



Bahçeşehir Study of Syrian Refugee Children in Turkey

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PREFACE

The media reports of the Syrian refugees pouring into Turkey, the plight of the women and children being displaced and not being able to attach meaning to their suffering, spurred a professional concern about their well-being among us as psychologists and researchers. We thought it was important to shed light over what these refugee children had experienced and share with the public our worries about the consequences that exposure to the cruelties of violent war may have for their health and psychological well-being. This was the backdrop of the Bahcesehir Study of Syrian Refugee Children in Turkey. We want to direct our warmest appreciation to the resident mothers and their children in the Islahiye camp, who willingly shared their experiences with the project team. Their efforts has contributed important knowledge to the general public about the hazards of a war that children have no choice but to be part of.

This study would not have been possible without the generous support of the Chairman of the Board of Trustees of Bahcesehir University, Mr. Enver Yücel.

Furthermore, the study could not have taken place without the support of Erdal Ata, The Governor of Gaziantep, and Osman Beyazyıldız, the Director of the. At the camp, the Turkish Educational Coordinator Kasım Tahiroğlu was an untiring asset.

Our students in the research team : Oğulcan Sözen (BUSAR Department Head), Sertaç Emil Kement , Fulya Gülada, Esin Enisoğlu, Kübra Arslan, Büşra Güler, Gökçe Ergin worked tirelessly to assist the children at the camp during the data collection. A special thanks also to Roda Akgün who put so much effort into the project from the planning phase to the entering of the data which has made possible the analyses of the children's responses. We also want to appreciate our student from Syria, Mohammed Memmeh, who was our guide and our interpreter throughout our visit in the Islahiye camp in Gaziantep and did this quietly and competently even though what we were observing was doubly hard for him as a compatriot of the residents. Finally, we would like to thank Turgay Polat and Yael Habif who helped us making our voice heard.

Thank you all,

Serap Özer

Selçuk Şirin

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Map of Syria and neighbouring countries.



Map retrieved from UNHCR (<http://www.unhcr.org/cgi-bin/texis/vtx/home/opendocPDFViewer.html?docid=50d192fd9&query=map%20syrian%20refugees>)

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Introduction



Background

Since civil unrest and fighting broke out in Syria in March 2011, more than 160.000 refugees have come across the border to Turkey. Although the figures vary from day to day it is indicated by governmental agencies that close to half of this population is under the age of 18 (AFAD, 2013). The Turkish government set up camps along the Turkish / Syrian border to provide shelter, food, and medical care.

The news reports from Syria have demonstrated that civilians are frequently caught up in the civil war between governmental forces and the rebels. With few places to escape, they are exposed to life threatening experiences and dangers, and there is no way of protecting the children more than the adults. It is well documented in the literature that children who are exposed to war and political violence have very high risk of suffering from mental health problems as a consequence (Ehnholt & Yule, 2006; Khamis, 2005; Qouta, Punamäki, & El Sarraj, 2003; Thabet, Abed, & Vostanis, 2002). However, in the case of the Syrian refugee children, there is a lack of

systematic data about the characteristics of the traumatic events they have encountered and how children react to these events.

The most common reactions to traumatic experiences are posttraumatic stress disorder (PTSD) and depression (Hasanovic, 2011, Thabet, Abed, & Vostanis, 2004), and this has been observed with a higher frequency among refugee children living in camps as opposed to urban or rural areas (Khamis, 2005). Additionally, children may also develop conduct disorders, including aggression and other affective disorders as a result of the traumatic events they have been exposed to. These mental health problems that onset during childhood have long term developmental toll for both for the child and the society at large. For the child the problems are typically associated with reduced level of functioning, within the family, among friends, or in relation to school or leisure activities. Even if most children who are surrounded by caring and supportive friends and family are able to cope with their mental health problems with time, some will develop chronic mental health problems. In general, children who experience mental health problems are at increased risk of reoccurrence of the problems throughout the life span. For society, this is costly, as mental health problems are the main cause of sick leaves and unemployment. Also, individuals with mental health problems are a substantial burden to their families and their local communities. All this may of course represent significant challenges to the rebuilding of societies when the war hopefully ends, and the refugees can return safely back to their homes.

Consequently, there are several reasons to gather systematic information about the war experiences and mental health problems of refugee children. It was the purpose of the current study to investigate the type and number of war related traumatic events Syrian children who are living in refugee camps in Turkey have been exposed to, and the prevalence of mental health

problems among them. The current study employed mixed methods of surveys and children's drawings. The surveys covered a wide range of demographic and mental health areas. Children's drawings have long been suggested as a tool to study their understanding and reflection of e.g. self-concept, gender roles, and emotional development (Gardner, 1980; Stiles, Gibbons & deSilva, 1996). More recently children's drawings have also been utilized to understand their conceptions of war and peace (McLernon & Cairns, 2001; Myers-Bowman, Walker & Myers-Walls, 2005). While most of the main findings of the current study is widely covered in Turkish and international press, this report provides a more detailed documentation of the findings with attention to methods and the design of the project.

The camp that was visited for the purposes of this research is located about 100 kilometres outside of Gaziantep, which is a medium sized industrial town

The Islahiye Refugee Camp in Gaziantep

in south-eastern Turkey. The camp is located in Islahiye at an old factory site. The tents are placed in the land of this setting. The few buildings on the site are being used for administration and health service purposes. At the time of the research the camp housed 8360 refugees. It was reported by the camp authorities that more than half of them were children. The families reside in tents. Three meals a day are provided by the camp authorities. Due to fire hazard they are not allowed to cook in their tents. The backside of this precaution might be that an important daily activity that may empower women and give routines to their time is not available to them. The residents are provided with an identification system which allows them to get in and out of the camp. We were informed that some of the refugees actually leave the camp to work in the fields and sometimes take their children with them.

A makeshift school has been set up at the camp. The school consists of 8 tents inside the deserted warehouse. There are desks and seats for about 20 children in each tent. The school is overseen by a teacher assigned by the Turkish government and a Syrian school counsellor. Because school attendances is voluntary, not all children attend to school. According to the information given to us, around 1000 children go to school on a regular basis. The children are taught by volunteer teachers using limited resources in Arabic. Children attend school in a shift system with younger children attending only a selection of the week-days, or alternatively there is a shift system where younger children attend in the morning and older children attend school in the afternoon.





Camp Life

The Syrian refugees have escaped fright, anxiety, the social upheaval and chaos in their home country, - the menaces of the bombing and shooting in the streets of their neighbourhoods, and found safety in the camps provided by the Turkish government. For the Syrian families and for all other families in refugee camps, this is a transitional placement, without specific time limits. Even if safe and protected from the dangers of the bombings and shootings, life in camp is nevertheless characterized by much uncertainty about the prospect of their future. Furthermore, adults and children alike are dependent on external sources of support in order to meet their basic needs, which may produce feelings of powerlessness and loss of authority. The refugees have all experienced several tangible losses in terms of the things associated with their homes, and also losses in terms of close friends and extended families.

Method

The Participants

The sample frame of the project consisted of the 1000 children that were said to attend the school. Informed consent forms approved by the *Internal Ethics Review Board* of Bahçeşehir University and a questionnaire including demographic information were sent to the parents with each of the school's students. The children of the 357 parents, who agreed to their offspring's participation, were targeted for inclusion in the project, but 46 of them did not show up, or did not want to participate themselves.

The final group of participating children were between 9 and 18 years old, with a mean age of 12.4 years. There were slightly more girls, 175 (56%) than boys 136 (44%).

Table 1. Ages and gender of children who participated in the study

Age	Girls	Boys	Total
9,00	7	10	17
10,00	22	8	30
11,00	34	36	70
12,00	40	37	77
13,00	24	25	49
14,00	27	13	40
15,00	16	6	22
16,00	4	1	5
18,00	1	0	1
Total	175	136	311

To what extent the participating children are representative of all the children residing in the Islahiye camp, is not known. However, in general mental health research has shown that people who volunteer for studies are usually the ones who are in better condition and have more psychological resources than the nonvolunteering. Because of this it is believed that the results presented in this report may be an underestimation of the problems being experienced by the children in the camps.



Procedures

The data collection of the 'Bahçeşehir Study of Refugee Children' took place in November 2012. The camp authorities made the school tents available for this purpose. A research team including faculty and advanced psychology students of Bahçeşehir University visited

the camp on 3 consecutive days to help and support the participating children in their efforts to fill in the questionnaires and make drawings about their experiences.

Parents provided demographic information such as age, gender, length of stay in the camp, and the place of origin in addition to some very basic health information about themselves and their children in the questionnaires they received with the consent form. Demographic data and drawings were obtained from all 311 children between the ages of 9 and 18, 175 girls and 136 boys. The children were also asked to fill a self-report questionnaire with standardized measures of the traumatic events they had been exposed to, their health and the social support available to them. Those children who refused to respond to the questionnaires or left all or large parts of the surveys blank, were not included in the quantitative analyses. Thus, after eliminating missing cases, there were a total of 185 girls and 103 boys with full data.

Data gathering took place in groups of 15-20 children. General information about the purposes of the study was given to the participating students by their teachers. The questionnaires were all in Arabic, and before they were given to the children, the Turkish researchers gave instructions that were translated by the translators. The members of the BAU research team were available to answer any other questions during the data gathering sessions again with the help of the translators. After the completion of the surveys, the children were provided with 3 sheets of paper. Initially they were asked to *“Draw a person”* followed by the instructions *“Draw a person, a whole person and not a stick figure”*. There were no time limitations while drawing. Following the completion of the Draw A Person, each child was then instructed to draw pictures of “War” and “Peace”.

Measures – Standardized Scales

Traumatic Events (Stressful Life Events Questionnaire :SLE) : The questionnaire listing 11 traumatic events (such as “Has someone died in your life that you really cared about, has someone ever hit, kicked, shot at or some other way tried to physically hurt you” etc.) was developed by Bean et al. (2007). The scale consisted of 12 items; the item questioning sexual abuse was left out since due to the use of interpreters in a group setting it was believed that it may prove to be sensitive. The children are given statements describing the events are asked to respond “yes” or “no”.

Social support was measured by Social Provisions Scale (Cutrona, 1987): This scale was developed by Cutrona (1987) to examine the degree to which respondent’s social relationships provide various dimensions of social support. It originally contained 24 items measuring Attachment, Social Integration, Reassurance of Worth, Reliable Alliance, Guidance, and Opportunity for Nurturance. A shortened twelve item version translated into Arabic was provided for the study by Wael, Alhassoon and Sasswan*. The children are asked to respond to the items using a 5 points Likert type scale (Strongly Disagree to Strongly Agree). The range of possible scores are between 12 and 60. For the purposes of the current study the items were reviewed and 4 items that appeared to be most meaningful for children (Items 1, 7, 11, and 12) were selected and used in the analysis (Cronbach alpha: .60).

Post Traumatic Stress symptoms were assessed by Children’s Revised Impact of Events Scale (*CRIES*): Psychometric data relevant to the reliability and validity of the 8-item version were presented in Yule (1997). The 8 item version was used in this study. The Arabic version utilized in the study was previously used and acceptable reliability was demonstrated (Children and war org.,

2012). In this test the children checked how often they experienced some feelings about a stressful event (Such as “Did you think about it when you didn’t mean to?”). 4 items describing avoidance of reminders and triggers of the event constitute the Avoidance subscale, while the other 4 items describing intrusive thoughts about events constitutes the Intrusion scale. The range of scores for the scale is 0 to 40.

Depression: Children’s Depression Inventory (CDI , Kovacs, 1981): The scale originally developed by Kovacs (1981) has been shown to have sturdy psychometric qualities . An Arabic version of the scale was provided for the study by Wael, Alhassoon and Sasswan*. This version was used in the study. In this scale the children are provided with 28 items. Possible range of scores is from 0 to 56. Each item includes three statements of different symptom severity and the child is asked to select one that describes him/her best. For example,

- I am sad once in a while (0).
- I am sad many times (1).
- I am sad all the time (2).

There are 4 subscales ; Negative Mood (9 items), Negative Self Esteem (6 items) , Ineffectiveness (8 items) and Interpersonal Problems (5 items).

Psychosomatic Problem (Oatis, 2002) : 5 questions regarding the frequency with which the child has experienced aches and pains in various body parts during the past month was assessed. The children were asked how frequently they experience some somatic problems ranging from everyday to once or 3 times a month.

*The team of Wael Al-Delaimy from University of San Diego, Sawssan R. Ahmed ,California State University, San Marcos and Omar M. Alhassoon , California School for Professional Psychology, who had used an Arabic version of CDI and Social Support scale in their research, generously shared their version with this project

Measures - Drawings

Children's Emotional responding (Human Figure Drawings, HFD): When children are asked to draw (vs. spontaneous drawing), the drawing is used as a method of communication and thus can be assumed as representing the individual's self-concept, anxiety, attitude, or conflict (Koppitz, 1984). Human figure drawings are generally evaluated for assessing the developmental level of the child or for assessing how a child responds or reacts emotionally to a situation. Various procedures have been proposed to evaluate the emotional content of a drawing, but the most frequently used is the Koppitz (1984) system. In this system the term "*Emotional Indicator*" is used to describe elements in the drawings that are not typical for children to use; that is they were included by less than 15% of children in a normative group of children. Furthermore, it has been demonstrated that such elements are more often found among children in clinical as opposed to non-clinical samples.

The Principal Investigator assessed the presence of *Emotional Indicators* in the children's drawings following the Koppitz system which includes 30 different Emotional Indicators (Koppitz, 1984). For example the presences of transparencies in the figure, genitals, large hands, long arms, extremely small or extremely large drawings are each scored as Emotional Indicators. Studies have shown the relationship between some of these Indicators and feelings of anger and aggression (Koppitz, 1984). Since there are 30 emotional indicators it is possible to obtain a total score ranging from 0 to 30.

Emotional Indicators that typically have been associated with feelings of aggression are the presence of teeth, crossed eyes, genitals, long arms, large figure, large hands and grotesque figures. Thus, the number of these aggressive items in each drawing represented the child's score of the "aggressive" dimension in his or her picture, where 0 implies none and 7

implies all aggressive indicators included in the drawing. Examples of some of the Emotional indicators are provided in Figures 1 and 2.



Fig. 1 Human Figure Drawing of a 10 year old boy.

Emotional Indicators: Teeth, Integrity of drawing, omission of hands

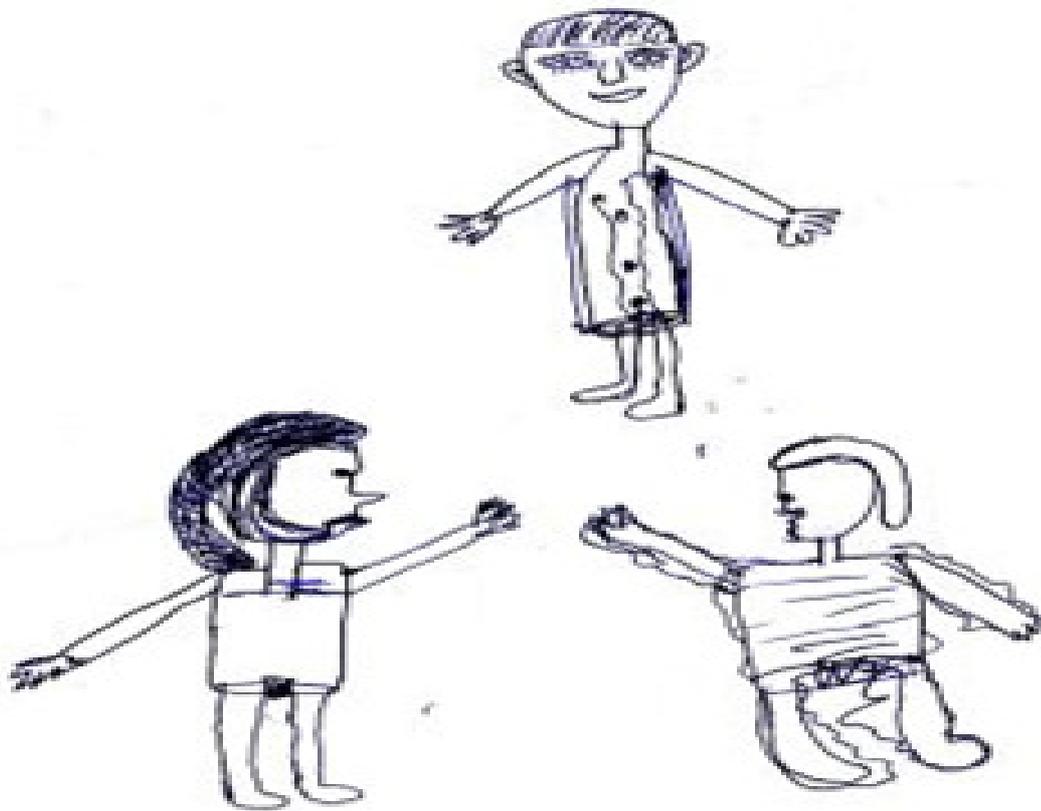


Fig. 2 Human Figure Drawing of a 13 year old boy.

Emotional Indicators: Shading of the face, shading of the body, genitals, and transparency.

The drawings of War and Peace were also scored by the Principal Investigator according to the coding system developed by McLernon and Cairns (2001). An example can be seen in Fig. 3

The categories of War were: 1: Images of weapons or soldiers; tanks, bombs, 2: Symbols and flags, 3: War activities such as shooting, stabbing, hitting, 4:

Negative consequences of war such as death or injury, 5: Negative emotions, such as people crying. An example of a war drawing may be seen in Figure 4.

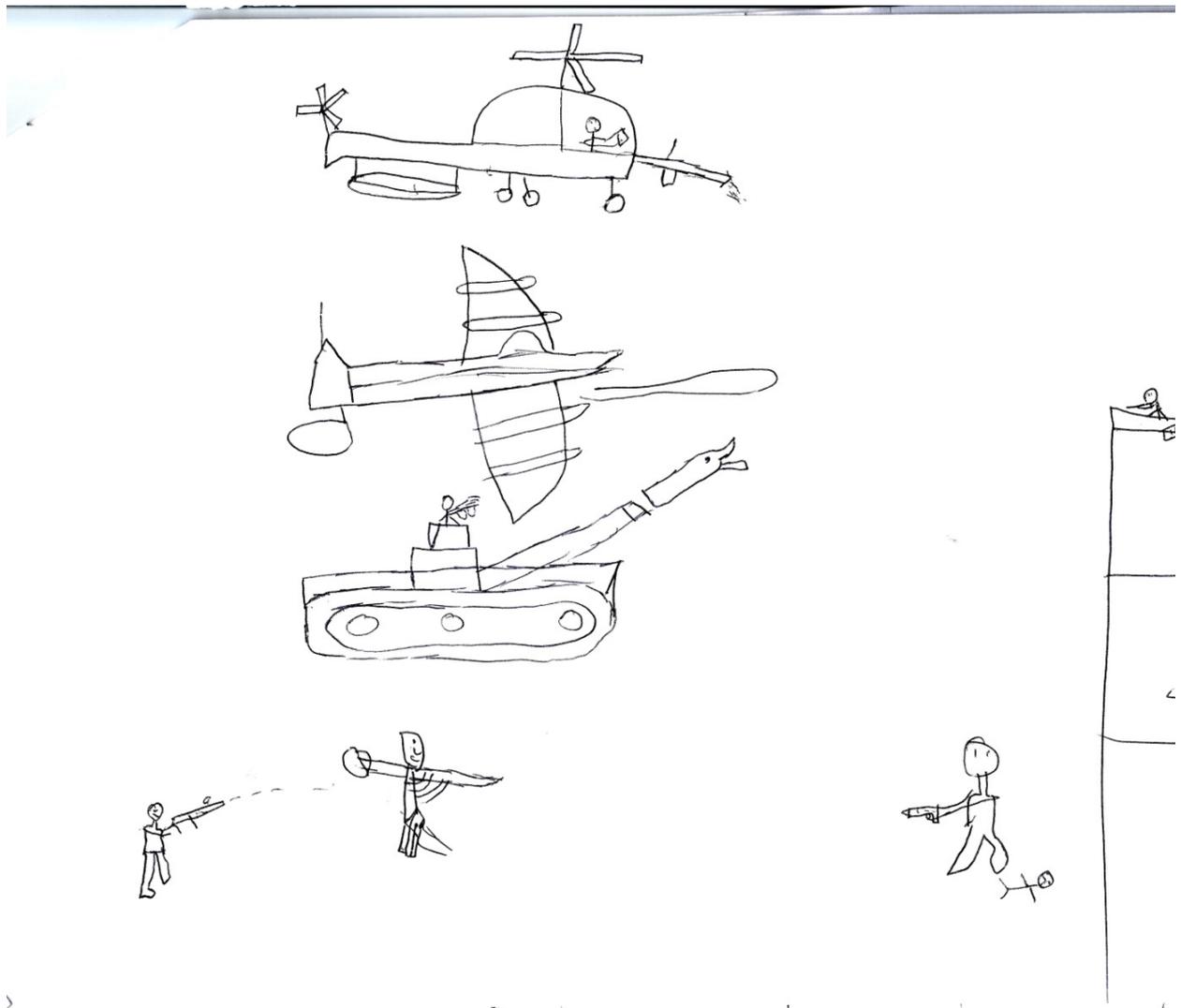


Fig 3. Drawing of war by a 12 year old boy. Categories: Weapons, War activities, death

Results

The Children's Background

Syrian families are generally large, something that is reflected in the number of children in the families participating in the Bahcesehir Study. The mean number of children in these families was close to 6. Research with posttrauma emotional reactions indicate that reactions are usually more intense closer to the trauma. When the research team met them, they had already been in the refugee camp in Turkey, for an average of almost half a year,

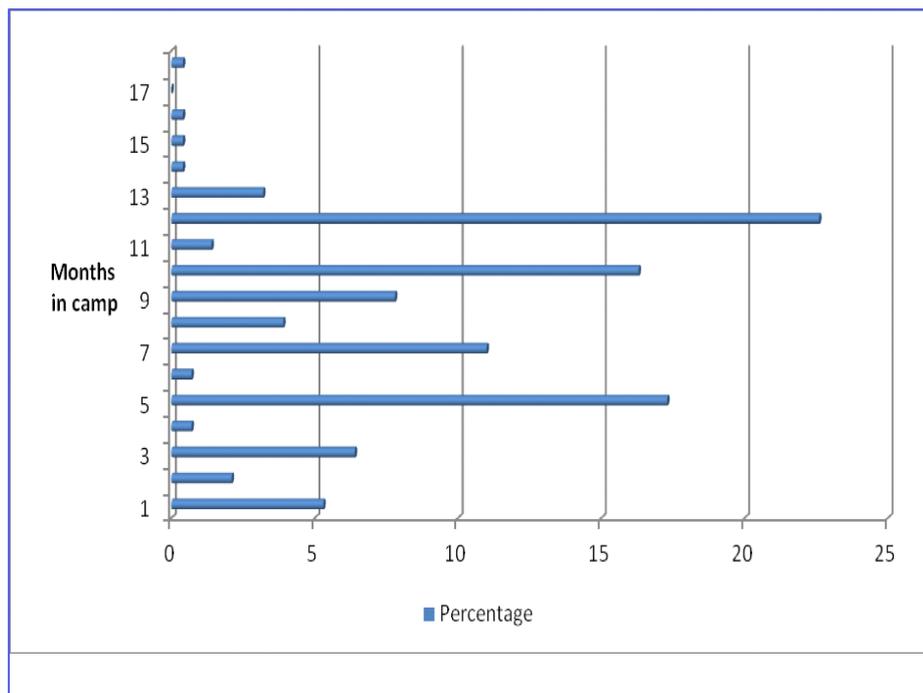


Fig. 4. Percentage of children and the number of months spent in camps.

Most of the families, (85%) reported that Turkey was the first destination of their flight after they left their homes the first destination of their flight after they left their homes.

The majority of the participating families originated in Aleppo (42.7%) and Idlep (38.8%), which is expected as these regions are close to the Turkish border. Of fathers, three in four had completed high school or higher educa-

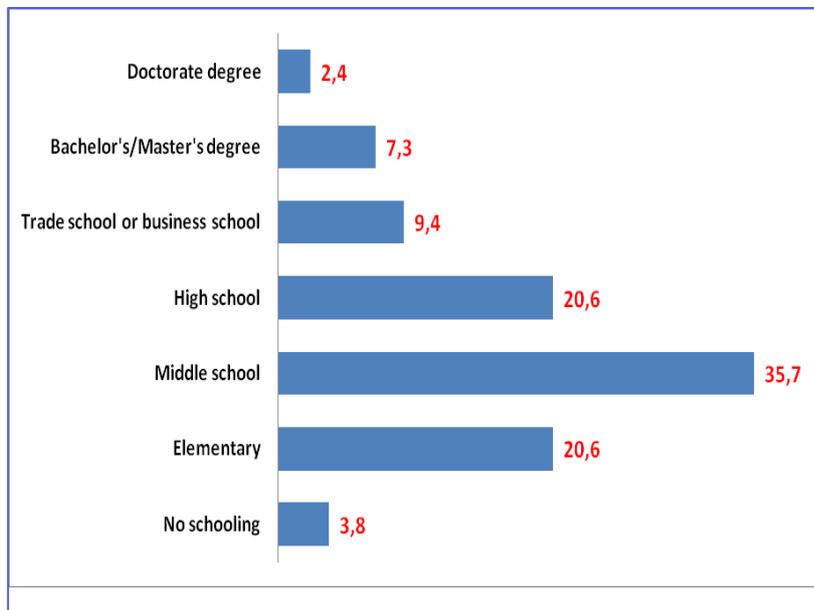


Fig. 5. Percentage of fathers education at various levels

As mentioned in the introduction, we do not know the extent to which the participating families are similar to the non-participating with respect to age, education, family structure etc. But the information about a relatively high level of education among the fathers, suggest that there are resources among the refugees that may assist their adaptation to the life in the camps. However, the unusually tragic changes in their lives and the traumas they have been exposed to may exceed their coping capacity.

Traumatic Events

The Percentage of children that reported having experienced each traumatic event is provided in Table 2. Interestingly, in spite of the fact that the families had fled their home towns and villages because of the threats of the

war, not all children seem to have realized this. Around 20% of the children did not indicate that they had experienced war in their country of birth. This may imply that some parents had been able to protect their children from the ongoing civil war, and also that some families left their homes before the shootings and bombings had escalated to today's level.

Table 2. Exposure to traumatic events. Percentage of children who reported each traumatic event

Have you ever experienced a war or an armed military conflict going on around you in your country of birth	79.3
Has someone died in your life that you really cared about	74.2
Did you experience any other very stressful life event where you thought that someone else was in great dan-	60.7
Did you experience any other very stressful life events where you thought that your life was in danger	57.9
Did you ever see someone else get kicked, shot at or some other way physically hurt in real life	59.6
Have there been drastic changes in your family during the last year	52.1
Have you ever been involved in a disaster	38.1
Have you ever been separated from your family against your will	30.2
Has someone ever hit, kicked, shot at or some other way tried to physically hurt you	29.6
Have you been involved in a serious accident	25.1
Have you had a life threatening medical problem	19.7

A very high proportion of the children in the camp, 74%, had experienced the loss of a family member or somebody else that they really cared about. This is also illustrated in many of the children's drawings in different ways, for example showing a mother with a baby on her lap, sitting beside her dead husband. We do not know the circumstances around these losses, nor the level of grief associated with them. Presumably these losses also affect the well-



Fig. 6. 15 year old girls drawing of a person.

being of the children's parents and may contribute to diminishing their capacity for care and support to the children. Reduced capacity for positive parenting is a condition that strongly increases the risk for maladaptive outcomes among children. In the case of the children in the refugee camps the absence of caring and supportive parent – child relationships may increase the mental health impact of the traumatic events they have been exposed to, make the mental health problems last longer and in the worst case, become chronic. Creating

conditions that enhance the parenting resources among adult refugees who themselves suffer from the sequels of the civil war, is maybe one of the most important interventions to promote the well-being of the children, both on a short term basis and in the long run.

From Table 2 it can also be observed that more than 60% of the children have experienced events where they felt their lives were at danger. These types of events are what defines trauma and a seriously high percentage of children have witnessed such traumatic events. It can also be seen from Table 2 that 30% of the children reported that they had been separated from their families. Unfortunately, being separated from parents, siblings, and/or other family members is an experience that is very common to children during war and other emergencies. Research has shown that when children lose their families in such frightening contexts, the chances are very high that they will develop long lasting psychological problems that impact on their present and future well-being and adaptation. The Syrian refugee children, who informed that they had been separated from family members, therefore represent a high risk group that under other circumstance would have been the target of preventive interventions.

Each of the listed traumatic events in and by themselves increases the risk for mental health problems among children. Consequently, having been subjected to an accumulation of such events may seriously impede the coping resources the children have available to deal with their experiences. Being exposed to some sort of traumatic events is unfortunately very common during childhood. Dutch and Belgian children from regular, non-refugee families, endorsed for example an average of 3 events on the same list as we present here (Bean et al., 2007). Still, as much as half of the participating refugee children in the Bahçeşehir study informed that they had witnessed 6 or more of the frightening events which

is an alarmingly high number. We can only speculate how this will affect their adaptation not only in the refugee camp, but more importantly when they are supposed to return to normal life when the war hopefully is over.

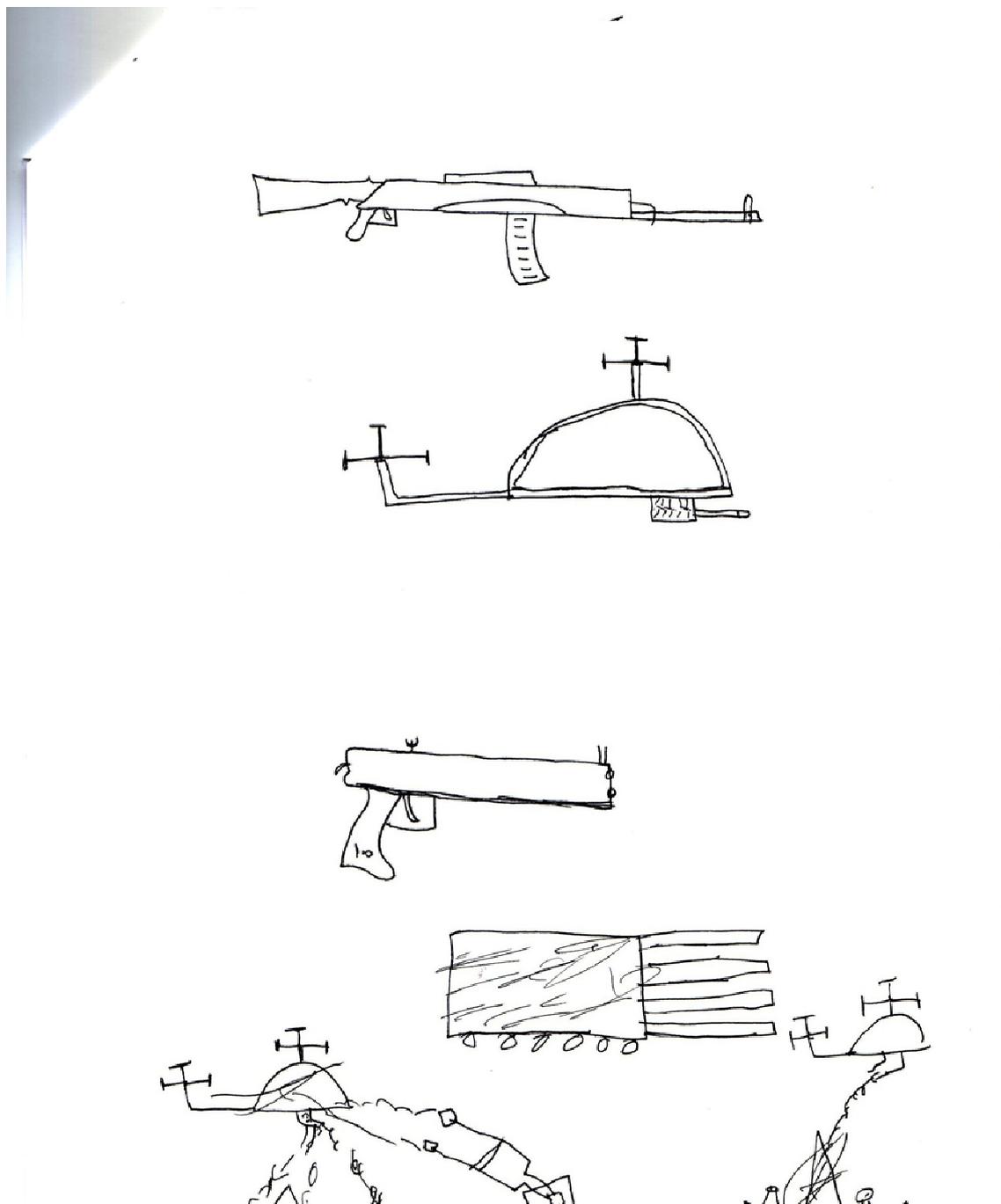


Fig. 7 A 12 year old boy's drawing of war

Social Support

The children's perception of social support available to them is important for their psychological well-being in general. When they are burdened with high levels of adversities, the perceived availability of support may reduce the impact the stressors have on their mental health outcomes. The social support that children can access in the anticipation of traumatic events, during and following exposure, has proven to be the most important factor that protects children from developing PTSD, or to speed up the recovery process among the affected children (Muller et al, 2000). For the purpose of this study we have used 4 items indicating the tangible and emotional support the children perceive as available to them. The maximum total score that may be obtained on this scale when we summarize the score for each item is 20.

Table 3 shows the percentage of children who "agreed" or "strongly agreed" to each of the items.

	Total	Boys	Girls
There are people I can depend on to help	67	58.7	71.4
There is a trustworthy person I could turn to	61.5	58.2	63.2
I have close relationships that provide me with sense of emotional security and well-	58.9	56.8	60
I feel a strong emotional bond with at least	56.2	61.3	53.5

As can be seen, most of the children reported that they had supportive relations that they could trust.

On the 4 items selected from this scale the children obtained a mean score of 14.45 (SD 3.02). Even if there appear to be gender differences in the percentage of boys and girls that endorsed each individual support item, there were no significant gender differences on the total score of social support perceived by the children.

Mental Health Problems

The mental health measures that have been used in the present study assess the level of symptoms the children report, i.e. the information tells us whether the child has high or low levels of symptoms of post-traumatic stress disorder or depression. In clinical praxis, on the other hand, it is more common to use diagnoses in terms of a disorder, implying that the level of function is severely reduced and the problems have been going on over time. A diagnosis of e.g. Post-traumatic stress disorder or depressive disorder, can only be made based on interviews with the child and/or his/her parents. However, most standardized mental health measures, like those used in this project, have been validated against clinical interviews, to identify the level of symptoms, or the score, that **likely** indicates that the child would have been diagnosed with a disorder if assessed by an interview. This distinction should be kept in mind while reviewing the following findings.

Symptoms of Post Traumatic Stress Disorder

As described in the section about the measures included in the present study, post-traumatic stress reactions, CRIES, involved 8 items 4 of which represent symptoms of intrusive memories and thoughts, while 4 indicate symptoms of avoidant behaviour to stay away from situations that resemble the traumatic events. Around 50% of the children reported that they experience these symptoms “sometimes” or “often” and the prevalence was equally high for boys and girls. Examples of the symptoms and the prevalence are illustrated in Table 4. The maximum score a child can obtain on the CRIES is 40, however a score of 17 or more imply that the symptom level is so high that the person most likely would have been diagnosed with a posttraumatic stress disorder if assessed in a clinical situation. The findings from the Syrian refugee children showed that 46% of girls and 44% of boys scored above the clinical cut off, but the gender difference between them was not statistically significant. Prevalence rates of PTSD in normal populations of children and adolescents are much lower. For example, a survey among American adolescents in the age ranges of 12 – 17 years, showed prevalence among boys of 3.7% and 6.3% among girls (Fairbank, Putnam & Harris, 2007). The level of post traumatic stress symptoms observed among the children in the Bahcesehir Study is in line with various studies that have investigated children in similar situations. For instance Thabet and Vostanis (2002) found that 42% of Palestinian children reported moderate to high levels of PTSD. During the war in former Yugoslavia, about half of the Bosnian children participating in a research project were reported to show clinical levels of PTSD (Hasanovic, 2011). Considering that the children have

been on the average about half a year in the safety of the camp, the proportion of children who suffer from severely high levels of PTSD symptoms appears disquieting. But, since this is a cross-sectional study, we do not know if the PTSD has persisted since the children were exposed to the traumatic event, if the symptoms come and go, or if they represent a delayed response to the traumatic experience.

Table 4. Percentage of children who reported that they experience each symptom sometimes” or “often”

	Total	Boys	Girls
AVOIDANCE SYMPTOMS			
Did you stay away from reminders of it (the events)	49.2	46.3	50.9
Did you try not to talk about it (the events)	46.6	52.7	43.1
INTRUSIVE SYMPTOMS			
Did you think about it (the events) when you did not mean to	50.6	55.7	47.5
Did pictures about it (the events) pop into your mind	49.2	51.1	48.1

The readers should be informed that the psychometric properties of the CRIES are not very good, and therefore the results regarding the total prevalence of disorder should be interpreted with some caution.

Symptoms of Depression

In addition to the PTSD symptoms, many children react to traumatic events by developing depressive moods. Children's depression may also be elicited by an accumulation of hassles in their everyday lives in the camp, such as worries about their parents, conflicts with friends, worries about the future, and problems at school and so on. Table 5 exemplifies some of the symptoms of depression the children endure, and the proportion of the participants who experienced each of the symptoms "many times" or "all the time".

The finding that the most frequently endorsed item on the depression scale involves bodily complaints is consistent with the ideas developed about psychosomatic problems. It has been frequently stated that in cultures where level of awareness about mental health problems is not high and where these type of problems are not directly expressed, somatic symptoms are common (Nolen-Hoeksema, 2008). These children may not be very articulate verbally about their problems, and they come from a culture where mental health problems are not commonly discussed, they express their feelings of psychological discomfort in bodily terms.

The depression scale has altogether 28 items, and the maximum score a child can obtain is 56. A score between 16 and 23 has been shown to indicate a level of symptoms of depression that affect the children's everyday activities in their families, with their friends, or at school. (Roelofs, al., 2010). This debilitating level of symptoms applies to 44.3 % of the Syrian refugee children. In addition, 20 % had a score above 23 which implies a depressive disorder with severe reductions in the youngsters emotional, behavioural and cognitive

Table 5. Percentage of children who experience depression symptoms “many times” or “all the time”

	Total	Boys	Girls
I worry about aches and pains all the time/many times	68	64.8	69.8
I feel cranky all the time/many times	63.7	62	64.7
I am sad all the time / many times	60.7	45.6	69.4
Most days/Many days I do not feel like eating	57.8	35.9	70
I feel like crying everyday/ many days	54.1	26.4	69.7
I have trouble sleeping every night/many nights	37.1	25.3	43.8
I fall asleep during the day all the time/many times	21.3	15.6	24.5

functioning. Unfortunately, we do not have information about to what extent this high level of depression is due to the traumatic events they have experienced, and to what extent ongoing problems in the camp affect the level of depression.

Significantly more girls than boys reported symptom levels in the clinical range – 54% vs. 26% ($F : 17.67, p < .01$). Gender differences in depression during adolescence are common, and have been observed in studies across

cultures and nations, including immigrants living in urban settings (Lewinsohn et al., 1993; Nolen-Hoeksema & Girgus, 1994) . However, in a normal population the prevalence of depressive disorder ranges typically from 3 – 8 % implying severely elevated levels among both boys and girls in the camp.

Psychosomatic Problems

Somatic complaints in terms of pain in various parts of the body, in particular the extremities, the head, stomach, and back, are sometimes associated with different types of mental distress, rather than with an external injury or other obvious cause (APA, 1994). If the bodily pain is considered a reaction to mental distress, it is typically labelled a “psychosomatic symptom”. It is often claimed that psychosomatic symptoms are common in cultures and individuals that do not recognize the existence of mental health problems, or where mental health problems are stigmatized and considered a shame (Nolen-Hoeksema, 2008). In Table 6 we have listed some of the most common psychosomatic symptoms found among children and adolescents (Oatis, 2002), and how often the Syrian refugee children informed that they suffered from them.

As Table 6 illustrates, the Syrian refugee children suffered frequently from bodily pains that may be expressions of psychosomatic symptoms. Around 25% reported that they endured pain in arms and legs on a daily basis, and more than one in three had pains in their extremities several times a week.

Table 6. Psychosomatic symptoms: Percentage of the children and the frequencies they report somatic pain

	Every day	1 – 3 times a week	1 – 3 times a month
Head	20.5	44.1	35.4
Stomach	13.4	39.2	47.4
Back	18.2	25.1	56.7
Arms & Legs	25.6	37.2	37.6
Other body parts	13.9	26.7	59.4

Furthermore, close to 21% informed that they suffered from headaches on a daily basis. As much as 76.5% of the girls reported that they suffered from headaches every day or several times a week as compared to 44.6% of the boys. Girls also reported significantly more pains in “other parts of the body” than boys, 45%, vs. 35% respectively informed that they suffered these kind of aches daily or several times a week. The proportion that suffered pains in their stomach, back, or arms and legs was the same among girls and boys.

It is likely that these pains are not due to injuries or other well-known and natural sources, but that they are instead caused by the traumas the children have been exposed to, or ongoing adversities in the refugee camp. From Table 6 we can see that somatic complaints are very frequent among the Syrian refugee children and we assume among refugee children in general. While it may be natural to treat these aches and pains with painkillers if they are available in the camp, it is important for parents and other responsible adults to be aware that the hurting most likely is part of a larger syndrome of reaction to the horrible experiences the children have been through.

Drawings

As discussed in the chapter describing the various measures included in the Bahcesehir study of refugee children, the total scores of Emotional Indicators on the children's drawings range from 0 to 30, while the range of aggressive



Fig. 8. Human Figure Drawing of a 14 year old girl.

emotional indicators runs from 0 to 7 . In nonclinical populations most children score below 1 , in clinical populations scores around two are observed (Catte & Cox,1999, Özer, 2009). The results from the coding of the children's "Human Figure Drawings" (HFD) showed an average score on Emotional Indicator of 1.60 (*S.D.*: 1.64). As mentioned earlier, studies with clinical samples, that is studying children diagnosed with a psychological problem have reported means similar to this (Catte & Cox,1999, Özer, 2009), Twenty-two percent of

the children's HFD - drawings were coded as having 3 or more Emotional Indicators. For example in a study with English children only 5% of the nonclinical group had 2 or more Emotional Indicators (Catte & Cox, 1999). While for the Syrian refugee children in the study, 8.3% for girls, 29.1% of boys showed three or more Emotional Indicators. When children were asked to "draw a person" 26 children spontaneously added blood, tears, death or guns to their drawings. (An example is provided in Fig. 8). Additions of this type in nonclinical populations are extremely rare and are considered significant (Koppitz, 1984). There were 13 boys and 13 girls who drew such pictures. Of these drawings 8 of the girls drawings included tears while only one of the boys did.

The children were also asked to draw pictures of war and peace; it was observed that boys drew more figures in both cases. Boys' pictures had more aggressive themes and more political content. To illustrate with an example, one of the categories in the scoring of drawings of war and peace was "writing slogans". Although 30% of the girls and 21% of the boys wrote slogans on their drawings, the content differed. While the slogans written by girls were almost exclusively about "peace" and "freedom", boy's slogans were about "identifying" and "vilifying" the Enemy, such as "death to Esed", "killer" etc. The children's war drawings as compared to their peace drawings were more detailed, there were more figures in the war drawings. War was drawn most frequently by the children showing weapons (67%), activities of war (51%) and by death (24%). While peace was most frequently symbolized through nature (33%), daily activities (29%) and peace symbols (13%).

Finally while we finish our results on Syrian refugee children, it should be noted that in spite of the dramatic histories of the refugees in Islahiye, the children that the research team met in the school appeared to be curious, active, and playful. This shows us that children have the capacity to switch

between positive functioning and adaptation, and experiences of serious mental distress and disorders, in terms for example of psychosomatic symptoms, PTSD, depression, and aggression. This is important knowledge, because the ordinariness of the children's behavior may bias our assessment of their need for help and support .

SUMMARY AND CONCLUSIONS

After having spent an average of half a year in the Islahiye refugee camp in Gaziantep, the findings from the Bahcesehir Study of Syrian Refugee Children showed

- On the positive side: 71% of the girls and 61% of the boys had strong close relationships they trusted on for help and support
- 74% of the children had experienced the death of somebody they cared strongly about, and 50% had been exposed to 6 or more traumatic events
- The mental health problems associated with the war experiences were very serious as 60% had symptoms of depression, 45% PTSD, 22% aggression, and 65% psychosomatic symptoms to a degree that seriously reduce the children's level of functioning. Of course, many children suffered from two or more of these mental health problems

It was felt by the researchers that it was important to address the issue of the children suffering from the Syrian conflict from a research based point of view. As with all conflicts and wars, there have been reports, opinions, anecdotes presented in the media and utilized by one side or the other. We believed that this type approach was distracting from the presentation of the suffering of the victims, the children, as in all wars and conflicts. A more objective, data based approach in taking a snapshot of the situation these

children were placed in was our main objective.

The information gathered for the purpose of this study is not sufficient to give directions for concrete and specific recommendations. However, as has been underscored many times throughout the present report, perceptions that social support is available can reduce the burdens of traumatic events and ongoing hassles on mental health. Even if the level of perceived social support is high among the Syrian refugee children, there is still a considerable group that needs to feel better support and protection. The school is an optimal arena for organizing structured peer support groups for the children. However, experiences from other studies have shown that strengthening the parents' potential for care and supportive relationships with their offspring may be the most valuable intervention in a refugee camp context.

The high proportion Syrian refugee children that was suffering from serious mental health problems in this study from the Islahiye camp in Gaziantep is not unique: Similar prevalence has been shown during other conflicts, in camps in other countries, and are probably within equal ranges among displaced and non-displaced children within Syria.

Within safe and supportive developmental contexts, some of the victimized Syrian children may recover from their physical and mental pain over time, but unfortunately this does not apply to all of them. The majority of them will continue struggling with intrusive memories from the traumatic war-experiences, they will use their energy to avoid situations that remind them of the horrors they have lived through, and they will have difficulties sleeping at night or getting up in the morning. At school they will have problems concentrating during classes thus not learning to their full potential, and among family and friends they will feel unsafe and anxious and maybe want to withdraw from social interactions altogether. As adolescents and adults they may not be able to take care of themselves, and therefore can become a

burden both on their families and the larger society.

The high numbers of children that are the innocent victims of the political conflicts are not only suffering now, but the opportunities for a self-fulfilling life have been stolen away from them. In the media, the Syrian children are often described as “The Lost Generation”. We would say they are the generation that has been robbed of their lives by a monster of war that most governments in the world – including the Syrian –have promised them the right to be protected against.

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