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ASSOCIATIONS BETWEEN MOTHERS' EXPERIENCE WITH THE TROUBLES IN NORTHERN IRELAND AND MOTHERS' AND CHILDREN'S PSYCHOLOGICAL FUNCTIONING: THE MODERATING ROLE OF SOCIAL IDENTITY

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Abstract

Relatively little research has examined the relations between growing up in a community with a history of protracted violent political conflict and subsequent generations' well-being. The current article examines relations between mothers' self-report of the impact that the historical political violence in Northern Ireland (known as the Troubles) has on her and her child's current mental health. These relations are framed within the social identity model of stress, which provides a framework for understanding coping responses within societies that have experienced intergroup conflict. Mother-child dyads ($N = 695$) living in Belfast completed interviews. Results suggest that the mother-reported impact of the Troubles continue to be associated with mothers' mental health, which, in turn, is associated with her child's adjustment. The strength of mothers' social identity moderated pathways between the impact of the Troubles and her mental health, consistent with the social identity model of stress.

Exposure to violence can take many forms, including experiencing and witnessing violent acts. In all forms, violence exposure can have detrimental effects on individuals and their family members (Cairns, 1996; Garbarino, Dubrow, Kostelny, & Pardo, 1992; Lynch, 2003; Margolin & Gordis, 2000; Weingarten, 2004). Within societies that have experienced conflict between communities, the experience of war and protracted conflict places an additional burden on families who are dealing with experiences of violence. The present study examines associations between the current mental health of mothers who have lived in a community since their childhood that has experienced protracted violent political conflict and the psychological adjustment of their children, the members of the next generation.

Participants include both mothers and children currently residing in Belfast, Northern Ireland.

Although initial investigations of relations between the political violence in Northern Ireland and the immediate psychological functioning of adults suggested less dramatic effects than expected (Cairns & Darby, 1998; see Cairns, Wilson, Gallagher, & Trew, 1995), more recent research suggests elevated psychopathology in post-conflict societies such as Northern Ireland (De Jong, Komproue, & Van Ommeren, 2003). Moreover, there has been little systematic study of these issues (Cairns & Darby), limiting knowledge regarding associations between the exposure to protracted violent political conflict and the psychological functioning of the parents and children in these communities.

These incongruent findings regarding associations between exposure to violent political conflict and psychological findings might be partially explained by the range of experiences and responses that adults and children show when experiencing violent political conflict. Such variability in responses to living in a community that has been defined by political violence underscores the need to identify risk and protective factors for those living in these societies (Kellezi, Reicher, & Cassidy, 2009). One potentially relevant factor in societies with negative intergroup relations is the degree to which community members identify with their culturally relevant in-group. One's social identity, which includes an individual's identification with any number of ingroups as well as the value and emotional valence of those memberships (Tajfel, 1972), has been recognized as an important influence on psychological outcomes in the conflict in Northern Ireland (Cairns, 1982). Social identity is linked with mental health in communities that have experienced political violence (Haslam, Jetten, Postmes, & Haslam, 2009), and researchers are beginning to untangle the complexities in the relations between social identity and mental health (see recent special issue in *Applied Psychology: An international Review*, Vol. 58, 2009). In the present study, to help further identify risk and protective factors for children and families in post-accord societies, social identity will be examined as a moderating variable in the links between mothers' experience with the Troubles and mothers' and children's current mental health.

The association between psychological well-being and child adjustment is well established. In an important review, Beardslee, Bemporad, Keller, and Klerman (1983) reported that children of depressed parents were at risk for a variety of adjustment problems. More recently, Weissman and colleagues (Weissman, Warner, Wickramaratne, Moreau, & Olfson, 1997; Weissman et al., 2006) also indicated that children of depressed parents are at a greater risk for a variety of problems, including psychological symptoms, medical problems, and substance abuse. Research has also supported transmission of psychological distress between parents and children with subclinical levels of psychological distress (Ge, Conger, Lorenz, Shanahan, & Elder, 1995). In this article, we focus on the possibility that parents in communities within post-conflict and post-accord societies such as Northern Ireland must continue to manage the effects of violence they experienced in the past, even after peace accords are signed. In turn, these links with maternal mental health may have implications for the next generation growing up in post-accord environments. For some time, experts (e.g., Punamäki, 1987) have proposed that in the context of war and political violence, mothers' mental health may directly impact her child's psychological functioning. For example, mothers who are under stress may become less effective parents because of heightened symptoms related to mental health problems. In recognizing the dynamic nature of the relations between parent and child mental health and the multiple causes of psychopathology, it is also plausible that children's mental health has a direct effect on mothers' mental health; however, this direction of relations is not examined in the current study.

The literature that examines relations between parents' exposure to political violence and the well-being of their children is relatively sparse (van IJzendoorn, Bakermans-Kranenburg, & Sagi-Schwartz, 2003; Sagi-Schwartz et al., 2003). Much of this literature is devoted to holocaust survivors and their children. Reflecting mixed findings, clinical research tends to report long-term associations that are intergenerational, whereas survey research often fails to replicate these results (van IJzendoorn et al.; Sagi-Schwartz et al.). According to van IJzendoorn et al., there is evidence that holocaust survivors may function normally during everyday life, but they may be "vulnerable in more extreme stressful conditions" (p. 460). For example, Solomon and Prager (1992) found that Holocaust survivors responded more negatively to missile attacks on Israel during the Gulf War. These findings underscore the notion that experience with political violence may contribute to well-being decades later.

Given the history of conflict in Northern Ireland, it is possible that the current generation of children and adolescents are experiencing secondary or indirect traumatization (Muldoon, Trew, & Kilpatrick, 2000). That is, adults living in Northern Ireland today grew up during the 30-year period of intense political violence known as the Troubles (Cairns & Darby, 1998); however, their children have grown up in the post-accord society, which is characterized by continued sectarian conflict that involves much less deadly forms of antisocial behaviour and sectarianism (Shirlow & Murtagh, 2006). For example, the number of deaths due to the security situation in Northern Ireland declined dramatically after the calling of paramilitary ceasefires in 1994. A mere 5.6% (195 persons) of all conflict-related deaths occurred during this period (Summary of Statistics Relating to the Security Situation, 2008–2009). Also, there has been a growth in inter-community rioting over the past decade because of contestations over parading and interface disputes, as well as attacks upon symbolic sites such as churches, Orange Order halls, and Gaelic Athletic Association premises (Shirlow & Murtagh). This continued tension is still likely to impact the mental health of both adults and children in these communities. Indeed, there is some evidence that post-traumatic stress disorder (PTSD) may be more common in post-conflict and post-accord societies than it is when the conflict is ongoing (De Jong et al., 2003).

The influence on mothers and their children who live in a community that experienced protracted political violence may also be related to other maternal factors. Theoretical and empirical research has identified social identity as an important variable that is associated with mental health and stress responses within contexts of intergroup threat and conflict. The motivational foundation of the social identity theory (Tajfel & Turner, 1986) is the drive for group members to positively differentiate their own group from relevant out-groups to achieve a sense of positive identity. In Northern Ireland, the conflict, which has existed for decades if not centuries, is in the main a struggle between two large groups. On the one hand, there are those who wish to see Northern Ireland remain part of the United Kingdom (the Protestants/Unionists), and on the other, there are those who wish to see the reunification of the island of Ireland (the Catholics/Nationalists; see Cairns & Darby, 1998, for a review). Furthermore, Catholic or Protestant identity is typically imposed from birth onwards. Based on the notion that ethnicity is socially constructed and encompasses cultural and historical components, Healy (2006) explains that "in Northern Ireland, religion or a person's perceived religious background has become the social marker for ethnicity" (p. 107). Thus, one's membership in either of these groups is virtually inescapable; in social identity theory terms, the group boundaries are impermeable (Cairns & Darby; Niens, Cairns, & Hewstone, 2003; Cairns, Kenworthy, Campbell, & Hewstone, 2006). In line with the social identity model of stress, those in post-accord Northern Ireland with a weak social identity have been found to be more likely to suffer from PTSD (Muldoon & Downes, 2007). Further supporting the role of social identity as a key process in this context, Muldoon, Schmid, and Downes (2009) found that national identity acted as a mediator in the link between experience with political violence and mental health.

Social identity theory (Tajfel & Turner, 1979) provides a framework for understanding the basis of different coping responses to stress in the context of status inequality. Specifically, Haslam and Reicher (2006) hypothesized that social identity may alter the psychological interpretation of a negative experience into a more “positive and productive social force” (p. 1038). They also suggest that when group membership is impermeable, these processes of altering the meaning of negative experiences in positive ways are more likely to apply to low-status groups. In other words, when group membership is inescapable, and group relations are changeable, individuals in low-status groups will choose a strategy that promotes change at the group level. On the other hand, if group boundaries are permeable, then they will likely choose individual mobility, attempting to change groups. In the case of impermeable group boundaries and unchangeable group relations, individuals will likely choose a strategy of changing the meaning of their identity, or changing comparison groups or the dimensions to which they make comparisons. Using an experimental approach modeled after the Stanford Prison Experiment (Haney, Banks, & Zimbardo, 1973), Haslam and Reicher found that feelings of shared identification buffered participants from the stress of being in a low-status group. Shared identity may provide a positive psychological foundation that can motivate in-group members in low-status groups to come together and work towards social change. On the other hand, members of the high-status group showed more negative reactions in response to inter-group threat and lower levels of social identity.

Stronger feelings of social identity can also be an indication that individuals are ideologically committed to group goals. Political activity and commitment to group goals are interwoven with social identity, as one’s identity with an in-group can give meaning and motivation to behavior (e.g., acts against an individual from the out-group), which might otherwise be seen to be meaningless at the individual level (e.g., personal assault; Cairns, 1996). Early research in this area (see Cairns for a review) suggested that parent political activity may impact the relationship between children’s exposure to political violence and their psychological symptoms (see also Punamäki, Quota, & El Sarraj, 1997). When examining family factors that are associated with child functioning within the context of political violence in Israel/Palestine, Punamäki (1989) found that mothers’ internal locus of control was a moderating or buffering factor for children. Punamäki and Suleiman (1990) also found that ideological commitment had a buffering effect for Palestinian women. Thus, maternal variables associated with a tendency towards taking action in these contexts (i.e., internal locus of control, social-political activity) appear to have ameliorating effects for the mother as well as for her child.

The aim of the current study is to ascertain those processes that are implicated in the associations between protracted political conflict and the family. Utilizing a large sample of families from Belfast, Northern Ireland, we will examine the following hypotheses: (a) mothers’ perceived impact of the Troubles will be directly related to mothers’ current mental health; (b) replicating the existing literature (Beardslee et al., 1983; Weissman et al., 1997, 2006), mothers’ mental health will be directly related to her child’s mental health; (c) following the social identity theory and the social identity model of stress, strength of mothers’ social identity will moderate the link between the impact of the Troubles and their own mental health; and (d) mothers’ ethnicity (Catholic or Protestant) will moderate relations between social identity and the impact of the Troubles on mothers’ mental health, creating a three-way interaction (impact of the Troubles $\times$ strength of social identity $\times$ Catholic/Protestant ethnicity). Historically, Catholics have been considered a lower status (Cairns et al., 2006); therefore, we would expect that strength of social identity will more likely to act as a buffering or protective factor for these families, consistent with social identity theory (Tajfel & Turner, 1979) and empirical findings (Haslam & Reicher, 2006).

METHOD

Participants

Participants for this study included 695 mother-child dyads from Belfast, Northern Ireland. The average age of the children was 12.17 years (standard deviation [*SD*] = 1.82), including 337 boys (49%) and 358 (51%) girls. Mothers' mean age was 37.13 years (*SD* = 6.13). Both single parent and two-parent families were included in the study, reflecting the demographic characteristics of the neighborhoods involved. Thirty percent (*n* = 206) of the sample was married and an additional 13% (*n* = 93) of mothers reported that they were living as married. Among the single parent families, mothers reported the following: 15% (*n* = 104) were separated; 8% (*n* = 59) were divorced; 2% (*n* = 17) were widowed; 5% were dating (*n* = 36), and 26% (*n* = 180) were never married. Sixty-one percent (*n* = 424) of mothers reported growing up in Protestant communities and 39% (*n* = 276) reported growing up in Catholic communities.

Sample Design and Procedure

Several variables guided the selection of neighborhoods (electoral wards) from which participants were drawn. The first goal was to ensure representative sampling of Catholics and Protestants. The second goal was to limit differences in socioeconomic status; thus, families were chosen from all working class, socially deprived neighborhoods. At the same time, we were interested in choosing neighborhoods with varying levels of sectarian violence historically.

Data used for the selection of study areas were derived from the Northern Ireland Housing Executive and the 2001 Northern Ireland Census of Population. The census was based upon Northern Ireland's 582 electoral wards, with an average population of around 3,500 residents per ward. In addition, most wards in Northern Ireland, and all wards in Belfast, are divided into Super Output Areas (SOAs), with an average population of around 600 across Northern Ireland. These small scale SOAs, given their low populations, generally contain homogeneous populations regarding religious/community background and socioeconomic conditions. Our study areas are located in 13 of Belfast's 48 wards and are constructed around 28 SOAs. The levels of religious segregation within the study areas are high when measured by the share of Catholics. Based on our sources of data, 47% of all residents within the Belfast Urban Area were Catholics and around 50% were Protestants. In effect, if all things were equal and there was no religious segregation, each study area would be expected to have relatively equal populations by religion. In reality around 68% of residents in Belfast live in wards that are at least 81% Catholic or Protestant, and it is the case that SOAs are generally more segregated when compared with wards (Shirlow & Murtagh, 2006). Within (as measured by SOA) the predominantly Protestant areas in this study, the population that was Protestant ranged from 90% to 97%. In the predominantly Catholic study areas, the percentage share of Catholics ranged from 91% to 99%. In each instance, the study areas were either grossly over-represented or underrepresented with regard to the percentage share of either ethnic group living within the wider Belfast Urban Area, but they were indicative of the level of religious segregation within highly deprived communities within the city.

Wards were also chosen based on a multiple deprivation measure. This index is measured against all 582 wards in Northern Ireland and is based upon a score of 1, which indicates the most deprived ward, and 582, which indicates the most affluent ward. Multiple deprivation rankings are determined by income, employment, health, education, proximity to services, crime, and the quality of the living environment. All of the areas in this study were located in wards within the worst fifth of all wards in Northern Ireland and 13 of the 18 study areas

are located within the worst tenth (range from rank of 2 to 94, of 582 wards in Northern Ireland).

To ensure variability in historical experience with the Troubles, other data were used, including police records regarding sectarian violence over the past 5 years and other historical information, including the volume and spatial distribution of politically motivated deaths within the city. The demographer also considered the spatial location of interface “peace” walls, as families living in communities adjoining an interface are likely to experience higher levels of violence compared with families that live with buffer zones between their community and the other community. The chosen study areas contained 48.2% of all politically motivated violence in Belfast between 1968 and 2008. The average number of deaths for the study areas (by ward) was 44.6 deaths compared with 16.7 for all wards in Belfast. The number of deaths within the study area ranged from 6–101. All of the study areas were interfaced (i.e., had at least one boundary between it and a community of the alternate political/religious persuasion).

Eighteen specific neighborhoods were identified with 35 to 40 families that were selected for participation from each area. Stratified random sampling was used to identify families across the chosen neighborhoods, so that equal numbers of boys and girls would be represented in the sample. Interviewers from an established market research firm in Northern Ireland surveyed addresses in the designated communities and selected families with a child in the age range of 7–17 years. If the family included more than one child in the designated age range, the youngest child was asked to participate. Prior to the data collection effort, community leaders in each of the 18 areas received letters describing the study and target sample. Interviews were conducted in participants’ homes. The study was conducted under the approval and direction of the institutional review boards at all participating universities, which included obtaining parental consent and child assent before the interviews began. All questionnaires were administered as interviews, which lasted approximately 1 hour for the mother and 30 minutes for the child. Families received £20 for their participation.

Measures

Mothers’ Perceived Impact of the Troubles—Mothers’ answered three questions about the impact of the historical political violence (i.e., the Troubles) on various aspects of her life when she was growing up. Using a 3-point response scale, 0 (*none*), 1 (*a little*), 2 (*a lot*), mothers retrospectively rated the negative impact that the Troubles had on her, her family, and her community in the past (When you were growing up, what was the impact of the Troubles on the area where you lived/your family/you?). Previous research in Northern Ireland has demonstrated that respondents’ both greater subjective experience of the Troubles and the objective level of violence in their area of residence (Cairns & Wilson, 1984) are related to important psychological processes that link political violence and mental health (Myers, Hewstone, & Cairns, 2009), supporting the use of subjective measures of impact of political violence. Responses to the three questions were used as indicators of a latent variable, representing the total perceived impact of the Troubles on mothers. Cronbach’s alpha for the current sample is .91.

Mothers’ Social Identity—Mothers answered five items designed to measure the strength of their in-group social identity in relation to one of the two principal ethno-political communities in Northern Ireland (Catholic or Protestant). Items for this scale were adapted from Brown, Condor, Mathews, Wade, and Williams’ (1986) group identification scale. Sample items include “Would you say you are a person who considers the ____ group important?” and “Would you say you are a person who identifies with the ____

community?” Participants responded to statements with a 5-point Likert-type scale, ranging from 1 (*never*) to 5 (*very often*). The reliability and validity of the scale have been established (Brown et al.), and the measure has been widely used in Northern Ireland. Cronbach’s alpha is .92 for the current sample. The items of the scale were used as indicator variables of a latent variable of social identity.

Mothers’ Adjustment—Mothers’ psychological well-being was measured using the 12-item version of the General Health Questionnaire (GHQ). The GHQ was developed as a screening instrument to identify psychological morbidity in primary care settings (Goldberg & Williams, 1988). The GHQ is sensitive to psychological distress, as it is commonly used as a screening instrument for depression and nonpsychiatric morbidity (Goldberg, Gater, Sartorius, & Ustun, 1997). Respondents use a 4-point Likert-type scale, ranging from 0 (*much less than usual*) to 3 (*much more than usual*), to respond to statements such as “Have you recently been able to face your problems” and “Have you recently been losing confidence in yourself.” For the current study, a continuous scale with all summed items was used. Possible scores range from 0 to 36, with higher scores indicating increased problems. The short, 12-item version of the measure has been used extensively in Northern Ireland and has been shown to be both reliable and valid among community samples in Northern Ireland (Curran, Bell, Murray, Loughrey, Roddy, & Roche, 1990). Cronbach’s alpha for the current sample is .89. The mean GHQ score for mothers was similar to a sample of respondents that completed the GHQ-12 as part of the Northern Ireland Household Panel Survey in 2001 (Murphy & Lloyd, 2007).

Child Adjustment—Children completed the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997). The SDQ includes 20 items with four subscales that reflect negative child behaviors (emotion problems, conduct problems, hyperactive symptoms, and peer problems) and 5 items that assess prosocial behaviors. Psychometric properties are well established in U.K. samples and shown to be preferable to the Child Behavior Checklist (CBCL; Achenbach, 1991) for use with community samples (Goodman & Scott, 1999). Participants responded to statements (e.g., “I worry a lot,” “I am restless, I cannot sit still for long”) with a 3-point scale, 0 (*not true*), 1 (*somewhat true*), and 2 (*certainly true*). For the current study, the items of the emotion problems subscale were used as manifest indicators of a latent variable that represents child emotion problems. Cronbach’s alpha for these items was .61. Low internal consistencies for the SDQ subscales have been identified across multiple samples (Palmieri & Smith, 2007). Modeling the subscales as indicators of a latent variable of child emotion problems decreases the bias of estimates, because the measurement error is estimated within the structural equation modeling framework utilized in the current study (Dunn, Everitt, & Pickles, 1993).

RESULTS

Means, standard deviations, and bivariate correlations for all study variables are included in Table 1. The construction of latent variables was supported by the significant correlations between indicator variables for the proposed variables. Correlations corresponding to factor indicators are in bold font in Table 1.

To test the main hypotheses, models were tested within a structural equation modeling framework using AMOS version 4.0 (Arbuckle & Wothke, 1999). To assess model fit, several indices are reported, including the chi-square discrepancy value, the root mean square error of approximation (RMSEA; Browne & Cudeck, 1993), the normative fit index, and the comparative fit index (CFI; Bentler, 1990). Acceptable model fit is suggested by scores below three on the χ^2/df index (Bollen, 1989), values above .90 for the CFI and NFI (Hu & Bentler, 1999), and RMSEA values below .08.

As a first step, the measurement model was tested by running a confirmatory factor analysis on the four latent variables. All indicators were forced to load on their given factors and the four latent variables were allowed to correlate. This base model had acceptable model fit: $\chi^2(98) = 380.81, p < .05$; $\chi^2/df = 3.89$; NFI = .94; CFI = .96; RMSEA = .064 (confidence interval [CI], .058, .071). All factors loaded significantly on their respective latent variables at the $p < .001$ level and all standardized factor loadings were .46 or higher.

To test for moderation between mothers' social identity and the impact of the Troubles, the unconstrained match pair approach was used to create the interaction term between the two variables (Marsh, Wen, & Hau, 2004). This approach specifies that the interaction term be created by multiplying the indicators of the two main variables in such a way that the indicator with the highest factor loading on the first variable be matched with the indicator with the highest factor loading on the second variable. This cross product is used as one indicator of the latent variable representing the interaction. The indicators with the second highest loadings are multiplied to create the second indicator and so forth. In this case, the impact variable has only three indicators; thus, the interaction latent variable will include only the cross-products of the three indicators from the impact variable and the three indicators with the highest loadings from the social identity variable. In this case, the three items with the highest loadings were item 5 (see yourself belonging to your community), item 4 (person who is glad to belong to your community), and item 3 (person who feels strong ties to your community).

Marsh et al. (2004) found that this approach performs well with non-normal data and the bias in estimation of parameters decreases with larger samples. Before multiplying the indicators to create the indicators of the interaction term, the items are centered; thus, the items for the latent variables representing social identity and the impact of the Troubles were all centered.

The proposed model was first tested with the full sample of participants. Results of the model can be seen in Figure 1. Model fit indices suggest the model fit the data well, $\chi^2(163) = 599.91, p < .05$; $\chi^2/df = 3.68$; NFI = .96; CFI = .97; RMSEA = .062 (CI, .057, .068). As hypothesized, there was a significant positive relationship between the impact of the Troubles on mothers and her current mental health as measured by the GHQ ($\beta = .11, p = .006$), reflecting that historical, self-reported impact of the Troubles on mothers was linked with more mental health symptoms in mothers. The mothers' GHQ symptoms, in turn, were significantly related to child symptoms ($\beta = .14, p = .006$), suggesting a pathway from the historical negative impact of the Troubles to mother's mental health symptoms to children's problems.

Group Comparisons

To test for differences in path coefficients between Catholics and Protestants, the base model was fit separately for each group with all paths free to vary. Using a χ^2 test, this model is then compared with a model in which the paths are constrained to be equal for both groups (Bollen, 1989). Consistent with the hypothesis, the path between the interaction term of social identity and the impact of the Troubles that predicts mothers' mental health was significantly different for Catholics and Protestants, $\chi^2 \text{ diff } (1) = 13.60, p < .05$. For Protestants, the interaction path was positive ($\beta = .15, p = .02$), indicating that higher social identity strengthened the association between the Troubles and mothers' current mental health, serving as a vulnerability factor for this group. However, for Catholics, the interaction term has a negative sign ($\beta = -.19, p = .005$), suggesting that social identity buffered the association for this group. In other words, for Catholic mothers with higher social identity, the link between the impact of the Troubles and her mental health is weaker compared with mothers with lower levels of social identity.

DISCUSSION

This study examined the relations between mothers' experience with violent political conflict during the Troubles, mothers' mental health, and the psychosocial adjustment of their children. Although research has established that growing up in a community defined by community violence is associated with deleterious outcomes (Garbarino et al., 1992; Lynch, 2003; Margolin & Gordis, 2000), there is a dearth of information about the associations between mothers living in a community that experienced protracted political conflict and the well-being of their children. Having recently experienced an extended period of violent political conflict, the post-accord status of Northern Ireland at this time (Cairns & Darby, 1998) provides an appropriate arena in which to examine such associations for mothers who have lived and continue to live in this divided society. The current study examined the relations between mothers' self-reported impact of the Troubles, her current mental health, and her child's current mental health, identifying potential processes through which political violence is linked with elevated mental health symptoms in multiple generations.

Consistent with the existing literature that shows increased symptomatology for adults who have experienced political violence (De Jong et al., 2003), we found that mothers' self-reports of the impact of the Troubles on her, her family, and the area in which she lived was related to elevated symptoms of psychological distress. In turn, mothers' symptoms were related to her child's mental health. Despite the sustained peace agreement that has been in place in Northern Ireland for over 10 years, this result could be interpreted as indicating that the effects of the Troubles continue to affect mothers in these communities. However, this interpretation is speculative, particularly given the impossibility of randomly (and ethically) assigning mothers to different levels of exposure to violence, and given the possibility that other factors not included in this study could have contributed to the results. At the same time, although mothers' accounts of the impact of the Troubles are retrospective, the present study provides evidence that her experiences are related to her mental health more than a decade after the ceasefire and peace agreement.

After the social identity model of stress (Haslam & Reicher, 2006), differences in these processes were examined separately for Catholics and Protestants. The social identity model of stress claims that group differences in stress responses will be observed under certain conditions. More specifically, Haslam and Reicher suggest that for group distinctions that center on impermeable boundaries of ethnicity, lower status groups will adopt a coping response that acts to bring individuals within the group together to promote social change. Given the historical conditions within Northern Ireland, it was hypothesized that social identity would have different associations with mothers' mental health for Catholics and Protestants. This hypothesis was supported by the significant differences in pathways between the interaction term (impact of the Troubles and mothers' ethno-political social identity) and mothers' current mental health. When estimated separately, the path between the interaction term and mothers' mental health was different for Catholics and Protestants, suggesting differences in the extent to which the impact of the Troubles relates to mothers' mental health currently. The impact of the Troubles was linked with poorer functioning mothers in both groups, suggested by the positive association between impact and mothers' symptoms. For Catholic mothers with stronger social identity, this link was weakened, suggesting that social identity may be protective for Catholic mothers. On the other hand, this path was stronger for Protestants with higher social identity, suggesting that social identity, as it is related to the Troubles, is a negative factor.

The results further support the notion that differences in the social identity processes can be partially explained by perceptions of the in-group's relative status. The differences in the role of mothers' social identity for mothers' mental health and her child's mental health may

be partially explained within the double-minority model (Jackson, 1971), which suggests that both Protestants and Catholics may consider themselves to have a minority status. More specifically, Protestants/Unionists may think of themselves as lower status when considering the entire island, including both the Republic of Ireland and Northern Ireland, whereas Catholics are and have been historically minorities in Northern Ireland. As demographics and relations between Catholics and Protestants have shifted since the Belfast Agreement, with some suggesting more upward progression for Catholics, Protestant minority status may have become more salient (Cairns et al., 2006); thus, given the dynamic nature of social identity, the moderating effects of social identity in Northern Irish society may be more complicated, as reflected in our results.

It would appear that the two identities operate in different ways. On the one hand, a sense of achievement for Catholics/Republicans/Nationalists may have resulted from the relative gains, socially, politically, and economically, since the Belfast Agreement (Shirlow & Murtagh, 2006). In cultural terms, there has been a growth in Irish language and Gaelic games, and in addition to this, government funding now supports being culturally Irish. Republicans/Nationalists also achieved greater economic access to the labor market and there are greater signs of social mobility and the acquisition of third-level qualifications. This has been paralleled by enhanced equality legislation.

In contrast, it would appear that possessing a stronger identity has negative implications for Protestant mothers. This, again, can be potentially explained in terms of the relative loss because of the Belfast Agreement (Shirlow & Murtagh, 2006). In Belfast, there has been a significant “loss” of territory and the city is constantly shifting from being predominantly Protestant to Catholic. In addition to this loss, the Protestant community has been more affected by deindustrialization and the loss of status within the labor market. There is a sense that the control of Orange Parades has been inspired by concessions to Republicans and that their cultural identity has been undermined. The changing nature of perceived status for Catholics and Protestants as Northern Ireland progresses in the post-accord period will be important to consider in future studies of the links between social identity and mental health.

The results of the current study should be considered within the limitations of the methodology. An important limitation is the cross-sectional nature of the data. Because these findings are based on one wave of data, causal inferences cannot be made, and it is possible that mothers’ current mental health status has influenced her recall about the impact of the Troubles. We also recognize that the mechanisms that contribute to and link both maternal and child mental health are likely many, including genetic predisposition and other shared components of the environment. The cross-sectional nature of the data also guided the decision to model social identity as a moderating variable. Considering the studies that have examined social identity as a moderator or buffering mechanism as well as the studies examining it as a process-level variable, it is expected that social identity filters an individual’s experience of intergroup threat (e.g., experiences of political conflict) and also changes in the face of such threat. This distinction would have been difficult to tease apart given the retrospective nature of the data, and thus, social identity was modeled as a moderator. Future studies should continue to examine the dynamic changes in social identity as both a process mechanism and a moderating (e.g., buffering or risk) variable.

It is also recognized that social identity is multidimensional, with components such as ethnicity, religion, and national identification, among other things (Muldoon, Trew, Todd, Rougier, & McLaughlin, 2007) intertwined in such a way that is masked by simple dichotomies. At the same time, research has indicated that a majority of people in Northern Ireland continue to identify with either the Catholic or the Protestant community. Future

research should examine the role of these various elements of social identity in mental health processes as Northern Ireland progresses in the post-Agreement period. The findings could also be strengthened with measures of child and mother mental health, including more rigorous assessments of depressive symptomatology and clinical interview data.

In summary, the results suggest that issues related to the Troubles may still be contributing to mothers' mental health, although mothers' reporting of their Troubles-related experiences was retrospective. More important, it would appear that these conflict-related experiences from the past might be associated with her child's current psychological well-being. Further, in line with the social identity model of stress, mothers' social identity moderated the links between the impact of the Troubles and her mental health with differences in the role of social identity for Catholics and Protestants.

These results have several policy implications for post-accord societies. To begin with, those conflict resolution solutions that aim to eradicate existing conflictual social identities by embracing a "melting pot," single identity solution, or one in which, for example, a majority group assimilates a minority group, should be viewed with some caution, given the possibility that they may be removing an important buffering mechanism where mental health is concerned. More important, if replicated, the current results indicate a need for increased mental health provision not just into the immediate post-accord period, but also beyond the lifetime of the generations who actually experienced the conflict. Finally, it is also important for policy makers and others to note that just because two communities are locked together in conflict does not mean that the same psychological processes are occurring within each group. In turn, this may mean that different solutions are needed to solve the same problems in each group.

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Figure 1.

Examining associations between the Troubles and children's mental health through mothers' mental health and social identity. *Note.* Standardized path coefficients reported. Error variances omitted from the model. * $p < .05$; ** $p < .01$. *f* indicates fixed path. Moderated path indicated in bold font. Model fit: $\chi^2(163) = 599.91, p < .05; \chi^2/df = 3.68; NFI = .96; CFI = .97; RMSEA = .062 (CI, .057, .068).$

Table 1
Bivariate Correlations, Means, and Standard Deviations for All Study Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	M	SD
1. Impact of the Troubles on You	–													0.80	0.77
2. Impact of Troubles on Family	.87***	–												0.92	0.80
3. Impact of Troubles on Area Lived	.69***	.73***	–											1.14	0.80
4. SI 1 (Consider community important)	.10*	.08*	.05	–										4.09	0.94
5. SI 2 (Identify with community)	.13***	.13***	.08*	.74*	–									4.02	0.93
6. SI 3 (Feel strong ties to community)	.09*	.09*	.10**	.69***	.69***	–								4.01	0.97
7. SI 4 (Glad to belong to community)	.13**	.13**	.12**	.64***	.61***	.70***	–							4.06	0.89
8. SI 5 (See self belonging to community)	.14***	.14***	.12**	.66***	.66***	.68***	.82***	–						4.07	0.86
9. GHQ Mom	.10**	.11**	.06	–.03	–.02	.01	–.02	–.01	–					10.94	5.64
10. SDQ 1 (somatic complaints)	–.01	–.02**	.06	–.13	–.12**	–.11**	–.07	.09*	.13**	–				0.37	0.63
11. SDQ 2 (worry)	.05	.03	–.01	–.06	–.07	–.03	–.03	–.03	.05	.22***	–			0.51	0.65
12. SDQ 3 (often unhappy)	–.05	–.02	–.02	–.09*	–.10**	–.09*	–.07	–.06	.05	.30***	.23***	–		0.28	0.55
13. SDQ 4 (nervous in new situations)	–.06	–.04	–.04	–.04	–.08*	–.09*	–.05	–.04	.03	.26***	.24***	.23***	–	0.69	0.73
14. SDQ 5 (many fears, easily scared)	–.13***	–.13***	–.18***	.05	–.01	–.01	–.05	–.01	.09*	.17***	.32***	.19***	.24***	0.51	0.67

Note. M = mean; SD = standard deviation; SI = Social Identity; GHQ = General Health Questionnaire; SDQ = Strength and Difficulties Questionnaire.

* $p < .05$;

** $p < .01$;

*** $p < .001$.