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Psychological symptoms in children who are victims of war and migration: Comparison of Turkish and Syrian students

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Abstract

The aim of this study is to examine whether exposure to war and migration trauma has a long-term effect on psychological symptoms in children. The Brief Symptom Inventory was administered to a total of 207 students, 111 of whom were Syrians and 96 of whom were Turks, studying at a secondary school in the Mamak district of Ankara. The data obtained show that Syrian students have higher average scores in the anxiety, negative self and somatisation sub-dimensions than their Turkish peers. This situation can be considered an important indicator as war and forced migration caused by war negatively affect children's mental health. As a matter of fact, the effects of post-traumatic mental health disorders in children who have experienced war trauma can be seen even 5 years after the traumatic event. Syrian students whose mental health was evaluated within the scope of this research have been living in Turkey for 4–6 years.

Keywords: Children, victims, psychological symptoms, war, migration;

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1. Introduction

According to the World Health Organisation, health is not just the absence of disease and infirmity, but it is a state of complete physical, mental and social well-being (WHO, 2021). In other words, humans have biological, psychological and sociological characteristics and these three concepts have a strong interaction with each other. The important thing is the well-being of these three elements. The Oxford English Dictionary (2021) defined well-being as 'general health and happiness'.

One of the main situations that negatively affect the psychological well-being of individuals is trauma experiences. The Turkish Psychiatric Association (TPD) has defined mental trauma as a situation created by unexpected events that frighten individuals, create a sense of horror and helplessness and cause death or injury to himself or his relatives (TPD, 2021). Studies show that migrant children who are victims of war experience post-traumatic stress disorder, generalised anxiety, somatisation, behavioural problems and academic problems (Betancourt et al., 2012). According to a systematic review study, immigrant children have more internalising behaviour problems. At the same time, first-generation immigrant children are in the risk group in terms of their mental status (Belhadj Kouider, Koglin, & Petermann, 2014).

Many refugees and asylum seekers experience or witness traumatic events, such as rape, torture, war, imprisonment, murder, physical injury, genocide before leaving their country (Nicholl & Thompson 2004). As a matter of fact, it is reported in studies that post-migration psychological tension, in other words, stress factors, have a strong negative effect on human psychology, rather than pre-migration traumas in asylum seekers/refugees (Teodorescu et al., 2012). The fact that children who have experienced trauma in wars and conflicts face uncertain life situations during and after migration cause an advanced level of danger and risk on their mental health. These risks are reported as losing their home and homeland while migrating, having to be separated from their parents, extended family, peers or caregivers, interruption of their school life, witnessing the torture and death of some of their family members. The dangers and risks during migration are reported as separation from the caregiver, exposure to bullying, violence and brutality, exposure to negative and harsh living conditions, such as refugee camps, unhealthy nutrition, uncertainty and hopelessness about the future (Ehntholt & Yule 2006; Kirmayer et al., 2011; National Child Traumatic Stress Network Refugee Trauma Task Force, 2005). Individuals who have experienced the trauma of migration and war and then settled in other countries as refugees generally convey their longing for the past about their families, the environments they used to live in and their children. Selective memories and fantasies about their home, hometown and 'definitive return' have both a narcotic and a healing effect on them (Gündüz, 2011). Factors such as Syrian immigrants fleeing war, violence and oppression, living under these difficult conditions for a while, the escape process itself and coming to a different region and culture as an asylum seeker can adversely affect the mental health of individuals, especially children (Uzunboylu et al., 2017).

The sociopolitical unrest that started in Syria in 2011 turned into conflicts in a short time and then into a civil war with numerous actors. Due to the war that has been going on for about 10 years, there has been a serious wave of migration, especially to neighbouring countries. 13.5 million people had to migrate to safe areas by changing their homes, cities and countries (AFAD, 2016). According to the 2020 report of the United Nations Refugee Organisation, the number of people in need of temporary protection in Turkey is 3 million 650 thousand (UNHCR, 2020). Again, according to the

latest report published by the Refugees Association (2021); the total number of Syrians under temporary protection in Turkey is 3 million 690 thousand 896 people. 1 million 774 thousand 520 (48%) of these people are children between the ages of 0 and 18 years.

The traumatic experiences of approximately one million Syrian migrant children living in Turkey, as well as the events they encounter during and after the migration process, can be an important risk factor for their mental health. This research was carried out in order to examine whether being exposed to the trauma of war and migration has an effect on psychological symptoms and to create a perspective for mental health professionals on this issue.

2. Methods

2.1. Study group

This research was carried out with the participation of 207 students, 111 of whom are Syrians and 96 of whom are Turks, studying at a secondary school in the Mamak district of Ankara, Republic of Turkey. The ages of the participants range from 11 to 15 years, with an average of 12.5 years. While determining the study group, the purposive sampling method, which is one of the non-probability sampling methods, was adopted. In the purposeful sampling method, the participants who will be included in the research are determined in accordance with the purpose of the research, based on the previous knowledge, experience and observations of the researchers (Ural & Kılıç, 2006). The Brief Symptom Inventory (BSI) was administered to the participants. Details regarding the demographic information of Turkish and Syrian students are shown in Table 1.

Table 1. Demographic data of the study group.

Nationality	Gender				Age	Socio-economic status						Trauma experience			
	Female		Male		Mean	Low		Medium		High		Yes		No	
	N	%	*N*	%		*N*	%	*N*	%	*N*	%	*N*	%	N	%
Syrian	55	49.5	56	50.5	12.70	25	22.5	77	69.4	9	8.1	84	75.7	27	24.3
Turkish	51	53.1	45	46.9	12.23	14	14.6	78	81.3	4	4.2	17	17.7	79	82.3

It is seen that the demographic characteristics of the study group selected for the research show similar characteristics in terms of variables such as age, gender and socio-economic level. The main difference between the two groups is whether they have encountered a traumatic life event in the past. While three-quarters of Syrian-origin students stated that they were exposed to trauma, this rate is around one-fifth for Turkish students. The Syrian students included in the study are educated in a public secondary school together with their Turkish peers. Therefore, it is thought that Syrian students' ability to understand and use Turkish is sufficient.

2.2. Measure

2.2.1. Demographic information form

It was developed by the researchers in order to obtain basic information about the study group and to reveal the relationship between these data and other variables. It consists of age, gender, class level and income status variables.

2.2.2. Brief symptom inventory (BSI)

It is a 5-point Likert-type scale created by Derogatis (1992) to measure various psychological symptoms by selecting 53 items of the SCL-90-R with the highest load in each factor. The Turkish adaptation of the scale was carried out in two separate studies (Şahin & Durak, 1994; Şahin, Batıgün, & Uğurtaş, 2002). In this form, there are five subscales: anxiety, depression, negative self, somatisation and hostility. Items in this subscale are listed as follows:

'Anxiety' : items 12, 13, 28, 31, 32, 36, 38, 42, 43, 45, 46, 47 and 49;

'Depression' : items 9, 14, 16, 17, 18, 19, 20, 25, 27, 35, 37 and 39;

'Negative Self' : items 15, 21, 22, 24, 26, 34, 44, 48, 50, 51, 52 and 53;

'Somatisation' : items 2, 5, 7, 8, 11, 23, 29, 30 and 33;

'Hostility' : items 1, 3, 4, 6, 10, 40 and 41.

The score that can be obtained from the scale varies between 0 and 212. High scores on the scale indicate the frequency of psychological symptoms. The Cronbach alpha value of the scale in the study was 0.937, which shows that the scale is quite reliable. The internal consistency coefficients for the anxiety, depression, negative self, somatisation and hostility sub-dimensions of the scale were 0.90, 0.91, 0.88, 0.90 and 0.79, respectively.

2.3. Data collection

In November 2019, the BSI was applied to Syrian and Turkish students in a secondary school located in a district in Ankara city centre where Syrians are densely populated. The applications were carried out in the classroom environment, by means of paper and pencil, under the supervision of the researchers. Measurement tools were applied to both groups in Turkish. In the application of the scale, consent was obtained from the individuals first. It is stated that the answers will be kept confidential. Non-volunteers were not included in the study. Answering the questions took 30–40 minutes, although it varied according to the speed of the people. Since the comparison between the groups will be made, the equality of the participants according to the nationality has been tried to be ensured as much as possible (111 = Syrian, 96 = Turkish). Afterwards, the data were transferred to the computer environment and SPSS package programme was used for analysis.

2.4. Analysis of the data

Before analysing the research data, it was examined whether the data met the assumptions of the parametric tests. For this purpose, the arithmetic mean, median and mode values of the brief symptom inventory and the skewness and kurtosis coefficients of the total score were calculated and analysed. The obtained values are given in Table 2.

Table 2. Descriptive statistics on BSI

	$\bar{x}$	Ortanca	Mod	Çarpıklık	Basıklık

BSI	38.75	32.00	13.00	0.874	0.253

When Table 2 is examined, it is seen that the skewness and kurtosis coefficients obtained from the brief symptom inventory total score are between +1 and –1. These obtained values can be interpreted as the data showing a normal distribution (Can, 2016). Since the normality assumption was met, there was a significant difference between the mean scores of Turkish and Syrian refugee children who were examined with the *t*-test.

3. Findings and discussion

In this section, the average scores of Syrian students living in Turkey and Turkish students from the brief symptom inventory were compared for the purpose of the research. Data on BSI mean scores are shown in Table 3.

Table 3. BSI *t*-test results of Turkish and Syrian secondary school students

Scales and Sub-dimensions	Groups	*N*	x̄	SS	SD	*t*	*p*
Anxiety	Syrian	111	10.55	8.39	205	2.51	,01
	Turkish	96	7.95	6.41			
Depression	Syrian	111	9.82	8.49	205	1.22	0.225
	Turkish	96	8.50	7.11			
Negative Self	Syrian	111	9.82	8.20	205	2.12	0.04
	Turkish	96	7.69	6.25			
Somatisation	Syrian	111	6.32	5.74	205	3.23	0.00
	Turkish	96	4.16	3.86			
Hostility	Syrian	111	5.95	4.52	205	−0.07	0.94
	Turkish	96	5.99	3.95			

The data obtained show that Syrian students have higher mean scores in the anxiety, negative self and somatisation sub-dimensions than their Turkish peers. No statistically significant difference was found in the sub-dimensions of depression and hostility.

There are research results that support the findings obtained within the scope of the research in the relevant literature. In a study examining 60 migrant children who were victims of war, 30% of the children had post-traumatic stress disorder; 26% had anxiety and somatisation; and 21% had trauma-related grief and behaviour problems (Betancourt et al., 2012). 75% of the Syrian migrant children participating in this research have trauma experience. One of the most important reasons for the mental health problems of migrant children, especially victims of war, is the traumatic life experiences they were exposed to before migration. Heptinstall, Sethna, and Taylor (2004) revealed in their study on 40 migrant children living in London that the trauma experience before migration was associated with the findings of post-traumatic stress disorder after migration.

This situation can be considered an important indicator as the war and forced migrations as a result of the war negatively affect the mental health of children. As a matter of fact, the effects of post-traumatic mental health disorders in children who have experienced war trauma can be seen even 5 years after the traumatic event (Sack, Him, & Dickason, 1999). Syrian students whose mental health was evaluated within the scope of this research have been living in Turkey for 4–6 years. This shows that the effects of traumatic events such as war can last for a long time. For example, Çeri et al. (2017), in their study, comparing the second-generation children of immigrant families with their non-immigrant peers, revealed that the second-generation children of immigrant families had higher depression, anxiety and post-traumatic stress disorder scores.

Although migration and changes due to migration have negative effects on children's mental health, some research findings do not support this result. In a systematic review study of 35 research articles from the USA and Canada, immigration alone cannot be a risk factor for children's mental health. Factors affecting the mental health of immigrant children are mostly family-based. Low language skills, stress caused by acculturation and strict parenting attitudes are the main factors that impair mental health in immigrant children (Belhadj Kouider, Koglin & Petermann, 2015). Better still, school and community-based interventions yield positive results in helping children overcome the challenges they face due to migration (Tyrer & Fazel, 2014).

4. Conclusion, recommendations and future directions

Forced migrations caused by different reasons and the subsequent adaptation process can have some negative effects on children's mental health. However, when suitable conditions are provided for children and their families, this effect can be reduced and minimised over time. In order to minimise the negative effects of forced migration on children, preventive psychoeducation programmes for children can be implemented. Regardless of whether they have a traumatic experience or not, the acquisition of skills that will help immigrant children to better understand the process will prevent long-term mental health problems.

A more detailed examination of immigrant children with long-term longitudinal studies and research in different areas such as social, cognitive, academic and personality with a comprehensive developmental perspective will contribute to the development of more effective preventive interventions. As a matter of fact, both direct interventions for children who are victims of war and

migration (Reynolds & Bacon, 2018) and interventions for migrant children's peers (Çekiç & Hamamcı, 2020) yield effective and positive results. The development and implementation of such intervention programmes and their dissemination through institutions that are important in social integration such as schools can be recommended to prevent possible mental health problems of migrant children who are victims of war and to improve the existing problems.

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