support. * $p < .05$; ** $p < .01$; *** $p < .001$.

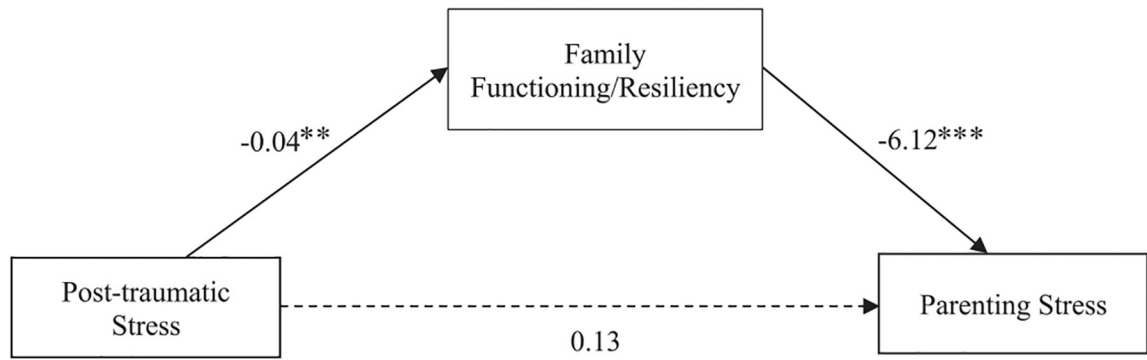


FIGURE 2. Unstandardized regression coefficients for the relationship between parental trauma and parenting stress as mediated by family functioning/resiliency. * $p < .05$; ** $p < .01$; *** $p < .001$.

TABLE 1

Demographic characteristics of the mother-child dyad sample ($n = 80$).

	<i>n</i> (%)	Mean (<i>SD</i>)	Range
Hispanic Region of Origin ^a			
Central America	61 (76.3)		
Caribbean Islands	11 (13.8)		
North America (Mexico)	2 (2.5)		
South America	2 (2.5)		
Other	5 (6.3)		
Housing			
Shelter	1 (1.3)		
Housed (e.g., rental, own)	79 (98.8)		
Marital status ^b			
Never married	44 (55.7)		
Married same sex	2 (2.5)		
Married opposite sex	24 (30.4)		
Separated/divorced opposite sex	9 (11.4)		
Number of children			
One	29 (36.3)		
Two	27 (33.8)		
Three	14 (17.5)		
Four or more	10 (12.5)		
Previous involvement with Department of Child and Family Services (at least once)	23 (28.7)		
Highest level of education			
Less than 11th grade	42 (52.5)		
12th grade/High school diploma equivalent	23 (28.9)		
College/university – 1st year completed	1 (1.3)		
College/university – Associate’s degree	5 (5.3)		
College/university – 3rd year completed	3 (5.3)		
College/university – Bachelor’s degree	6 (7.9)		
Employment (past 6 months)			

	<i>n</i> (%)	Mean (<i>SD</i>)	Range
Unemployed – not looking for work	31 (38.8)		
Unemployed – looking for work	10 (12.5)		
Unemployed – volunteer/disabled	2 (2.6)		
Employed – part-time	19 (23.8)		
Employed – full-time	18 (22.5)		
Household income level (annual) ^c			
\$0–\$9,999	19 (32.8)		
\$10,000–\$24,999	25 (43.1)		
\$25,000–\$49,999	11 (19.0)		
\$50,000–\$74,999	1 (1.7)		
\$100,000+	2 (3.4)		
Dyad child's age		32.3 (21.2)	0–84
Dyad mother's age		30.1 (6.5)	19–50

^aEthnicity is not a mutually exclusive variable.

^bMarital status data missing for *n* = 1.

^cIncome data missing for *n* = 22.

TABLE 2

Descriptive statistics and bivariate correlations between life stressors, parenting stress, and protective factors.

Measure	Mean (SD)	1	2	3	4	5	6
1. PSI	82.6 (20.3)						
2. PCL	26.0 (14.5)	.27 [*]	–				
3. PFS-FFR	4.5 (1.7)	–.55 ^{***}	–.33 ^{**}	–			
4. PFS-SS	4.7 (1.7)	–.46 ^{***}	–.40 ^{**}	.42 ^{**}	–		
5. PFS-CS	3.7 (1.9)	.18	–.17	–.04	.06	–	
6. PFS-NA	6.2 (.9)	–.65 ^{***}	–.22	.46 ^{**}	.39 ^{**}	–.20	–

Abbreviations: PCL, PTSD Checklist; PSI, Parenting Stress Index; PFS-CS, Protective Factors Scale – Concrete support; PFS-FFR, Protective Factors Scale – Family functioning/resiliency; PFS-NA, Protective Factors Scale – Nurturing and attachment; PFS-SS, Protective Factors Scale – Social support.

*
 $p < .05$;

**
 $p < .01$;

 $p < .001$.

TABLE 3

Simple and multiple regression results predicting PSI.

	Model 1		Model 2		Model 3		Model 4		Model 5					
	<i>B</i>	<i>SE</i>	<i>B</i>	<i>SE</i>	<i>B</i>	<i>SE</i>	<i>B</i>	<i>SE</i>	<i>B</i>	<i>SE</i>				
PCL	.37*	.15	.27	.15	.43**	.15	.31	.15	.13	.14	.09	.18	.12	-.13
PFS-CS			2.50*	1.15	.24									
PFS-SS					-5.11***	1.33	-.42							
PFS-FFR							-6.12***	1.18	-.52					
PFS-NA														-14.5***
<i>R</i> ²	.07*		.12**		.22**		.31***		.34***					

Abbreviations: *B*, unstandardized coefficient; *SE*, standard error; *β*, standardized coefficient.

* *p* < .05;

** *p* < .01;

*** *p* < .001.