IBN HALDUN UNIVERSITY
SCHOOL OF GRADUATE STUDIES
DEPARTMENT OF PSYCHOLOGY

MASTER THESIS

RESILIENCE OF SYRIAN CHILDREN AND ADOLESCENTS LIVING IN TURKEY

FATMA SEVDE KURT AKKOYUN

THESIS SUPERVISOR: ASSIST. PROF. SENEM EREN

ISTANBUL, 2020

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RESILIENCE OF SYRIAN CHILDREN AND ADOLESCENTS LIVING IN TURKEY

by

FATMA SEVDE KURT AKKOYUN

A thesis submitted to the School of Graduate Studies in partial fulfillment of the requirements for the degree of Master of Arts in Clinical Psychology

THESIS SUPERVISOR: ASSIST. PROF. SENEM EREN

ISTANBUL, 2020

ACADEMIC HONESTY ATTESTATION

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

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ÖZ

TÜRKİYE'DE YAŞAYAN SURİYELİ ÇOCUK VE ERGENLERDE PSİKOLOJİK SAĞLAMLIK

Kurt-Akkoyun, Fatma Sevde
Klinik Psikoloji Yüksek Lisans Programı
Tez Danışmanı: Dr. Öğretim Üyesi Senem Eren
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Psikolojik sağlamlık bireylerin psikolojik iyi oluşlarını koruyarak dirençli olmalarını sağlayan çok boyutlu bir yapıdır. Bu çalışmanın amacı, yaşı 10-18 arasında değişen 133 çocuğun psikolojik sağlamlık düzeylerinin algılanan sosyal destek, arkadaş ilişkileri, ebeveyn ilişkileri, depresyon, anksiyete, stres, ihlal, kaçınma, aşırı tepkisellik, duygusal problemler, travma sonrası stres bozukluğu, davranım (conduct) bozukluğu, hiperaktivite ve prososyal davranış açısından incelenmesidir. Katılımcılara Olayların Etkisi Ölçeği, Depresyon, Anksiyete, Stres Ölçeği (DASS-42), Çok Boyutlu Algılanan Sosyal Destek Ölçeği, Çocuk ve Genç Psikolojik Sağlamlık Ölçeği (ÇGPSÖ-12), Güçler ve Güçlükler Anketi (GGA) ve Aile Akran İlişkileri Ölçeği uygulanmıştır. Katılımcıların %44.4'ü (n=59) kızlardan ve %55.6'sı (n=74) erkeklerden oluşmuştur. Yapılan analizler sonucunda Suriye'de kırsal kesimde yaşayan ve Suriye'de okula giden çocuk ve ergenlerin psikolojik sağlamlığının daha yüksek olduğu bulunmuştur. Korelasyon analizleri sonucunda, psikolojik sağlamlığın aile, arkadaş, özel birinden algılanan sosyal destek ve toplam algılanan sosyal destek, ebeveynle birliktelik, arkadaş ilişkileri ve ebeveynin arabulucu oluşu ile pozitif yönde ilişkili olduğu; depresyon, anksiyete, stress, ihlal, kaçınma, aşırı tepkisellik ve duygusal problemler ile negatif yönde ilişkili olduğu; davranım bozukluğu, hiperaktivite, arkadaş problemleri, prososyal davranış ve ebeveynlerle yakınlık ile anlamlı bir ilişkisinin olmadığı bulunmuştur. Yapılan regresyon analizleri sonucunda aileden algılanan sosyal desteğin, arkadaş ilişkilerinin, hiperaktivitenin, depresyonun, anksiyetenin, stresin ve travma sonrası stres bozukluğunun bireylerin psikolojik sağlamlığını yordadığı bulunmuştur. Çalışma bulguları, literatürdeki araştırma sonuçlarıyla büyük oranda tutarlılık göstermektedir. Suriyeli çocukların ve ergenlerin psikolojik sağlamlığı üzerinde olumlu veya olumsuz etkiye sahip olabilecek faktörlerin

belirlenmesi önleme ve müdahale programlarının geliştirilmesi açısından önemli olacaktır.

Anahtar Kelimeler: Algılanan sosyal destek, anksiyete, arkadaş ilişkileri, çocuk, ebeveyn ilişkileri, ergen, depresyon, mülteci, Psikolojik sağlamlık, Suriyeli, stres, TSSB

ABSTRACT

RESILIENCE OF SYRIAN CHILDREN AND ADOLESCENTS LIVING IN TURKEY

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Resilience is a multidimensional construct which helps individuals to be powerful and maintain their psychological well-being. The aim of this study was to investigate the resilience of 133 children aged 10-18 years in terms of perceived social support, peer relations, parent relations, depression, anxiety, stress, intrusion, avoidance, hyperarousal, emotional problems, PTSD, conduct problems, hyperactivity and prosocial behaviour. Impact of Event Scale-Revised (IES-R), Depression, Anxiety and Stress Scale (DASS-42), The Multidimensional Scale of Perceived Social Support (MSPSS), Child and Youth Resilience Measure (CYRM-12), Strengths and Difficulties Questionnaire (SDQ) and Family Peer Relationship Questionnaire (FPRQ) were administered to the participants. The sample in the study included 59 (44.4%) girls and 74 (55.6%) boys. As a result of the analysis, it was found that the resilience of the children and adolescents who were living in rural regions in Syria and who had an education while in Syria was found to be higher than those who lived in urban areas and didn't have an education. As a result of the correlation analyses, resilience were positively correlated with perceived social support from family, friends, significant other and total perceived support, togetherness with parent, peer relations and parent as a mediator; negatively correlated with depression, anxiety, stress, intrusion, avoidance, hyperarousal and emotional problems. It was found that there was no significant relationship between resilience and conduct problems, hyperactivity, peer problems, prosocial behaviour and nurture disclosure of parents. As a result of ordinary least square regression analyses, it was found that, perceived social support from family, peer relations, hyperactivity, depression, anxiety, stress and Post Traumatic Stress Disorder predicted resilience. The findings of the study were mostly consistent with the related literature. Determining the factors that can have a positive or negative

impact on resilience of Syrian children and adolescents will no doubt be significant for developing prevention and intervention programs.

Keywords: Adolescents, anxiety, children, depression, parent relations, peer relations, perceived social support, PTSD, refugee, resilience, stress, Syrian

To all children who had to migrate…

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Many thanks to my dear family, my mother Hürrem Kurt, my father Turgay Kurt and my sister Zeynep Elif Kurt. They always make me feel their love throughout their lives. We spend our good and bad times together and overcome many difficulties with love. My mother and father always supported me throughtout my education. Thanks for their devotion and friendship.

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Fatma Sevde Kurt Akkoyun

İSTANBUL, 2020

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LIST OF ABBREVIATIONS

ADHD	Attention Deficit Hyperactivity Disorder
AIDS	Acquired Immune Deficiency Syndrome
ANOVA	Analysis of Variance
APA	American Psychiatric Association
CYRM	Child and Youth Resilience Measure
DASS	Depression, Anxiety and Stress Scale
DSM	The Diagnostic and Statistical Manual of Mental Disorders
FPRQ	Family Peer Relationship Questionnaire
HIV	Human Immunodeficiency Virus
IES	The Impact of Event Scale
IES-R	Impact of Event Scale-Revised
IOM	International Organization for Migration
MSPSS	The Multidimensional Scale of Perceived Social Support
NGO	Non-Governmental Organizations
OLS	Ordinary Least Square
PTSD	Post Traumatic Stress Disorder
SDQ	Strengths and Difficulties Questionnaire
UK	United Kingdom
UNHCR	United Nations High Commissioner for Refugees
USA	United States of America
n	Number of Participants
p	P value
r	Correlation Coefficient
SS	Standard Deviation
t	t value
$\bar{x}$	Mean

CHAPTER I

INTRODUCTION

War is a disaster that causes irrevocable harms for all beings. Exposure to war has a long-term effect both on physical health and mental health. In the time of conflict and war, people can be traumatized by many disruptive situations as being tortured, sexual assault, physical violence, loss of properties or a loved one. Imagine that your house set on fire while you were inside with your family, your loved ones were killed in front of your eyes, you tortured, your human needs were ignored, you cannot find the opportunity to benefit health care, appropriate shelter, enough food, and education. Stressful experiences affect individual's wellbeing with collapsing individual's sense of control, connection and meaning (Herman, 2015).

War collapses families and individuals extended social networks. Losing social networks that an individual belongs to can have an impact on individuals' sense of control, connection and meaning. Individuals who are directly exposed to war report higher levels of PTSD (Meyer et al., 2018), depression (Ikin et al., 2016), anxiety disorders (Ginzburg, Ein-Dor & Solomon, 2010), problem drinking (Ciarleglio et al., 2018). War also has an impact on disabled individuals (Shpigelman & Gelkopf, 2018), therapists (Roizblatt, Biederman & Brown, 2011) and medical personnel (Lim, Stock, Oo & Jutte, 2013). War and conflict can indirectly cause secondary traumatization. Research demonstrates that secondary traumatization is common in Vietnam Veterans' partners and children (Yager et al., 2016). Thus, war does not only affect individuals who are experiencing it; it also affects their families.

According to International Organization for Migration forced migration is "a migratory movement which, although the drivers can be diverse, involves force, compulsion, or coercion" (International Organization for Migration, 2019). In the world, 30 people are forced to leave their countries every minute and in 2018 the total number of people forcibly displaced is 68.5 million around the world (UNCHR, 2018).

The number of children living in a conflict zone is also increasing, in 2016 it was reported that more than 357 million children were living in a conflict zone and in the world half of the 17.2 million refugees are children (Save The Children, 2018). According to United Nations High Commissioner for Refugees (2017), half of the world's 24.2 million refugees are children, which equates to 52% of the refugee population.

CHAPTER II

LITERATURE REVIEW

2.1 Being a Syrian Refugee

The Syrian government started to use lethal force in April 2011 to suppress the anti-government protests. Individuals were forced to leave their homes because of the conflict and almost 12 million people, which equals to 65 percent of Syria's population were either internally displaced or continued their lives as refugees outside of their country (UNHCR, 2018). The majority of refugees fled to Turkey, with others also seeking refuge in Lebanon, Jordan, Egypt, Iraq, The Middle East and North Africa (UNHCR, 2018). The number of registered Syrian refugees in Turkey is approximately 3.6 million, in Lebanon 1 million, in Jordan 670,000, in Iraq 250,000, in Egypt 130,000, in Libya 110,000 (UNHCR, 2019). After the conflict started, only about 1 million people entered to Europe, mostly residing in Germany. Less than 1% of displaced Syrian people are now living in Canada and the United States.

After the civil war started in Syria, Turkey has followed an 'open-door policy' which allowed Syrian refugees to enter Turkey without any restrictions. According to United Nations High Commissioner for Refugees (2018), over 3.6 million Syrian refugees were registered in Turkey as of January 2019, with almost 10 percent of them living in temporary camps. Total Syrian immigrant population in Turkey is composed of 44.8% youth aged under 18 (UNHCR, 2018). The majority of refugees in Turkey Approximately 44.8% of refugees living in Turkey are youth aged under eighteen.

Refugee children and adolescents experienced a radical change in their lives and they generally experience exposure to violence, war, loss of loved ones, economic problems and change in their stable environment which are difficult for a child to cope with and these experiences that children find it difficult to cope with can lead to stress and mental health problems. Although the current literature is mostly focused on

psychopathology in this population, it is also important to explore resilience and the factors impacting resiliency in these children and adolescents. Resilience is under researched in refugee children and adolescent populations. It is crucial to take steps through understanding positive adaptation to adverse situations to enhance children and adolescents psychological well-being, especially those who experience diverse situations such as forced displacement, immigration and war.

2.2 The Mental Health of Refugee Children and Adolescents

Children and adolescents are more vulnerable to stress and uncertainty (Broekman, 2011)/ They are exposed to violence, separation from parents, malnutrition in the migration phase and these are risk factors for mental health challenges (Ajdukovic & Adjukovic, 1998). Refugee children and adolescents who experienced traumatic loss, separation, forced displacement, community violence and domestic violence are prone to develop mental health problems (Betancourt et al., 2012). Arriving to a host country may also be a stress factor for children in terms of adapting to a new culture, acculturation, discrimination and language barriers. Separation from loved ones and drop out from schooling and the uncertainty of their future may also be a risk factor for the development of mental health challenges.

With the increasing displacement in the world, studies look at the role of resilience in children in the face of adversity caused by war and immigration. Studies conducted with refugee children and adolescents indicate that they are at a higher risk for developing mental health challenges (Khan, Shilpi, Sultana, Sarker, Razia, Roy, Arif, Ahmed, Saha & McConachie, 2019). The experience of war is associated with higher rates of post-traumatic stress disorder (Sack et al., 1993), depression and anxiety disorders (Yalin Sapmaz et al., 2017), guilt and extreme pessimism (Goldstein et al., 1997), disturbed sleep, adjustment and conversion disorder (Ceri et al., 2016) and grief symptoms (Morgos et al., 2008). One study done by Khan and colleagues (2019) with displaced Rohingya children living in Bangladesh's refugee camps indicate that mental health problems are common especially emotional problems and peer problems (Khan et al., 2019). In another study, 218 Syrian refugee children and adolescents between

the ages of 9 to 15 years were examined, Post Traumatic Stress Disorder, anxiety-related disorders and emotional problems were found in the children examined (Gormez et al., 2017).

2.3 Depression

Depression is a serious mood disorder that affects an individuals' life. Individuals suffer from depression experience depressed mood, lost interest in activities, slowing down of thought, weight loss and decreased appetite, decreased energy and concentration, thoughts of death, feelings of worthlessness (American Psychiatric Association, 2013). Depression is a rising mental health problem, which affects all age groups and all individuals. Stressful experiences can trigger depression and depressive symptoms (Roth, Goode, Williams & Faught, 1994). Lifetime prevalence of depression is 10% to 15% (Lepine & Briley, 2011). Depression rates are higher among females than males (Grigoriadis & Robinson, 2007).

In the DSM-V under the heading of mood disorders there are ten specific conditions of depression. Depressed children and adolescents show different symptoms. In children, depression is typically characterized by symptoms of temper tantrums, shyness, high dependence to parents, angry outbursts, various fears, hyperactivity, sleep disturbances, appetite disorders, physical symptoms while adolescents show lower academic achievement, panic attacks, behavioural deficits, tiredness and unwillingness symptoms (Ozturk, 2007). According to Abela and Hankin (2008) by the age of fourteen at least 9% of children and adolescents experienced depression.

2.3.1 Depression Research in Immigrant Children and Adolescents

Refugee children and adolescents are at high risk for mood disorders. Several studies demonstrated that regardless of the age refugees are at high risk for depression. A study conducted with 1144 Lebanese, Palestinian and Iraqi refugee psychiatric patients living in a refugee camp in Lebanon, the prevalence of depression found as 28% (Bastin et al., 2013). Research done with North Korean migrants in China which examined mental health, reported higher rates of depression as 81% (Lee, Lee, Chun,

& Lee, 2001). In a study done with 310 Syrian refugees living in Beirut and Mount Lebanon prevalence of depression reported as 43% with no difference across socio demographic characteristics (Naja et al., 2016).

In a study, 943 adolescents living in The Republic of The Gambia in West Africa were examined (O'Donnell & Roberts, 2015). It is found that exposure to violence and levels of traumatic stress and depression were high in refugee adolescents compared to non-refugee peers. A longitudinal study of 46 Cambodian refugee adolescents illustrates the importance of war trauma and resettlement stress. It is found that the rate of PTSD was 10%, the rate of depression was 50%. After 3 years, the levels of PTSD and depression were still high 48%, 41% respectively (Sack et al., 1993). As Betancourt and colleagues (2012) state comorbidity is common in with the symptoms of anxiety, grief, post-traumatic stress and depression in refugee children.

2.3.2 Depression Research in Syrian Children and Adolescents

Research shows that children and adolescent who have been exposed to war developed psychological problems (Thabet, Ibraheem, Shivram, Winter & Vostanis, 2009; Catani, Jacob, Schauer, Kahila & Neuner, 2008; Macksoud & Aber, 1996). Naja, Aoun, Khoury, Abdallah and Haddad (2016) investigated 310 forcibly displaced Syrian refugees and found the pre-migration depression rate as 6.5% and the current depression as 43.9%. A group of researchers investigated 355 Syrian children and adolescents living outside refugee camps in Şanlıurfa, Turkey and reported 47.9 % percent of children have depressive symptoms (Kandemir, Karataş, Çeri, Solmaz, Kandemir & Solmaz, 2018). In another study, Şengün and Öğretir (2018) examined 256 Syrian children and adolescents who lost first degree relatives in the Syrian war and found that the level of depression was higher in children aged between 8-9 than 12-15 years. Furthermore, the level of depression was higher in children and adolescents whose family incomes are lower and who have a parent who is not working. A cross-sectional study conducted with Syrian children in Jordan shows that 24% of children reported that they feel depressed (Hamdan-Mansour, Abdel Razeq, Abdulhaq, Arabiat & Khalil, 2017).

2.4 Anxiety

Anxiety is a useful emotion in times of danger that causes a change in hormones, brain and behaviour which makes an individual ready for 'fight or flight'. The American Psychological Association defines anxiety as 'emotion characterized by feelings of tension, worried thoughts and physical changes like increased blood pressure'. When the intensity and duration of the anxiety is too much than the actual danger, it causes anxiety disorder. Individuals who have an anxiety disorder can face symptoms such as restlessness, being easily fatigued, difficulties on concentrating, irritability, muscle tension, sleep disturbance (American Psychiatric Association, 2013).

In today's world there is a lot of events that cause anxiety. After mood disorders, anxiety disorders are the most common mental health problem among children and adolescents. Research indicates that approximately with one in five children experience anxiety symptoms (Krain et al., 2007). Chansky and Kendall (1997) compared children with anxiety disorders and children with non-anxiety disorders, and reported that anxious children have more negative expectancies and thoughts on social situations. Children who have experienced adverse situations such as war, racism, separation from family, death of parents, poverty, hunger, malnutrition, exposure to violence, immigration, discrimination are vulnerable to develop physical, mental and behavioural health problems (Zare et al., 2018; Gjelsvik et al., 2014; Hassan, Ventevogel, Jefee-Bahloul, Barkil-Oteo & Kirmayer, 2016).

2.4.1 Anxiety Research in Refugee Children and Adolescents

Traumatic events are risk factors that can cause anxiety disorders (Shevlin, Dorahy & Adamson, 2007). Research evidence shows that children aged between 8 and 17 years, who experience a large number of adverse experiences are more likely to experience anxiety disorders (Barber, Kohl, Kassam-Adams & Gold, 2014). Refugee children might be exposed to traumatic events in premigration, migration and post migration phases. So, refugee children and adolescents can be more vulnerable to develop anxiety disorders in comparison with non-immigrant children. A group of researchers examined Bosnian refugee children who experienced the Bosnian war and found the

rate of possible anxiety as 23% (Papageorgiou, Frangou-Garunovic, Iordanidou, Yule, Smith & Vostanis, 2000). Betancourt and colleagues investigated war-affected refugee children in United States and reported the rate of anxiety disorder as 26.8%. One study of 119 Cambodian refugee children and adolescents found high scores of anxiety (Muecke, Sassi, Lipson & Paul, 1992).

2.4.2 Anxiety Research in Syrian Children and Adolescents

In one study, Javanbakht and colleagues (2018) evaluated possible mental health problems among 131 Syrian children and adolescents 6 to 17 years old. Based on the screening, 53 percent of children had a probable anxiety diagnosis. In their study of 355 Syrian children and adolescents living in Turkey, Kandemir and colleagues (2018) reported the prevalence rate of possible anxiety disorders as 53.2%. Another study conducted with 218 Syrian children in Turkey found that the rate of anxiety related disorders was 69% (Görmez, Kılıç, Örengül, Demir, Demirlikan, Demirbaş, Babacan, Kınık & Semerci, 2017). In a recent study, 1115 Syrian children aged between 9-15 years were examined and it was found that refugee children and adolescents have higher levels of anxiety (Yayan, Düken, Özdemir & Çelebioğlu, 2019). Similarly, Javanbakht, and colleagues (2018) examined 131 Syrian refugee children aged between 6-17 years resettling in United States and found possible anxiety disorder to be as high as 57.5% in girls and 50% in boys. Possible separation anxiety rates were high in the same group of Syrian children, 72.5% in girls and 80.4% in boys. Possible social anxiety percentages were 32.5% for girls, 37% for boys (Javanbakht, Rosenberg, Haddad & Arfken, 2018). Because of the fact that Turkey is the country that hosts the highest Syrian refugees, further research is required.

2.5 Post-Traumatic Stress Disorder

Post-traumatic stress disorder is a mental health condition triggered by a stressful life experience such as car crash, natural disasters, death of a loved one, witnessing war, attack, sexual abuse, serious illness. PTSD was first seen in World War I soldiers in 19th century. It was known as ‘shell shock’, ‘combat fatigue’ and ‘war neurosis’ (Crocq & Crocq, 2000). Individuals with PTSD can experience symptoms such as

being unable to fall asleep, nightmares, difficulty in concentrating, flashbacks, anxiety, numbness, hypervigilance (American Psychiatric Association, 2013). Stress symptoms generally occur immediately after the event but sometimes symptoms can be delayed (American Psychiatric Association, 2013). Lifetime prevalence of PTSD is 7.3% in United States. According to the National Center for PTSD the prevalence of PTSD is 3% to 15% in girls and 1% to 6% in boys (National Center for PTSD, 2019).

Research shows that if humans cause the traumatic event it leads to higher PTSD scores in individuals than traumatic events that happened naturally (Charuvastra & Cloitre, 2008). When individuals who have survived terrorist attacks and individuals who have survived motor vehicle accidents are compared, it is found that survivors of terrorist attack have higher rates of PTSD than other group of individuals (Shalev & Freedman, 2005). Most of the refugee children have been exposed to war trauma and it is also possible for them to be affected from these experiences.

2.5.1 PTSD Research in Refugee Children and Adolescents

Research indicated that PTSD rates are high among children exposed to war trauma (Nader, Pynoos, Fairbanks, al-Ajeel & al-Asfour, 1993; Thabet et al., 2009; Lavi & Solomon, 2005) and violence (Macksoud & Aber, 1996; Almqvist & Brandell-Forsberg, 1997). Refugee children and adolescents are vulnerable to develop PTSD (Paardekooper, de Jong & Hermanns, 1999; Kinzie, 1986). Heptinstall, Sethna & Taylor (2004) have found that PTSD scores were higher in refugee children who experienced violent death of a family member in pre-migration phase. Furthermore, post-migration stress about uncertainty about asylum in country of resettlement also caused PTSD in refugee children and adolescents (Heptinstall, Sethna & Taylor, 2004; Li, Liddell, Nickerson, 2016). In a cross-sectional study done with 364 internally displaced Bosnian children who experienced war and between 6 to 12 years, the rate of PTSD found as 94% (Goldstein, Wampler & Wise, 1997). A group of researchers investigated 331 displaced children and reported the rate of PTSD as 75% PTSD (Morgos, Worden & Gupta, 2008).

2.5.2 PTSD Research in Syrian Children and Adolescents

Şengün and Öğretir (2018) indicated that out of 256 Syrian children in Ankara, Turkey, children exposed to violence in the family reported higher PTSD scores than children who are not exposed to violence in the family. In one study, Afghan, Syrian and Eritrean children and adolescent refugees in Germany were examined (Müller, Büter, Rosner & Unterhitzenberger, 2019) and the rate of PTSD found as 36.7%. In another study conducted in Turkey, 44.2% of Syrian children and adolescents showed moderate to severe PTSD (Görmez et al., 2017). The prevalence of PTSD has been reported as 33% in Syrian children living in a camp in Germany (Soykoek, Mall, Nehring, Henningsen & Aberl, 2017). Similarly, post-traumatic stress disorder is investigated in a group of Syrian children aged between 11-18 living in Jordan and reported the prevalence as 31% (Beni-Yonis, Khader, Jarboua, Al-Bsoul, Al-Akour, Alfaqih, Khatatbeh & Amarneh, 2019). Khamis (2019) also investigated post-traumatic stress disorder in 1000 Syrian refugee children and adolescents aged between 7-18 and found the PTSD rate as 45.6%. This research also illustrated that comorbidity with emotion dysregulation is high in children and adolescents (Khamis, 2019). In another study, 492 Syrian children between the ages of 8-15 were examined and PTSD was found as the most common mental health problem among children and adolescents with the rate of 35.1% (Perkins, Ajeeb, Fadel & Saleh, 2018).

Although effects of war trauma on PTSD can be seen in Syrian children and adolescents further research is needed with a larger sample.

2.6 Attention-Deficit/Hyperactivity Disorder

Attention Deficit Hyperactivity Disorder is a common neurodevelopmental disorder in children and adolescents. There are three main symptoms of Attention Deficit Hyperactivity Disorder (ADHD): inattention, hyperactivity and impulsivity. ADHD is a developmental impairment in executive functions. Children with impulsivity are not able to learn lessons from mistakes and they can easily repeat mistakes. Children with inattention have difficulty in become organized. They have trouble finishing a task and paying attention. Daydreaming is another symptom in children with ADHD. Because

they daydream too much, they can forget to do even the daily tasks. Children with ADHD also have impairment in academic achievement (Biederman, Monuteaux, Doyle, Seidman, Wilens, Ferrero, Morgan & Faraone, 2004). Their grades can be lower because of the impulsivity and inattention. ADHD has a great impact on children's social interactions. Children who have ADHD generally seen negatively by their peers especially because of impulsivity (Hoza et al., 2005). Also, ADHD found in several cultures and symptoms are similar across different cultures (Bauermeister et al., 2010). It shows that ADHD is not culture specific and the symptoms do not differ between cultures. It is known that children with ADHD are also vulnerable to experience problems such as aggression and substance abuse in adulthood (Barkley, Fischer, Smallish & Fletcher, 2004).

According to the American Psychiatric Association (APA), ADHD occurs in %5 of children in USA (American Psychiatric Association, 2013). In a study, 770 primary school children were examined in Coimbatore, India. The children were aged between 6 and 14 years. The prevalence of ADHD was 11.33% (Venkata & Panicker, 2013). Among the children male students had higher rates on ADHD diagnosis. Studies have also been conducted to find out prevalence rates of ADHD in Turkey. For example, a cross sectional study conducted with 2045 children aged between 7 and 15 years, reported the prevalence of ADHD as 6.2% (Senol et al., 2017). A 4-year longitudinal study reported the ADHD prevalence rate as 12% in school aged children in Turkey (Ercan et al., 2013). A cross sectional study conducted with 1000 children in Saudi Arabia reported the prevalence rate of ADHD as 3.4% (Albatti et al., 2017). The lifetime prevalence of ADHD for adolescents aged between 13 to 18 years was 8.7% in the USA (Merikangas et al., 2010) Also, research showed that there is a comorbidity between ADHD and PTSD (Adler, Kunz, Chua, Rotrosen & Resnick, 2004; Biederman, Petty, Spencer, Woodworth, Bhide, Zhu & Faraone, 2012).

2.6.1 Attention-Deficit/Hyperactivity Disorder Research in Children and Adolescents

There are also studies conducted to assess Attention Deficit Hyperactivity Disorder in refugee populations. Mexican and Latin American refugee children showed ADHD

symptoms (Kinzie, Cheng, Tsai & Riley, 2006). In another study, researchers examined a group of children in West London including 90 refugee children, mostly Middle Eastern, and found ADHD in only two children (O'shea, Hodes, Down & Bramley, 2000). Daud and colleagues (2008) investigated 80 refugee children in Sweden aged between 6-17 and found that children whose parents reported high exposure to trauma diagnosed with ADHD more than children whose parents reported lower trauma exposure. This shows the intergenerational aspect of ADHD in refugee populations.

2.6.2 Attention-Deficit/Hyperactivity Disorder Research in Syrian Children and Adolescents

Karadag, Gokcen, Dandil and Calisgan (2018) examined 51 Syrian children and adolescents aged between 3 and 17, living in refugee camps in Gaziantep, Turkey. Among 51 children and adolescents ADHD was the most common mental health problem with the percentage of 33.3%. The high prevalence of ADHD among immigrant population requires more attention to spread treatment of ADHD into disadvantaged populations. ADHD studies are generally conducted with non-immigrant populations.

2.7 Conduct Problems

Conduct Disorder is defined as 'a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of at least three of the following criteria in the past 12 months from any of the four categories and with at least one criterion present in the past 6 months (American Psychiatric Association, 2013). These four categories are aggression to people and animals, destruction of property, deceitfulness or theft, serious violations of rules. In conduct disorder main problems are aggression and antisocial behaviour (Pilling, Gould, Whittington, Taylor & Scott, 2013; Kazdin, 2001; Prinz, 1998; Glicken, 2009). Different studies conducted in different countries reported prevalence of conduct disorder as 1.8% in 1210 Yemeni children (Alyahri & Goodman, 2007), 5.6% in white and 5.3% in African American children and

adolescents (Angold, Erkanli, Farmer, Fairbank, Burns, Keeler & Costello, 2002), 1.2% in Irish adolescents (Lynch, Mills, Daly & Fitzpatrick, 2006).

2.7.1 Conduct Problems Research in Children and Adolescents

Although this is a serious disorder in the development of children and adolescents, there are not many studies conducted with refugee populations. In one study that compared psychopathology in British children and refugee children in UK, it is found that conduct disorder was higher in British children than refugee children (Howard & Hodes, 2000) In another study, refugee childrenin UK and UK born children were compared and it was reported that refugee children have higher conduct problems than their British born peers (Leavey, Hollins, King, Barnes, Papadopoulos & Grayson, 2004). A group of researchers examined psychopathology in 203 Canadian refugee children and adolescents between 13-19 and reported that the rate of conduct disorder was high in the sample with 6%.

2.7.2 Conduct Problems Research in Syrian Children and Adolescents

Additionally, in their study conducted with Syrian refugee children, Eruyar et al. (2018) reported that parental psychopathology is a significant predictor for conduct problems in these children and adolescents. Alsayed and Wildes (2018) found that the prevalence of conduct problems is higher in 9 to 15 years Syrian children than Turkish children living in Antalya, Turkey. Çeri and Nasıroğlu (2018) examined 85 Syrian children from 2nd to 8th grades and found the conduct problems rate as high as 27.3%. They also find that prevalence of conduct problems is higher in boys than girls. Up to now, very few studies have been conducted to find out conduct problems in Syrian refugee children and adolescents.

2.8 Resilience

The origin of the word resilience dates back to the 17th century and originates from the Latin verb *resilire* which means to rebound. A review of the current literature indicates that there are a number of different definitions for resilience. Masten and Powell

(2003) refer to resilience as being "patterns of positive adaptation in the context of significant risk or diversity." Panter-Brick and Leckman (2013) defines resilience as "the process of harnessing biological, psychosocial, structural and cultural resources to sustain well-being." Rutter (2006) defines resilience as balancing significant risk experiences "with a relatively positive psychological outcome." Bonanno (2004) defines the term comprehensively as the "ability of adults exposed to an isolated and potentially highly disruptive event to maintain relatively stable and healthy levels of psychological and physical functioning." Masten, Best and Garmezy (1990) defines resilience as "the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances." Agaibi and Wilson (2005) define resilience as a "complex repertoire of behavioural responses to trauma which includes recovery from trauma to optimal states of functioning" American Psychological Association (2014) refers to resilience as "the process of adapting well in the face of diversity, trauma, tragedy, threats or even significant sources of stress." As observed, the literature has not reach a consensus with regards to the exact definition of resilience, but what underlines these definitions is an ability to cope with challenges and adapt to new conditions after being exposed to adverse situations.

The term resilience is generally conceptualized as being an elastic (Kohli, 2006), dynamic process (Stainton et al., 2019), where an individual bounces back (Masten, 2014), adapts in the face of risk or diversity (Luthar et al., 2000) and strengthens their capacity to cope in adverse situations (Earnest et al., 2015). According to Luthar and colleagues (2000) some researchers believe that resilience is a reaction to a particular event, while others treat resilience as a steady adapting style to the new circumstances (Cicchetti, 2010; Curtis & Cicchetti, 2007).

A review of the literature indicates that resilience has been examined in the context of gender-related victimization (Bariola et al., 2015), loss and traumatic events (Bonanno et al., 2011), individual protective factors such as self-esteem, self-efficacy and positive emotions (Arslan, 2015), parental/caregiver support and monitoring (El-Khani et al., 2018), sociocultural and individual factors (Aitcheson et al., 2017), depression and anxiety (Aitcheson et al., 2017), family cohesion (Nam et al., 2016), friendship quality (Rubin et al., 2004), hope (Muñoz et al., 2019), social support and

academic stress (Song et al., 2019), health-related quality of life (Qiu et al., 2019) and perceived ethnic discrimination and ethnic identity (Lee, 2005).

2.8.1 Resilience Studies in Children and Adolescents

Adverse childhood experiences such as experiencing violence, abuse, death of a loved one has effects on both children's cognitive, physical and psychological well-being (Anda, Felitti, Bremner, Walker, Whitfield, Perry, Dube, & Giles, 2005; Dube, Felitti, Dong, Chapman, Giles, & Anda, 2003; Brown, Anda, Tiemeier, Felitti, Edwards, Croft, & Giles, 2009; Chapman, Whitfield, Felitti, Dube, Edwards, & Anda, 2004). Resilience prevents diverse situations from becoming traumatic and devastating experiences (Masten, 2014).

Fleming and Ledaogar (2008) indicate that the focus of resilience research with children and adolescent populations has changed over time. The first wave of research focused on understanding the individual factors that led to a child being more resilient (Cowen & Work, 1988). Factors such as receiving attention from others (Milgram & Palti, 1993), having a sense of control and empathy (Parker, Cowen, Work & Wyman, 1990), being invulnerable (Anthony, 1974) and having strong problem-solving skills (Werner, 1984) were found to be some of the key qualities of resilient children and adolescents. Later, the scope of the research expanded from individual to environmental factors. Researchers examined individual, community and family protective factors and their impact on the resilience of children and adolescents (Fleming & Ledaogar, 2008; Masten & Garmezy, 1985; Werner, 1982). The third wave of resilience research examines protective factors extensively and focuses on fostering positive change in different children and adolescent populations who experienced adverse situations such as domestic violence (Martinez-Torteya, Bogat, Von Eye & Levendosky, 2009; Howell, 2011), community violence (Reinemann & Ellison, 2008), poverty (Garmezy, 1993), and racism (Miller & MacIntosh, 1999). In the last 10 years, studies have been focusing on genetic and neurobiological factors which contribute to the development of resilience (Feder, Nestler & Charney, 2009; McCrory, De Brito & Viding, 2010; Bradley, Davis, Wingo, Mercer & Ressler, 2013;

Kim-Cohen & Turkewitz, 2012; Cicchetti & Blender, 2006; Cicchetti & Rogosch, 2012).

2.8.2 Factors Which Impact Resilience in Children and Adolescents

A review of the literature demonstrates that resilience promoting factors can be divided into individual, family and environmental factors (Garmezy, 1993; Masten, 2014; Brooks, 1994; Garmezy, Masten, & Tellegen, 1984). Each of these categories will be examined in further detail.

2.8.2.1 Individual Factors Which Impact a Child's Resilience

Research on individual factors illustrate that several characteristics are common in resilient children and adolescents (Werner, 1984; Bland, Sowa & Callahan, 1994; Cortes & Buchanan, 2007). Buckner and colleagues (2003) investigated 155 children between the ages of 8-17 years and reported that children who had the ability to self-regulate had higher levels of resilience than children who did not have the ability to self-regulate. Self-esteem was also found to be an important factor that enhanced the resilience of these children (Buckner, Mezzacappa & Beardslee, 2003). Wang and Kong (2019) examined 467 Chinese adolescents aged between 14-19 years and reported that adolescents who had higher levels of self-esteem were more resilient than adolescents who had lower levels of self-esteem. Similarly, a study by Radke-Yarrow and Brown (1993) found that resilient children had higher levels of self-confidence than children who were not resilient. In another study, Önder and Gülay (2008) investigated resilience in 98 eighth grade students and reported that resilient children had a higher positive self-concept.

2.8.2.2 Family Factors Which Impact a Child's Resilience

A number of studies have examined how parental marital status impacts the resilience of children (Emery & Forehand, 1996; Stolberg & Bush, 1985). Singh and colleagues (2019) examined 416 adolescents between the ages of 13-19 years living in Nepal and found that adolescents whose parents were divorced reported lower levels of resilience

than adolescents whose parents were together. In contrast, other studies demonstrate that despite parental separation and divorce, children and adolescents can still be resilient (Kelly & Emery, 2003; Karela & Petrogiannis, 2018). Ruschena and colleagues (2005) conducted a longitudinal study of 1260 infants, which they followed up until the age of 18 years. In terms of children who experienced parental separation, divorce, remarriage or death, they found no significant differences between these groups with regards to behavioural and social adjustment, academic outcomes or social competence and illustrated the resilience of children who experienced family disruption in the early stages of life.

A large number of studies examining family factors which impact resilience have focused on children and adolescents living with parental mental health challenges (Fraser & Pakenham, 2009; Radke-Yarrow & Brown, 1993; Musick, Stott, Spencer, Goldman & Cohler, 1987). Foster and colleagues (2011) examined resilience promoting factors in children who have parents with mental health issues and emphasized the importance of psychosocial support, especially from other family members. Another study examined 44 children ages between 12-17 years who have a parent with mental health disorder and found that in these children behaviour and emotional problems were higher and social connectedness were lower (Fraser & Pakenham, 2009). Pretis and Dimova (2008) illustrate that the mental health challenges of parents impact the biopsychosocial development of children but due to inherent resilience factors, not all the children are affected to the same degree. Although children's knowledge of parental psychopathology is important for them to cope with the situation, and so that children experience less psychological problems because of parental psychopathology (Maybery & Reupert, 2009), it is also emphasized that this knowledge may be a disadvantage for some children (Grove, Reupert & Maybery, 2013).

2.8.2.3 Environmental Factors Which Impact a Child's Resilience

A variety of environmental factors impact resilience in children and adolescents such as poverty (Garmezy, 1993; Luthar, 1999), maltreatment (Yoon, Howell, Dillard, McCarthy, Napier & Pei, 2019; Cicchetti, Rogosch, Lynch & Holt, 1993), abuse

(Holmes, Yoon, Voith, Kobulsky & Steigerwald, 2015; Daigneault, Hebert & Tourigny, 2007), war (Diab, Peltonen, Qouta, Palosaari & Punamäki, 2015; Halevi, Djalovski, Vengrober & Feldman, 2016), domestic violence (Zhang, Wang, Ning, Yang, Zhang, Shan, Chen, Wang, Tao & Zhang, 2019; Hildebrand, Celeri, Morcillo & Zanolli, 2019), community violence (Namy, Carlson, Norcini Pala, Faris, Knight, Allen, Devries & Naker, 2017), and diseases (Danaher, Brand, Pickard, Mack & Berry, 2017; Rosenberg, Bradford, McCauley, Curtis, Wolfe, Baker & Yi-Frazier, 2018; Murphy, Bettis, Gruhn, Gerhardt, Vannatta & Compas, 2017; Penner, Sharp Marais & Skinner, 2018; Li, Chi, Sherr, Cluver & Stanton, 2015).

Children and adolescents who experience environmental diversity are vulnerable to develop substance abuse (Thornberry, Henry, Ireland & Smith, 2010), physical illnesses (Graham-Bermann & Seng, 2005) and mental health problems (Murad & Abdelaziz, 2017). Nevertheless, there are also protective factors which helps these children and adolescents overcome environmental difficulties. In one study conducted with 750 children including orphaned children because of AIDS-related causes, aged between 7-11 years it is found that children who perceive that their peers and teachers are caring for them in the school were more resilient and had less mental health problems than children who do not perceive it (Penner, Sharp, Marais & Skinner, 2018). Similarly, Li and colleagues (2015) also examined HIV-infected children and found that resilience is mostly affected by perceived social support from family and friends.

Perkins and Jones (2004) investigated effects of abuse on resilience in 16,313 children going to seventh, ninth and eleventh grades. Although a number of problematic behaviours such as higher rates of substance use found in abused children, they also reported resilience promoting factors. Peer groups, religiosity and positive school environment found as protective factors against the negative consequences of abuse in children (Perkins & Jones, 2004).

2.8.3 Resilience Studies in Immigrant and Refugee Children and Adolescents

With the increasing displacement in the world, studies look at the role of resilience in children in the face of adversity caused by war and immigration. A review of the literature examining resilience and related factors in immigrant and refugee children was conducted and the findings summarized in Table 2.8.3.

The review was limited to studies published between 2008-2019. Aitcheson and colleagues (2017) examined factors which contribute to the resilience in 335 Palestinian adolescents between 17-19 years and living in refugee camps in Gaza. It is found that adolescents who had stronger self-regulation, ethnic belonging and coping skills were found to be more resilient (Aitcheson, Abu-Bader, Howell, Khalil & Elbedeour, 2017). Similarly, Costigan and colleagues conducted a research with 95 immigrant Chinese children ages between 9-15 years and reported that resilience was high in children and adolescent who have strong ethnic identity. A group of researchers conducted a longitudinal examination of 234 immigrant adolescents aged between 10-14 and found that resilient adolescents have life satisfaction (Jiang, Ming, Tian, Huang, Sun, Li & Zhang, 2019). A group of researchers also examined 710 war-exposed adolescents and reported that resilience scores were higher in individuals who have leisure activities and use problem-solving techniques (Fayyad, Cordahi-Tabet, Yeretzian, Salamoun, Najm & Karam, 2016). As a result, individual differences in self-regulation, ethnic belonging, coping and problem-solving skills and being satisfied with life have a significant effect on resilience of immigrant children and adolescents.

Resilience in refugee children was also examined in terms of family factors. In one study, Daud, Klinteberg and Rydelius (2008) compared refugee children from different nationalities who have parents with traumatic experiences and children who have parents who did not experience traumatic events and found that resilience levels were higher in children of not traumatized parents.

Hadfield and colleagues (2017) emphasize that post-arrival experiences of refugee children are also an important predictor of psychological well-being as well as their

pre-immigration experiences. Several environmental factors were also found to contribute resilience in refugee children and adolescents. Kanji and colleagues (2010) examined Muslim Afghan refugee children aged between 13-17 years and reported that resilience in children who have social support from their religious community was higher. As another research indicates self-regulation is also important for refugee children's level of resilience (Aitcheson et al., 2017).

Table 2.8.3: International resilience studies in refugee and immigrant children and adolescents

Study	Population	Sample	Age	Results
Aitcheson et al. 2017	Palestinian adolescents	335	17-19 years	Resilient children had stronger self- regulation, ethnic identity, family sense of coherence and coping skills
Costigan et al. 2010	Immigrant Chinese children	95	9-15 years	Resilient children had high ethnic identity.
Daud et al. 2008	Refugee children in Sweden (Egypt, Syria, Morocco)	80	6-17 years	Children who have traumatized parents scored lower on resilience.
Kanji et al. 2010	Muslim Afghan refugee children	7	13-17 years	Religion and support from religious community promotes resilience in these children
Katisi et al. 2019	Orphaned children in Botswana, Africa	650	11-17 years	Resilience increased after the intervention program designed to enhance well-being of children

2.8.4 Resilience Studies on Syrian Children and Adolescent

Whilst many studies have been conducted examining resilience in children and adolescents (Bland, Sowa & Callahan, 1994; Costigan, Koryzma, Hua & Chance, 2010; Jefferies, Ungar, Aubertin & Kriellaars, 2019; Silk, Vanderbilt-Adriance, Shaw, Forbes, Whalen, Ryan & Dahl, 2007; Sun & Stewart, 2007) fewer studies have examined resilience in Syrian refugee children and adolescents. Research with Syrian refugees is generally done with adult populations (Acarturk, Cetinkaya, Senay, Gulen, Aker & Hinton, 2018; Acarturk, Konuk, Cetinkaya, Senay, Sijbrandij, Cuijpers & Aker, 2015; Alpak, Unal, Bulbul, Sagaltici, Bez, Altindag, Dalkilic & Savas, 2015; Arar, Örücü, Ak Küçükçayır, 2020; Cengiz, Ergun & Cakici, 2019; Ceylan, Algan, Yalcin, Yalcin, Akin & Kose, 2017;Elliott, Das, Cavailler, Schneider, Shah, Ravaud, Lightowler & Boulle, 2018; Kira, Shuwiekh, Rice, Al Ibraheem & Aljakoub, 2017; Tekeli-Yesil, Işık, Unal, Aljomaa-Almossa, Unlu & Aker, 2018; Woltin, Sassenberg & Albayrak, 2018). The majority of studies conducted with Syrian refugee children and adolescents have focused on psychopathology (Eruyar, Maltby & Vostanis, 2018; Gormez, Kilic, Orengul, Demir, Demirlikan, Demirbas, Babacan, Kinik & Semerci, 2018; Jabbar & Zaza, 2014;Kira, Shuwiekh, Rice, Al Ibraheem & Aljakoub, 2017; Özer, Sirin & Oppedal, 2013; Yayan, Duken & Ozdemir, 2019), with very few studies examining resilience in this population. The reason for this may be to be able to intervene it is important to understand the problem first. Also, there is a language-barrier to conduct studies with Syrian refugees and this may result in less studies conducted with this population.

As seen in non-immigrant children population, individual and family factors also affects resilience of immigrant children and adolescents. Kira and colleagues (2019) examined post traumatic growth in a total of 552 Syrians including internally displaced Syrians and refugees in the Netherlands and Egypt. Research shows that post traumatic growth was seen in individuals who can reconsider the traumatic situation with the help of increased identity salience (Kira et al., 2019).

Environmental factors such as social support and experiences in phases of immigration also have an impact on resilience of children and adolescents. Oppedal, Ozer and Sirin

(2018) examined 285 Syrian refugee children living in Turkey and found that children who perceive social support were more resilient than children who do not perceive social support. Panter-Brick and colleagues (2018) examined 603 Syrian and Jordanian children and adolescents between 11 to 18 years and reported that education level affects resilience significantly. Also, it is found that children who perceive social insecurity had lower levels of resilience than children who do not perceive social insecurity (Panter-Brick et al., 2018). Recently Demir and Aliyev (2019) investigated resilience in 10 migrated Syrian university students in Turkey and found that students had higher levels of resilience. They also reported that support from family, Turkish society and other immigrants are protective factors. Although most of the research is done with Syrian children and adolescents living outside of Syria, there are a few studies conducted to assess children still living in Syria. Perkins and colleagues (2018) examined mental health challenges of 492 Syrian children aged between 8-15 years living in Damascus and Latakia and reported that family network and school affects resilience levels of children. Hadfield and colleagues (2017) emphasize that post-arrival experiences of refugee children is also an important predictor of psychological well-being as well as their pre-immigration experiences.

It is known that intervention programs help children and adolescents to reduce psychopathology symptoms (Morina, Koerssen & Pollet, 2016; Ugurlu, Akca & Acarturk, 2016) and increase psychological well-being. Ugurlu and colleagues (2016) developed an intervention program for traumatized Syrian children living in Turkey. Art therapy intervention implemented on 64 Syrian refugee children between the ages 7-12. It is reported that trauma symptoms, depression, post-traumatic stress disorder and anxiety scores were higher before the implementation of the program. So, it can be clearly stated that art therapy can be used to increase resilience of Syrian children and adolescents. Similarly, Gormez and colleagues (2017) conducted an intervention-based research with 32 Syrian refugee children aged between 10-15 years and they also reported that after the intervention program anxiety and post-traumatic stress disorder scores dramatically decreased.

2.9 Individual and Social Factors

2.9.1 Perceived Social Support

Humans are by nature social beings and need to communicate with others such as family, friends and close ones in order to receive social support. Social support is defined by Wortman and Dunkel-Schetter (1987) as shelter and help given to others which can be in the form of care, warmth, resources and help. Shumaker and Brownell (1994) describe social support as an integrative process that includes conscious exchange of resources between two people, with the purpose of this exchange being to enhance the wellness of the person who receives it. Albrecht and Adelman (1987) refer to social support as being the verbal and nonverbal communication between two individuals which serves to decrease uncertainty and increase the receiving person's perceptions of control over the situation. Despite these differing definitions of social support, the two underlying communalities of these definitions refer to the fact that social support is interpersonal and gives benefit to the receiver.

Cutrona and Shur (1992) divide social support into five key categories. Of these, informational support includes advice, suggestions and information related support. Emotional support includes trust, love, empathy and care. Esteem support includes expressions of confidence which contributes to advance capacity and skills. Social network support includes messages that help to increase a sense of belonging. Lastly, tangible support refers to material and physical support. Although the sources of social support may vary, regardless of the source, social support is an important factor which buffers against mental health challenges (Holt-Lunstad, Smith & Layton, 2010).

In the literature, social support is generally divided into structural support and functional support. Structural social support refers to the quantity of relationships and includes the number of social support sources whilst functional social support refers to the quality of social support and includes the enhancing role of social support on an individual's well-being (Schwarzer & Knoll, 2007). Even if a person has a large network of social support resources, the support they provide may not make a positive change in an individuals' life. Functional social support is further divided into perceived and received social support. Received social support is the direct reflection

of the amount of support an individual receives, whilst perceived social support is the perception of the amount of social support the person perceives (Norris & Kaniatsy, 1996).

2.9.1.1 Research on Perceived Social Support

Perceived social support is a subjective evaluation of the level of social support that an individual receives and is therefore open to interpretation. Research indicates that while the existence of the social support itself is important, what is most important is the perception that an individual is cared and valued for by others and has access to support when it is needed (Lakey & Cohen, 2000; Turner & Brown, 2009).

Individuals who have a strong perceived social support are better able to cope with adversity than individuals who perceive less social support (Brewin, Andrews & Valentine, 2000). In one study conducted with 142 trauma-exposed firefighters, it was found that individuals who had the highest scores on measures of PTSD, depression and anxiety reported lower levels of perceived social support (Meyer, Zimering, Daly, Knight, Kamholz & Gulliver, 2012). Furthermore, co-worker support was the most effective type of support identified in this study. In another study, a group of researchers conducted a longitudinal examination of 816 adults aged between 21-30 and examined the relationship between perceived family support, friend support and depression levels based on self-report questionnaires and found that the level of depressive symptoms decreased as the level of perceived social support increased. (Pettit, Roberts, Lewinsohn, Seeley & Yaroslavsky, 2011). Noret, Hunter and Rasmussen (2019) investigated 3737 eighth grade students and found that as the level of perceived social support decreased, reported mental health difficulties increased in these children. Studies show that the capacity to cope with difficulties increases as perceived social support increases in difficult groups (Aydın, Kahraman & Hiçdurmaz, 2017; Rubin, Dwyer, Booth-LaForce, Kim, Burgess & Rose-Krasnor, 2004; Sangalang & Vang, 2017) which may be an important factor to consider especially in communities who have been disposed by war and face forced migration.

2.9.1.2 Perceived Social Support Research in Refugee Children and Adolescents

Research shows that perceived social support is an important factor in promoting resilience in children and adolescents, especially those exposed to war trauma (Pine & Cohen, 2002; Oppedal, Ozer & Sirin, 2018; Shrira, Palgi, Ben-Ezra & Shmotkin, 2010).

Reed, Fazel, Panter-Brick and Stein (2012) have found that refugee children and adolescents who perceived social support in the country of resettlement, had significantly less mental health problems and higher levels of resilience than those who didn't perceive social support. Paardekooper, Jong and Hermanns (1999) compared children living inside and outside refugee camps in Uganda and reported that children living in refugee camps perceived less social support and had higher levels of PTSD compared to other children. In another study conducted with Namibian adolescent refugees, it was found that levels of depression were higher in those who perceived less social support (Shisana & Celentano, 1985). Studies show that perceived social support is an important protective factor for the development of mental health challenges in refugee children and adolescents (Ben-Ari & Gil, 2004; Measham, Rousseau, Blais-McPherson, Guzder, Pacione & Nadeau, 2014; Shisana & Celentano, 1985; Lee, 2005).

Whilst many studies have been conducted examining perceived social support in refugee children and adolescents (Oppedal & Idsoe, 2015; Mels, Derluyn & Broekaert, 2008; Stewart, Anderson, Beiser, Mwakarimba, Neufeld, Simich & Spitzer, 2008; Short & Johnston, 1997; Chou, 2009) fewer studies have examined perceived social support in Syrian refugee children and adolescents. Of these Oppedal, Özer and Sirin (2018) evaluated 285 Syrian refugee children and adolescents in Turkish camps and found that refugee children who experience more traumatic events perceived more social support and as the level of perceived social support increase, depression levels decreased in Syrian children and adolescents. Although stressful experiences of Syrian children and adolescents are high, it has been found that perceived social support has reduced the psychological problems that will arise as a result of these experiences. Research conducted with Syrian children and adolescents shows that perceived social

support is also essential for Syrian children and adolescents and their adaptation in resettlement countries (Hamdan-Mansour, 2016).

2.10 Prosocial Behaviour

Prosocial behaviour refers to voluntarily helping other individuals (Batson, 2011; Carlo, Mestre, McGinley, Tur-Porcar, Samper & Streit, 2013) and promoting their wellbeing (Gupta & Thapliyal, 2015) without expecting a reward (Gonzalez, Caprara, Garces de los Fayos & Zuffiano, 2014). Prosocial behaviour is thought to be a multidimensional construct, which means that multiple factors contribute to it being triggered (Decety, Bartal, Uzefovsky & Knafo-Noam, 2015). Prosocial behaviour is an interrelated term which can be influenced by genetics (Onaka, Takayanagi & Yoshida, 2012), perspective taking (Tamnes, Overbye, Ferschmann, Fjell, Walhovd, Blakemore & Dumontheil, 2018; Knight, Carlo, Basilio & Jacobson, 2015), empathy (Bengtsson & Johnson, 1992; Farrant, Devine, Maybery & Fletcher, 2012), sympathy (Vaish, Carpenter & Tomasello, 2009), bystander effect (Plötner, Over, Carpenter & Tomasello, 2015).

Genetic involvement in prosocial behaviour is investigated such as the role of specific genes, hormones and neurotransmitters (Michael & Inga, 2011; Onaka, Takayanagi & Yoshida, 2012; Crockett, 2009). However, as Knafo-Noam and Markovitch (2015) illustrated it is hard to repeat genetics studies.

Parenting styles and relationship with parent also affects prosocial behaviour in children. Authoritative parents' children are found to be engaged in more prosocial behaviour (Krevans & Gibbs, 1996; Hastings, Zahn-Waxler, Robinson, Usher, & Bridges, 2000). Parental warmth contributes to children and adolescents' prosocial behaviour (Davidov & Grusec, 2006; Malonda, Llorca, Mesurado, Samper & Mestre, 2019). Also, verbal hostility by fathers has a negative impact on adolescents' prosocial behaviour (Padilla-Walker, Nielson, & Day, 2016).

One of the factors that contributes to the act of prosocial behaviour is empathy (Krevans & Gibbs, 1996), whereby understanding other individuals' emotional states and taking their perspectives may drive us to help others. Social support is another

important factor that has an impact on prosocial behaviour (de Guzman, Jung & Do, 2012). Schools, teachers and parents can help children to develop prosocial behaviour (Eisenberg, 2006). Twenge and colleagues (2007) found that prosocial behaviour decreases with social exclusion.

In a longitudinal study prosocial behaviour on war exposed children was examined and it found that prosocial behaviours increased during war period (Raboteg-Šaric, Žužul & Keresteš, 1994). In another study, parents of refugee children and adolescents living in South Australia rated their children's prosocial behaviour, for the age group 13-17 parents rated high prosocial behaviour in children (Ziaian, de Anstiss, Antoniou, Baghurst & Sawyer, 2011). In Peshawar refugee school and a government school in Kabul, Afghanistan, caregivers rated children's prosocial behaviour higher than children themselves (Panter-Brick, Grimon & Eggerman, 2013).

2.11 Peer Relationship

Peer relation is an important aspect for children's social, emotional development and psychological well-being (Hay, Payne & Chadwick, 2004; Sturaro, van Lier, Cuijpers & Koot, 2011; Parker & Asher, 1993). Peers help children to develop empathy (Brownell, Zerwas & Balaram, 2001), cooperation (Endedijk et al., 2015), and self-esteem (Laible et al., 2004).
One study investigated 1247 students and found lower resilience levels in adolescents who perceive psychological maltreatment than peers who do not perceive psychological maltreatment (Bostan & Duru, 2019).

Even though peer relations is important for a child who experiences diverse situations, it is inevitable that peer relations is important for a child who experience diverse situations. Positive peer relations predict psychological well-being in refugee children and adolescents (Ziaian et al., 2012). Peer relations also play an important role on adapting new society (Strohmeier & Spiel, 2012). A group of researchers investigated mostly Arabic refugee children and adolescents in Australia aged between 5-17 years and compared them with Australian non-immigrant peers. It is found that refugee children and adolescents reported higher peer problems (Jenkinson, Silbert, De Maio & Edwards, 2016).

Peer problems may cause mental health challenges in immigrant children. In one study, 1,249 immigrant adolescents living in Belgium and 602 non-immigrant adolescents were compared and found that immigrant adolescents had higher levels of peer problems and avoidance symptoms (Derluyn, Broekaert & Schuyten, 2008). Peer support decreases anxiety in children (Hill & Madhere, 1996).

2.12 Parent Relationship

The importance of relationships with family members is also highlighted in the literature (Welsh & Brodsky, 2010), whereby having at least one warm and supportive parent has been shown to buffer children against the impact of adversity and the development of psychological challenges (Masten & Coatsworth, 1998).

The quality of the relationship between parent and child is important and affects cognitive development (Sethna, Perry, Domoney, Illes, Psychogiou, Rowbotham, Stein, Murray & Ramchandani, 2017), mental health (Suh, Fabricius, Stevenson, Parke, Cookston, Braver & Saenz, 2016), academic achievement (Lara & Saracostti, 2019; Cutrona, Cole, Colangelo, Assouline & Russell, 1994), and social development (Guajardo, Snyder & Petersen, 2009; Maccoby, 1992). Although there are significant risk factors that affect children's resilience negatively such as psychopathology in a parent (Fendrich, Warner & Weissman, 1990; Frick, Lahey, Loeber, Stouthamer-Loeber, Christ & Hanson, 1992), maltreatment and neglect (Mak, 2007; Radford, Corral, Bradley & Fisher, 2013; Sidebotham & Golding, 2001), hostile aggressive parenting (Stover, Urdahl & Easton, 2012) it is known that parental factors contribute to resilience in children and adolescents (Abu-Bader, Howell, Khalil & Elbedour, 2017; Aitcheson, Soleman; Nam, Kim, DeVylder & Song, 2016).

In this study, parents availability is the time spent together with children, togetherness is activities done together, nurture disclosure is "nurturance through disclosure by the child to the parent of a variety of positive, negative, and neutral experiences", and another dimension parent as a mediator is "the extent to which the parent encourages or aids the child in maintaining peer relations" (Aroian, Hough, Templin & Kaskiri, 2008).

One study demonstrates that children who spend time with their mother and have a close relationship have fewer behaviour problems at school and home (Amato & Rivera, 1999). Booth and colleagues (2002) examined both the quantity and quality of the relationships between mothers and infants. In quantity they looked at the hours physically being with children and the place, while examining the quality, researchers observed the interaction with children and especially focused on the positive and negative responses of mothers such as shouting and annoyance. Research found that "the quality of the relationship doesn't affect by the amount of time spent apart."

2.13 Aims and Hypotheses

Diverse situations may negatively impact children and adolescents development and psychology. Although, these experiences have a strong power on individuals, it is known that some individuals can cope with diverse situations better than others while some individuals have a difficulty to adapt and overcome these experiences and as a result, they may become vulnerable to mental health challenges. Resilience helps individuals to easily cope with difficulties. So, it is crucial to take steps to investigate factors which have a positive and negative impact on resilience levels. This is no doubt significant for developing prevention and intervention programs.

In the literature, there are a few studies conducted with Syrian children and adolescents and a very few of them conducted to investigate Syrian children and adolescents psychological well-being with an actual focus on resilience. This study will investigate an under researched population. Studies conducted with this population mostly focuses on mental health challenges. This study's main purpose is to investigate resilience and the factors may contribute resilience in this population. The aim of this study was to investigate the resilience in terms of perceived social support, peer relations, parent relations, depression, anxiety, stress, intrusion, avoidance, hyperarousal, emotional problems, PTSD, conduct problems, hyperactivity and prosocial behaviour. As far as we are aware, no other studies have looked at all these variables in a single study. The information obtained will be discussed in light of the literature and suggestions for future studies will be made.

The research questions of this study are as follows:

1. What is the relationship between resilience and socio-demographic variables?
2. What is the relationship between perceived social support, depression, anxiety, stress, peer relationships, parent relationship and resilience?
3. Does perceived depression, anxiety, stress levels and social support, peer relationships, parent relationship and individual strength and difficulties predict the level of resilience in Syrian refugee children and adolescents?

Hypothesis:

1. Perceived social support, prosocial behaviour, peer relationships and parent relationship are positively correlated with refugee children and adolescents' levels of resilience.
2. Children and adolescents who perceive higher levels of peer support, family support and individual support have higher levels of resilience.
3. Depression, anxiety, stress scores, emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems are negatively correlated with refugee children and adolescents' levels of resilience.
4. Peer relationships, perceived social support and prosocial behaviour predict higher levels of resilience in children and adolescents.
5. Conduct problems, hyperactivity/inattention predict lower levels of resilience in children and adolescents.
6. Depression, anxiety, stress and PTSD scores predicts lower levels of resilience in children and adolescents.

CHAPTER III

METHOD

3.1 Participants

One hundred and thirty-three children participated in the study which included 74 boys and 59 girls. All children were aged between 10 and 18 years. Participants were recruited from an NGO called Syrian Forum. It is offering service in Istanbul, Austria, USA, Qatar and Lebanon. I contacted the NGO's İstanbul office to reach Syrian children. Children were eligible to participate in the study if they had no known intellectual disabilities, had no Autism diagnoses, were between the ages of 10 and 18, were born in Syria and now resided in Turkey. All the sample met the inclusion criteria and no children were excluded from the study.

3.2 Measures

Socio-Demographic Questionnaire, Impact of Event Scale-Revised, Depression, Anxiety and Stress Scale, The Multidimensional Scale of Perceived Social Support, Child and Youth Resilience Measure, Strengths and Difficulties Questionnaire and Family Peer Relationship Questionnaire were used in this study. In order to use these scales, written permission was obtained from the researchers who made the adaptation to Arabic. The psychometric properties of the scales can be found in Appendix 1.

3.2.1 Socio-Demographic Questionnaire

The Socio-Demographic Questionnaire was developed by the researcher. It includes a total of 18 questions related to children's demographical and social information, such as gender, birth date, children's attendance to the schools in Turkey and in Syria, family, friends, level of Turkish, past and/or present psychological illness and stressful events experienced.

3.2.2 Impact of Event Scale-Revised

The Impact of Event Scale (IES; Horowitz, 1979) is a 15 item self-report measure. It is not developed to use with children or to assess PTSD, but it is successfully used to assess PTSD in child and adolescent population (Joseph, 2000). In 1997, Weiss and Marmar revised the scale by adding seven items. Impact of Event Scale-Revised (IES-R; Weiss, 1997) is a widely used valid and reliable 22 item self-report measure that assesses the impact of a stressful event on aspects intrusion, avoidance and hyperarousal in individuals. This measure assesses symptoms during the past week. Each item is rated on a 0 = 'not at all', 1 = 'a little bit', 2 = 'moderately', 3 = 'quite a bit', 4 = 'extremely'. The scores can range from 0 to 88.

3.2.3 Depression, Anxiety and Stress Scale

Depression, Anxiety and Stress Scale (DASS-42; Lovibond and Lovibond, 1995) is a 42 item self-report instrument measuring depression, anxiety and stress symptoms in the last week. There are 14 items measuring depression, 14 items measuring anxiety and 14 items measuring stress. This is 4-point Likert scale in which respondents are asked to rate each item from 0 to 3 with 0 = 'did not apply to me at all', 1 = 'applied to me to some degree or for some of the time', 2 = 'applied to me to a considerable degree or for a good part of time', 3 = 'applied to me very much or most of the time'. The scores can range from 0 to 42 for each subdomain. The high scores indicate that the individual has higher scores on depression, anxiety and stress subdomains.

3.2.4 The Multidimensional Scale of Perceived Social Support

The Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet and Farley, 1988) is a 12 item self-report instrument designed to measure perceptions of social support from family, friends and significant other. Each of the three scales contains 4 items. This is a 7-point Likert scale in which respondents are asked to rate each item from 1 to 7 with 1 = 'very strongly disagree', 2 = 'strongly disagree', 3 = 'mildly disagree', 4 = 'neutral', 5 = 'mildly agree', 6 = 'strongly agree', 7 = 'very strongly agree'. High score indicates high levels of perceived social support.

3.2.5 Child and Youth Resilience Measure

Child and Youth Resilience Measure (CYRM-12; Liebenberg, Ungar, Leblanc, 2013) is a brief 12 item self-report resilience instrument which designed for children between the ages 5 through 9 years old and for youth between the ages 10 through 23 years old. It is the short version of original 28 item Children and Youth Resilience Measure, developed with data collected from 1,451 child and adolescents in 11 different countries: Canada, China, Colombia, India, Israel, Palestine, Russia, Tanzania, the Gambia, United States of America and South Africa (Liebenberg et al., 2013). The questionnaire uses a 5-point Likert scale in which respondents are asked to rate each question from 1 to 5 with 1 = 'does not describe me at all', 2 = 'describes me a little bit', 3 = 'describes me moderately', 4 = 'describes me quite a bit', 5 = 'describes me extremely.' High score indicates high level of resilience.

3.2.6 Strengths and Difficulties Questionnaire

Strengths and Difficulties Questionnaire (SDQ; Goodman, Meltzer and Bailey, 1998) is a revised form of originally developed Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) for completion by parents and teachers of 4 to 16 year old children. The SDQ is 25 item self-report instrument designed to measure emotional symptoms, conduct problems, hyperactivity/inattention, peer relationships problems and prosocial behaviour in the past 6 months. It is developed for the completion of ages between 11 and 16. Respondents are asked to choose for each item from 'not true', 'somewhat true' and 'certainly true'.

3.2.7 Family Peer Relationship Questionnaire

Family Peer Relationship Questionnaire (FPRQ; Ellison, 1983) is developed to assess children's relationships with parents and peers. There are two versions of FPRQ: parent domain, for parents to complete and child domain, for children to complete. Parent domain of the FPRQ has three subscales: availability, togetherness and nurture-disclosure rated on a 5-point Likert scale on frequency of behaviours from 1 to 5 with 1 = 'never', 2 = 'a few times a year', 3 = 'about once a month', 4 = 'about once a

week', 5 = 'almost every day'. There are some questions about peer relationships such as number of friends, length of friendship rated on a 5-point Likert scale on frequency of behaviours from 1 to 5 with 1 = 'never', 2 = 'hardly ever', 3 = 'sometimes', 4 = 'often', 5 = 'always'.

3.3 Procedure

3.3.1 Translation of the Instruments

The translation of the information sheet, consent form and socio-demographic questionnaire into Arabic was undertaken by three native speakers. The finished responses were translated back into English by a psychology graduate Syrian living in Turkey. For the remaining six forms, the Arabic versions were used, which are approved reliability and validity tests.

3.3.2 Method

Ethical approval was obtained from Ibn Haldun University Social and Humanities Scientific Research and Publication Ethics Committee in order to carry out this research. The period for the data collection was from 19 0ctober 2018 to 10 February 2019. Participants for the current study were sought via the Syrian Forum NGO. Employees from Syrian Forum contacted each family and child who met the study criteria via telephone to see if they were interested in participating in the study. They were provided a copy of the information sheet and consent form. A copy of this form can be found in Appendix 3. After the consent forms were collected from each participant, they became part of the study. The study was conducted in a quiet room that the Syrian Forum provided in its building in Istanbul. The self-reported seven questionnaires took approximately 45 minutes to complete for each participant.

3.4 Analyses

In socio-demographic variables, some suitable sub-groups were combined into a single group in order to keep the number of participants in the sub-groups close to each other.

The distribution of normality of the data was examined. It was chosen to use parametric tests in scales showing normal distribution and non-parametric tests in scales without normal distribution. In order to test socio-demographic variables, univariate methods are used which are frequency and descriptive analysis. Independent sample t-test is applied to determine difference between the research scale scores in the two-categorical variables. Variance analysis (ANOVA), were used for detecting differences between research scale scores in variables with more than two categories. Lastly, to identify the sources of differences between the groups Ordinary Least Square multiple regressions was used. Significance level was accepted as 0.05 in the statistical analysis.

In the regression analysis of the last hypothesis depression, anxiety, stress and PTSD were analysed separately because of having multi-collinearity effect with each other. Hence, while interpreting the results, it should be considered that R^2 and "Model p" values must be evaluated separately.

CHAPTER IV

RESULTS

In the coming chapter the socio-demographic characteristics of participants and the relationship between resilience and perceived social support, peer relationships, perceived social support, prosocial behaviour, conduct problems, hyperactivity, depression, anxiety, stress and PTSD will be presented.

4.1 Socio-Demographic Characteristics

Children were asked to report the stressful life events that they have experienced. The top five most experienced stressful life events were war at 67.7%, death of a loved or close one at 37.6%, peer problems at 15%, economic problems at 13.5%, followed by violation of private area is 6%. A detailed outline of the prevalence of stressful life events can be seen in Table 4.1.1.

Table 4.1.1. Prevalence of stressful life events

	n	***%***
Stressful life events		
War	90	67.7
Death of a loved or close one	50	37.6
Peer problems	20	15
Economic problems	18	13.5
Violation of private area	8	6.0
Exposure to physical violence	5	3.8
Naturel disasters	4	3.0

Table 4.1.1 Prevalence of stressful life events (continued)

	n	***%***
Serious traffic accident	4	3.0
Fire	3	2.3
Serious physical accident	2	1.5
Involuntary detained	2	1.5

n = number of participants, *%* = percentage

As shown in Table 4.1.2 there was no statistically significant differences across groups with respect to gender (t(131) = .566, *p* =.57), age (F(2, 130) = .134, *p* =.89), years living in Turkey (F(2, 130) = .644, *p* = .52), education status in Turkey (t(131) = -.955, *p* =.34), living status of parents (t(131) = .541, *p* =.58), number of siblings (F(2, 130) = .852, *p* =.42), having relatives in Turkey (t(131) = -.375, *p* =.70) and the level of resilience of children and adolescents.

Statistically significant differences were found in terms of education in Syria where children were going to school in Syria were found to be more resilient than children and adolescents who were not going to school while in Syria and the region participants living in Syria before they come to Turkey (t(131) = 2,324, *p* =.02).

Statistically significant differences were found in terms of education in Syria (t(131) = 2,324, *p* =.02), where children who went to school in Syria were found to be more resilient than children who did not going to school in Syria. Statistically significant differences were also found in terms of the region participants were living in Syria before they came to Turkey (t(131) = 2,177, *p* =.031). Children who lived in rural regions were found more resilient than children who lived in urban regions.

Table 4.1.2. Resilience scores according to socio-demographic data

	n	%	$\bar{x}$	*SS*
Gender				
Female	59	44.4	47.32	9.13
Male	74	55.6	48.25	9.86
Age				
10-13 years	25	18.8	47.00	9.67
14-15 years	65	48.9	47.93	9.77
16-18 years	43	32.3	48.18	8.97
Years living in Turkey				
0-3 years	191	33.8	47.02	10.27
4-6 years	157	63.9	48.09	9.05
7 years and above	17	2.3	53.00	7.93
Education status in Turkey				
Going to school	128	52.3	47.68	9.53
Not going to school	5	43.0	51.80	5.93
Education in Syria *				
Was going to school	115	86.5	48.58	8.95
Was not going to school	18	13.5	43.11	11.27
Region in Syria *				
Rural	7	5.3	40.28	12.25
Urban	124	93.2	48.17	9.16
Living status of parents				
At least one parent dead	10	7.5	49.40	5.81
Both parents alive	123	92.5	47.71	9.68
Number of siblings				
0 to 3 siblings	36	27.1	49.16	9.33
4 to 6 siblings	81	60.9	47.71	8.66
7 siblings and above	16	12.0	45.50	13.04

Table 4.1.2. Resilience scores according to socio-demographic data (continued)

	n	%	$\bar{x}$	*SS*
Has relatives in Turkey				
Yes	116	87.2	47.72	9.55
No	17	12.8	48.64	8.83

n = Number of participants, % = percentage, $\bar{x}$ = mean, *SS* = standard deviation

4.2 Correlations between Resilience and Perceived Social Support, Intrusion, Avoidance, Hyperarousal, Emotional Symptoms, Conduct Problems, Hyperactivity/Inattention, Peer Relationship Problems, Prosocial Behaviour and Parental Relationship

As shown in the Table 4.2.1, there was a positive correlation between resilience and Multidimensional Scale of Perceived Social Support $r = 0.413$ ($p < .01$), significant other $r = 0.311$ ($p < .01$), family $r = 0.434$ ($p < .01$) and friend $r = 0.271$ ($p < .01$) scales. The higher the level of Multidimensional Scale of Perceived Social Support total score, perceived social support from significant other, from family, and from friends, the higher the level of the resilience observed in children and adolescents.

Table 4.2.1. The relationship between perceived social support and resilience

Perceived social support scale and subscales		**Resilience**
Multidimensional Scale of Perceived Social	*r*	0.413
Support total score	*p*	0.000**
Significant other subscale	*r*	0.311
	p	0.000**
Family subscale	*r*	0.434
	p	0.000**
Friends subscale	*r*	0.271
	p	0.002**

**$p < .01$

As shown in Table 4.2.2, there was a negative correlation between resilience and depression r = -0.350 (p < .01), anxiety r = -0.433 (p < .01) and stress r = -0.328 (p < .01). The pattern of correlations indicated that the lower the level of depression, anxiety, stress, the higher the level of resilience in children and adolescents.

Table 4.2.2. The relationship between depression, anxiety, stress and resilience

Depression, Anxiety and Stress		**Resilience**
Depression	*r*	-0.350
	p	0.000**
Anxiety	*r*	-0.433
	p	0.000**
Stress	*r*	-0.328
	p	0.000**

**p < .01

As illustrated in Table 4.2.3, there was a significant negative correlation between resilience and Impact of Events Scale-Revised total score r = -0.310 (p < .01), intrusion r = -0.360 (p < .01), avoidance r = -0.321 (p < .01) and hyperarousal r = -0.355 (p < .01). The pattern of correlations indicated that the lower the level of total score of the Impact of Events Scale-Revised, intrusion, avoidance, and hyperarousal the higher the level of resilience was in children and adolescents.

Table 4.2.3. The relationship between intrusion, avoidance, hyperarousal, Impact of Events Scale-Revised total score and resilience

Impact of Events Scale-Revised and subscales		**Resilience**
Impact of Events Scale-Revised total score	*r*	-0.310
	p	0.000**

Table 4.2.3. The relationship between intrusion, avoidance, hyperarousal, Impact of Events Scale-Revised total score and resilience (continued)

Impact of Events Scale-Revised and subscales		Resilience
Intrusion	*r*	-0.360
	p	0.000**
Avoidance	*r*	-0.321
	p	0.000**
Hyperarousal	*r*	-0.355
	p	0.000**

**$p < .01$

As observed in Table 4.2.4., there was a significant negative correlation between resilience and emotional problems $r = -0.284$ ($p < .01$). The pattern of correlations indicated that the lower the level of emotional problems, the higher the level of resilience was in children and adolescents. There were no statistically significant relationships between resilience and conduct problems $r = -0.009$, $p = .919$, hyperactivity $r = 0.132$, $p = .131$, peer problems $r = 0.154$, $p = .078$ and prosocial behaviour $r = -0.032$, $p = .716$.

Table 4.2.4. The relationship between emotional problems, conduct problems, hyperactivity, peer problems and resilience

SDQ scale and subscales		Resilience
Emotional problems subscale	*r*	-0.284
	p	0.001**
Conduct problems subscale	*r*	-0.009
	p	0.919
Hyperactivity subscale	*r*	0.132
	p	0.131
Peer problems subscale	*r*	0.154
	p	0.078

Table 4.2.4. The relationship between emotional problems, conduct problems, hyperactivity, peer problems and resilience (continued)

SDQ scale and subscales		Resilience
Prosocial subscale	*r*	-0.032
	p	0.716

**$p < .01$

As illustrated in Table 4.2.5, there was a positive relationship between resilience and togetherness with parent $r = 0.314$ ($p < .01$), parent as a mediator $r = -.329$ ($p < .01$) and peer relations $r = 0.388$ ($p < .01$). The pattern of correlations indicated that the higher the level of togetherness with parent, parent as a mediator and peer relations, the higher the level of resilience was in children and adolescents. There was no statistically significant relationship between resilience and nurture disclosure $r = 0.155$ ($p = .095$).

Table 4.2.5. The relationship between family relation, peer relations and resilience

FPRQ scale and subscales		Resilience
Togetherness subscale	*r*	0.314
	p	0.001**
Nurture disclosure subscale	*r*	0.155
	p	0.095
Peer relations	*r*	0.388
	p	0.000**
Parent as a mediator subscale	*r*	0.329
	p	0.000**

**$p < .01$

4.3 Impact of Peer Relationships, Perceived Social Support, Prosocial Behaviour, Conduct Problems, Hyperactivity, Depression, Anxiety, Stress and the PTSD on the Resilience of Children and Adolescents

Ordinary Least Square (OLS) regression analysis was conducted to examine the impact of perceived social support from family, friend, significant other, togetherness with parent, prosocial behaviour and peer relations on the resilience scores of participants. This model was statistically significant and found to predict 45% of the cases (R^2 = 0.449, F(6, 127) = 5,38; $p < .01$).

As shown in Table 4.3.1. perceived social support from family has the strongest impact on resilience (*ß* score 0.387). As perceived social support from family increases resilience also increases. According to the model, peer relations has the second strongest impact on resilience as peer relations increase, resilience also increases (*ß* score 0.248).

Table 4.3.1. Impact of peer relationships, perceived social support and prosocial behaviour on the resilience of children and adolescents

Dependent Variable	Independent Variables	*ß*	*Std. ß*	*p*	F	Model (*p*)	R^2
Resilience	Constant	14.942	-	0.000	5.382	**0.000****	0.449
	Perceived social support from friend	-0.153	-0.026	0.780			
Resilience	**Perceived social support from family**	**2.314**	**0.387**	**0.000****			
Resilience	Perceived social support from significant other	0.230	0.044	0.665			

Table 4.3.1. Impact of peer relationships, perceived social support and prosocial behaviour on the resilience of children and adolescents (continued)

Dependent Variable	Independent Variables	*ß*	*Std. ß*	*p*	F	Model (*p*)	R^2
Resilience	Prosocial Behaviour	-0.765	-0.141	0.102			
Resilience	Togetherness	1.385	0.131	0.150			
Resilience	**Peer Relations**	**2.200**	**0.248**	**0.005****			

***p* < .01

Table 4.3.2. shows the impact of conduct problems and hyperactivity measures on participant's resilience scores. This model is statistically significant and predicts 18.5% of the cases (R^2=0.185, F(2, 131) = 3,66; *p* < .01). Hyperactivity was found to significantly impact resilience scores as hyperactivity increased, resilience scores decreased (*p* =.024 < 0.05). As hyperactivity increase, resilience decrease (*ß* = -1.057). Conduct problems were not found to significantly predict resilience scores (*p* =.205 > 0.05).

Table 4.3.2. Impact of conduct problems and hyperactivity on the resilience of children and adolescents

Dependent Variable	Independent Variables	*ß*	*Std. ß*	*p*	F	Model (*p*)	R^2
Resilience	Constant	24.705	-	0.012	3.662	**0.000****	0.185
	Conduct Problems	-0.658	-0.117	0.205			
Resilience	**Hyperactivity**	**-1.057**	**-0.223**	**0.024***			

**p* < .05 , ***p* < .01

Table 4.3.3. shows the effects of depression, anxiety, stress and PTSD scores on resilience levels of participants. The model is statistically significant and predicts 28% of the cases ($R^2 = 0.282$, $F(1, 132) = 4,67$; $p < .01$). Depression has the strongest impact on resilience ($\beta = .326$). As depression levels increase resilience decreases. The model for anxiety is statistically significant and predicts 30% of the cases ($R^2 = 0.301$, $F(1, 132) = 5,11$; $p < .01$). According to the model, anxiety has the second strongest impact on resilience as anxiety increase, resilience decreases ($\beta = .391$). The model for stress is statistically significant and predicts 27% of the cases ($R^2 = 0.279$, $F(1, 132) = 4,59$; $p < .01$). As stress increase, resilience decrease ($\beta = .332$). The model of PTSD is statistically significant and predicts %28 of the cases ($R^2 = 0.277$, $F(1, 132) = 4,55$; $p < .01$). As PTSD increase, resilience decrease ($\beta = .041$).

Table 4.3.3. Impact of depression, anxiety, stress and PTSD on the resilience of children and adolescents

Dependent Variable	Independent Variable	*ß*	*Std. ß*	*p*	Constant	F	Model (p)	R^2
Resilience	Depression	-0.325	-0.353	**0.000****	24.653	4.676	**0.000****	0.282
Resilience	Anxiety	-0.391	-0.379	**0.000****	25.685	5.113	**0.000****	0.301
Resilience	Stress	-0.332	-0.349	**0.000****	26.701	4.594	**0.000****	0.279
Resilience	PTSD	-0.164	-0.041	**0.000****	28.042	4.552	**0.000****	0.277

CHAPTER V

DISCUSSION

The study was comprised of three specific aims (i) to examine the relationship between resilience and socio-demographic characteristics, (ii) to examine the relationship between resilience and perceived social support, depression, anxiety, stress, peer relationships and parent relationship, (iii) to examine how depression, anxiety, stress, perceived social support, peer relationships and individual strength and difficulties predict resilience.

In this section, the findings will be evaluated within the framework of the relevant literature and the limitations of the research and recommendations for future studies will be presented.

5.1 The Relationship between Resilience and Socio-Demographic Characteristics

5.1.1 The Relationship between Resilience and Gender

In the current study, resilience scores did not differ with respects to gender. A study conducted with Palestinian children reported that girls are more resilient then boys (Thabet & Thabet, 2015). Another study conducted with asylum seeking adolescents reported that boys are more resilient than girls (Hodes, Jagdev, Chandra & Cunniff, 2008). Meanwhile, other studies report no significant differences in gender in both normal (Goel, Amatya, Jones & Ollendick, 2013), immigrant (Flores, Cicchetti & Rogosch, 2005; Correa-Velez, Gifford & McMichael, 2015) and Syrian refugee children (Panter-Brick, Hadfiels, Dajani, Eggerman, Ager & Ungar, 2018). Research on the role of gender on the resilience of Syrian refugee children and adolescents is limited.

5.1.2 The relationship between Resilience and Age

In the current study, resilience scores did not differ in terms of age. As far as we are aware, although studies have not examined this factor in Syrian children and adolescents before, this finding is consistent with some of the resilience studies conducted with children and adolescent populations (Murad & Abdelaziz, 2017; Ziaian, De Anstiss, Antoniou, Baghurst & Sawyer, 2012). One study conducted with 400 adolescents including 200 males and 200 females between the ages of 15-18 years did not find a difference in resilience levels in terms of adolescents age (Murad & Abdelaziz, 2017).

5.1.3 The relationship between Resilience and Years Living in Turkey

In the current study, resilience scores did not differ in terms of the number of years children and adolescents were living in Turkey. As far as we are aware, studies have not examined this factor in Syrian children and adolescents before. This finding is consistent with a few studies that examine resilience in youth (Correa-Velez, Gifford & McMichael, 2015) and adult (Arnetz, Rofa, Arnetz, Ventimiglia & Jamil, 2013) refugee populations. Arnetz and colleagues (2013) found that resilience scores did not differ in terms of the time from entry to resettlement country. In contrast, Ziaian and colleagues (2012) investigated resilience in 170 refugee adolescents aged between 13-17 years and found that adolescents living up to five years in the country of resettlement had lower resilience than adolescents living in the country of resettlement for more than five years.

5.1.4 The Relationship between Resilience and Region in Syria

In the current study, with regards to resilience levels, children and adolescents who were living in rural regions in Syria were found to be more resilient than children and adolescent who were living in urban regions. As far as we are aware, studies have not examined this factors effect on resilience of Syrian children and adolescents before. One study examined resilience in refugee adolescents from Africa, the Middle East and the Former Yugoslavia and found that region of origin does not have an impact on

resilience levels of adolescents (Ziaian, de Anstiss, Antoniou, Baghurst & Sawyer, 2012). Rural communities feel the effect of war more slowly than those living in urban regions (Ensminger, 1943). Similarly, when the Syrian Civil War first started the target was the two major cities: Damascus and Aleppo and because of this, Syrian children and adolescents coming from rural regions may have higher levels of resilience. Hegney and colleagues (2007) examined resilience in individuals living in rural regions of Australia and found that family ties, cultural characteristics, being hard-working and being tough in the face of adversity are some of the resilience promoting factors in these individuals. Similarly, family ties may be stronger in children and adolescents who were living in rural areas before migration, also their cultural values and individual characteristics such as being tough and being hard-working might encourage them to overcome difficulties.

5.1.5 The Relationship between Resilience and Education Status in Syria

In the current study, children and adolescents who went to school in Syria were more resilient than children who did not attend school in Syria. Children and adolescents who attended school in Syria have an understanding of the school system (Bettmann, Taylor, Gamarra, Wright, & Mai, 2017) and this may help them to adapt another school system easily. According to Sirin and Rogers-Sirin (2015), "children who are not formally educated are more likely to feel marginalized and hopeless." So, children who were going to school in Syria may be more hopeful and may feel less discrimination in the country of resettlement which can lead to higher resilience levels in these children than their non-educated peers before immigration. In addition, children's access to education was disrupted because of the Syrian Civil War.

According to the Syrian Centre for Policy Research 2 years after the start of the conflict, almost 51% of Syrian children's access to education disrupted and these children were unable to attend schools (Syrian Centre for Policy Research, 2015). So, duration of resettlement in Turkey can be a significant factor that affects this finding. These children and adolescents might be in the 49% which had access to the education while in Syria, or some of them might have been resettled to Turkey before education was disrupted in their territories.

5.1.6 The Relationship between Resilience and Education Status in Turkey

In the current study, with regards to resilience levels, children and adolescents who are going to school in Turkey did not differ from children who were absent from schooling in Turkey. The findings of previous studies are divisive with regards to gender differences in resilience (Abu-Amsha & Armstrong, 2018; Hadfield, Ostrowski & Ungar, 2017). Education status in the resettlement country was found to be significant in a few studies conducted with both Syrian refugee children (Hadfield, Ostrowski & Ungar, 2017) and refugee other children (Kia-Keating & Ellis, 2007) Abu-Amsha and Armstrong (2018) compared Syrian refugee children aged between 8-12 years who continued a formal education in the country of resettlement with children who did not continue formal education but were engaged in informal education. Although education is seen as a resilience promoting factor in the literature, they reported that education may not play such an important role in resilience of refugee children because of a variety of challenges such as language barriers, discrimination from peers and teachers and lack of support (Abu-Amsha & Armstrong, 2018).

5.1.7 The Relationship between Resilience and Living Status of Parents

In the current study, resilience scores did not differ in terms of whether or not a child's parents were alive. Although there are studies in the literature that indicates that death of an important person is a risk factor for mental health challenges in Syrian children and adolescents (Gormez, et. al., 2018) and refugee children and adolescents (Papageorgiou et al., 2000), as far as we are aware, studies have not examined the effect of parental death in resilience in Syrian children and adolescents. An examination of the literature pertaining to children, indicates that children who have lost one of the parents have more psychological challenges than those who have not lost their parents (Dowdney, 2000; Sandler, Reynolds, Kliewer & Ramirez, 1992). Although, parental death plays a significant role on a child's resilience level, relationship with alive parent can be a protective factor (Howell, Barrett-Becker, Burnside, Wamser-Nanney, Layne & Kaplow, 2015).

5.1.8 The Relationship between Resilience and Number of Siblings

In the current study, resilience scores did not differ in terms of the number of siblings in a child's family. As far as we are aware, studies have not examined the direct effect of this factor on resilience of Syrian children population. Şengün and Öğretir (2018) investigated 256 Syrian children and adolescents aged between 8-18 years old and found that as the number of siblings increase, the level of empathy increases. In contrast, Ghannam and Thabet (2014) examined 400 Palestinian adolescents and found that children who had more siblings had less resilience. Another study, conducted with 764 high school students, found that the number of siblings in a child's family did not impact resilience levels (Gündaş, 2013). Yöndem and Bahtiyar (2016) investigated resilience in 328 college students between 13-18 years old and reported that resilience scores did not differ in terms of the number of siblings.

5.1.9 The Relationship between Resilience and Having Relatives in Turkey

In this study, no significant differences were found in terms of having relatives in Turkey. As far as we are aware, studies have not examined this factors' direct effect on the resilience of Syrian children. It is known that individuals whose relatives are left in Syria or who lost their relatives unexpectedly, had higher levels of stress (United Nations Human Rights Council, 2013). One study that investigated psychological well-being of nursing students and found that students who are living with their relatives had lower resilience than those who are living with their birth families (Aydın, Kahraman & Hiçdurmaz, 2017). Although relationship with relatives can contribute to psychological well-being of individuals, relationship with parents and friends may buffer the absence of relatives.

5.2 Correlations between Resilience and Perceived Social Support, Intrusion, Avoidance, Hyperarousal, Emotional Symptoms, Conduct Problems, Hyperactivity/Inattention, Peer Relationship Problems, Prosocial Behaviour and Parental Relationship

5.2.1 The Relationship between Perceived Social Support and Resilience

In the current study, as predicted, it was found that there was a significant positive relationship between resilience and perceived social support from family, friends, significant others and total perceived support. As children's perceived social support from family, friends and significant others increased, resilience also increased. This finding is consistent with the literature (Oppedal, Özer & Sirin, 2018). Oppedal, Özer and Sirin (2018) investigated 258 Syrian children living in a refugee camp in Turkey and reported that higher levels of perceived social support contribute to their levels of resilience. Sierau and colleagues (2018) investigated 105 Syrian and Afghan adolescents between ages 14-19 and found that lower levels of perceived social support causes mental health challenges. In another study, Merhi and Kazarian (2012) investigated 221 Lebanese individuals aged between 21-75 years and found that perceived social support from families, friends and significant others enhances individuals psychological well-being. Similarly, another study conducted to assess perceived social support's role on resilience of 95 first year university students between ages 17-19 and reported that students who perceive higher levels of social support also had higher resilience (Dawson & Pooley, 2013). In another study 207 Israeli and Arab undergraduate students were compared and it was found that as perceived social support increased, psychological well-being of students also increases (Ben-Ari & Gil, 2004). Aydin and colleagues (2017) conducted a study to assess university students' resilience and reported that perceived social support from friends, family and significant others significantly predicted resilience.

Perceived social support in the classroom promotes school success in elementary school minority children (Elias & Haynes, 2008) Social support also indirectly enhances refugee children's coping with discrimination (Oppedal & Idsoe, 2015). Perceived social supports' role on coping skills and academic success may influence

resilience in Syrian children. Studies show that social support helps children and adolescents cope with stress and new situations (Sandler, Miller, Short & Wolchik, 1989) and reduces mental health challenges (Nho, Yoon, Seo & Cui, 2019; Reavell & Fazil, 2016), and is therefore thought to increase resilience levels.

5.2.2 The Relationship between Depression, Anxiety, Stress and Resilience

In the current study, as predicted, it was found that there was a significant negative relationship between resilience and depression, anxiety and stress. As children's level of depression, anxiety and stress increased, resilience levels decreased. This finding is consistent with the literature (Perkins et al., 2018). Perkins and colleagues (2018) examined 492 Syrian children ages between 8-15 years and found that psychological well-being is affected in children with PTSD, depression and anxiety. In a study by Nam and colleagues (2016) 304 North Korean adult refugees were examined. It was found that the probability of clinical depression decreases as resilience increases. In another study, resilience in 7639 adolescents between ages 13-18 were investigated and it was found that resilience factors protect adolescents against developing depression and anxiety symptoms (Skrove, Romundstad & Indredavik, 2012). Resilience decreases negative emotions (Samani, Jokar & Sahragard, 2007) and this can cause mental health problems to decrease. Having poor coping mechanisms can be a factor for the occurrence of mental health problems (Gloria & Steinhardt, 2014) such as depression, anxiety and stress, and this can lead to lower resilience levels. Poverty can cause mental health challenges in children (Beiser, Hou, Hyman & Tousignant, 2002), and children and adolescents who experience poverty may have higher levels of depression, anxiety, stress and resilience levels might be low.

5.2.3 The Relationship between Intrusion, Avoidance, Hyperarousal, Impact of Events Scale-Revised Total Score and Resilience

In the current study, as predicted, it was found that there was a significant negative relationship between resilience and intrusion, avoidance, hyperarousal and the Impact of Events Scale total score. As children's levels of intrusion, avoidance and hyperarousal increased, resilience levels decreased. Although, there are studies in the

literature investigating intrusion, avoidance, hyperarousal symptoms in Syrian refugee children and adolescents (Gormez, et. al., 2018; Perkins et al., 2018; Gormez, Kilic, Orengul, Demir, Mert, Makhlouta, Kinik & Semerci, 2017) as far as we are aware, there are no studies looking at the direct relationship of these symptoms with resilience in Syrian children. In one study conducted to assess post traumatic growth in 111 refugee adolescents aged between 12-17 years, no relationship was found with intrusion and post traumatic growth (Sleijpen, Haagen, Mooren & Kleber, 2017). In another study, 95 Bosnian refugee children aged between 8-13 years were examined and it was found that as the number of traumatic experiences increase, intrusion and avoidance scores also increase in these children (Papageorgiou et al., 2000). Because higher intrusion and avoidance levels can cause mental health problems, resilience levels of Syrian children may be affected by this. Intrusion causes children to remember unwanted experiences and brings up with emotions such as guilt, shame, helplessness and disgust. These emotions, occurring after intrusions, may also cause lower levels of resilience.

5.2.4 The Relationship between Emotional Problems, Conduct Problems, Hyperactivity, Peer Problems and Resilience

In this study, in contrast to our hypothesis, there were no significant relationships between resilience and conduct problems, hyperactivity, peer problems, prosocial behaviour. Family support and access to education can reduce negative effects of hyperactivity in children (Modesto-Lowe, Yelunina & Hanjan, 2011; Dvorsky & Langberg, 2016). Positive parenting can be a protective factor for conduct problems (Vanderbilt-Adriance, Shaw, Brennan, Dishion, Gardner & Wilson, 2015) and peer problems (Stadler, Feifel, Rohrmann, Vermeiren & Poustka, 2010). As predicted, a significant negative relationship was found between resilience and emotional problems, whereby as emotional problems increased, resilience levels were found to decrease. As far as we are aware, there is no studies looking at the direct relationship of these symptoms with resilience in Syrian children, but this finding is consistent with the literature on emotional problems and resilience in refugee children and adolescents (Ziaian, De Anstiss, Antoniou, Baghurst & Sawyer, 2012; Zwi, Woodland, Williams, Palasanthiran, Rungan, Jaffe & Woolfenden, 2017). Ziaian and colleagues (2012)

reported that refugee adolescents suffering from emotional problems had lower resilience than adolescents who did not suffer from emotional problems. In a recent study conducted with 51 Chinese adolescents, it is reported that as resilience increases, emotional problems decreased (Huang, Chen, Greene, Cheung & Wei, 2019). As Derluyn and colleagues (2008) indicate, the number of exposed traumatic events and current situation of living can cause emotional problems in immigrant children and adolescents. Children and adolescents who experienced more traumatic events may become less resilient because of their vulnerability to develop more emotional problems.

5.2.5 The Relationship between Parent Relation, Peer relations and Resilience

In this study, contrary to expectations, it was observed that there was no significant relationship between nurture disclosure and resilience. As predicted, a significant positive relationship was found between togetherness, peer relations, parent as a mediator and resilience. As togetherness, peer relations and parent as a mediator levels increase, resilience also increases. This finding is consistent with the literature (Fayyad, et. al., 2016).

In their study, Panterbrick and colleagues (2018) compared Syrian refugee adolescents and Jordanian non-refugee adolescents. They reported that relationship with family was an important predictor of their access to social sources. Because family relations help adolescent relationship with outside world, this may be a cause of higher resilience levels (Panter-Brick, Hadfield, Dajani, Eggerman, Ager & Ungar, 2017). In one study on resilience, 710 war exposed adolescents between grades of 7-12 were examined, and “parental support, parents spending time with adolescents and having non-iritable or not sad parents” was found as important promoting factors of resilience in adolescents (Fayyad et al., 2016).

Daud and colleagues (2018) examined Syrian children aged between 9-15 living in Turkey and illustrated the importance of strengthening children’s peer and family relationships to enhance resilience. Peer and caregiver relationships are important for immigrant children and adolescents adjustment and resilience because these

relationships serve children's self-confidence, belonging and sense of safety (Juang, Simpson, Lee, Rothman, Titzmann, Schachner, Korn, Heinemeier & Betsch, 2018). These factors may also have an effect on Syrian children's resilience. Also, children can find the support in peers and family to cope with the stress of displacement (Elbedour, Bensel & Bastiel, 1993; Betancourt & Khan, 2008).

5.3 Evaluation of Findings for Predictors of Resilience

5.3.1 Impact of Togetherness, Peer Relationships, Perceived Social Support and Prosocial Behaviour on the Resilience of Children and Adolescents

In this study, the predictive effects of togetherness, perceived social support from friend, perceived social support from significant others and prosocial behaviour in resilience was not found to be significant. The predictive effects of peer relations, perceived social support from family in resilience was found to be significant. It is observed that having peer relations and perceived social support from family increases children's resilience levels. In one study conducted to assess resilience in refugee adolescents living in Australia, it is reported that peer problems negatively affect resilience in adolescents (Ziaian, De Anstiss, Antoniou, Baghurst & Sawyer, 2012). Negative experiences with peers such as bullying and rejection have an impact on the mental health of children and adolescents (Gazelle & Druhen, 2009; Chang, Lee, Chiu, Hsi, Huang, & Pan, 2013). As Chang and colleagues (2013) reported, depression was found to be higher in bullied adolescents. So, this can be a risk factor which lowers resilience in children and adolescents. Klima and Repetti (2008) conducted a longitudinal study which assessed peer relations in children from fourth grade through sixth grade and reported that children who experience a discrimination by peers develop more externalizing and internalizing symptoms, and this may be a factor for peer relations importance in predicting resilience. Cheng and Furnham (2002) examined 90 adolescents aged between 16-18 and found that peer relations impact adolescent's happiness. Increasing happiness as a result of peer relations may help children to cope with adverse situations. Also, because self-confidence (Gorsy & Panwar, 2015) and self-esteem (Laible, Carlo & Roesch, 2004) are related with peer

relations, these factors may also have an impact on resilience of children and adolescents.

Gez (2018) examined perceived social support and resilience in 147 Syrian refugee children and reported that social support perceived from the family has an impact on children's psychological well-being. Daud and colleagues (2008) examined 80 refugee children aged between 6-17 and reported that supportive family relations predicts resilience in children and adolescents. In another study, Thabet and colleagues (2009) investigated 412 children aged between 12-16 years who live in Gaza and found that perceived parenting support is a protective factor for mental health problems in children and adolescents. Perceived social support from family predicts positive relations with others and psychological well-being in 300 nursing students in Turkey (Aydin, Kahraman & Hicdurmaz, 2017). Perceived social support from family's role on relations with others may predict resilience in youth, children and adolescents with giving them sources to cope with life challenges through their ability to establish healthier relationships with others. In children and adolescents who perceive family support, loneliness scores were lower (Zhao, Li, Fang, Zhao, Hong, Lin & Stanton, 2011). Feeling of not being lonely can help children to overcome difficulties and this factor can enhance resilience.

5.3.2 Impact of Conduct Problems and Hyperactivity on the Resilience of Children and Adolescents

In this study, the predictive effect of conduct problems on resilience was not found to be significant. Hyperactivity was found to significantly impact resilience scores. As hyperactivity increased, resilience scores decreased. This finding is consistent with the research conducted with non-Syrian immigrant children (Ziaian et al., 2012). No similar study has been conducted with a Syrian refugee population. In one study, 170 refugee adolescents aged between 13-17 years were examined and it was found that as children's levels of hyperactivity increase, resilience decreases (Ziaian et al., 2012). Another study found that hyperactivity is associated with learning difficulties in a refugee children sample (Rousseau, Drapeau & Corin, 1996). So, children who had hyperactivity may experience difficulties in learning and this challenge can cause the

decrease in their resilience levels. Cotter and colleagues (2019) compared immigrant and non-immigrant children and adolescents and reported higher hyperactivity levels in immigrant children compared to non-immigrant children. Also, add that this finding may be a reflection related to difficulties adapting to the new environment and "a need to seek acceptance and affirmation from their new peer groups" (Cotter, Healy, Ni Cathain, Williams, Clarke & Cannon, 2019). In another study conducted to assess resilience of 45 adolescents aged between 12-17, with attention deficit hyperactivity disorder it was found that attention deficit hyperactivity disorder predicted lower levels of resilience in adolescents (Regalla, Segenreich, Guilherme & Mattos, 2019). Similarly, a study compared 20 adolescents with attention deficit hyperactivity disorder with 12 normal developing adolescents and reported that adolescents in the ADHD group had lower resilience than the control group (Regalla, Guilherme, Aguilera, Serra-Pinherio & Mattos, 2015).

5.3.3 Impact of Depression, Anxiety, Stress and PTSD on the Resilience of Children and Adolescents

In this study, as expected, the predictive effects of depression, anxiety, stress and PTSD scores on resilience was found to be significant. As depression, anxiety, stress and PTSD levels increase resilience decreases. This finding is consistent with studies conducted with non-immigrant children (Hjemdal, Aune, Reinfjell, Stiles & Friborg, 2007; Hjemdal, Vogel, Solem, Hagen & Stiles, 2010). Hjemdal and colleagues (2010) examined resilience in 307 Norwegian children aged between 14-18 and found that higher resilience levels predict lower levels of depression and anxiety in children. Yayan and colleagues (2020) evaluated 1115 Syrian children aged 9-15 years and found that there is a significant relationship between depression, anxiety and stress in this population. Aitcheson and colleagues (2017) examined factors which contributed to the resilience in 335 Palestinian adolescents between 17-19 years and living in Gaza and found that resilient children almost had no depression or anxiety symptoms. Aitcheson's study also shows that factors such as optimism, coping-skills and family coherence are predictors of resilience (Aitcheson et al., 2017). Despite mental health challenges such as depression, anxiety, stress and PTSD, children and adolescents still can be resilient with the help of other factors. Nam and colleagues (2016) examined

304 adult refugees and indicate that higher levels of resilience predicted lower levels of clinical depression. In another study, 426 Congolese adult refugees were examined and resilience was found as a stronger predictor of post traumatic symptoms in refugees (Ssenyonga, Owens & Olema, 2013). If depression is not detected earlier, in adolescence it may be seen as an anger outburst. Anger outbursts may affect resilience because it may harm the relationship with family and friends. Also, depression and anxiety may cause lower life satisfaction, positive perception, sense of purpose and this can also affect resilience.

5.4 Conclusion

In conclusion, children and adolescents who were living in rural regions in Syria and who went to school in Syria were found to be more resilient than children who were living in urban regions and had not gone to school in Syria. As a result of correlation analyses, positive relationships were found between resilience and perceived social support, togetherness, peer relations and parent as a mediator. In contrast, there was a negative relationship between resilience and depression, anxiety, stress, intrusion, avoidance, hyperarousal and emotional problems. There was no significant relationship found between resilience and conduct problems, hyperactivity, peer problems, prosocial behaviour and nurture disclosure. As a result of regression analysis, it is found that peer relations, perceived social support from family, hyperactivity, depression, anxiety, stress and PTSD predicts children and adolescents resilience. The hypotheses in this study were mostly confirmed.

5.5 Limitations and Future Research

In this study, a cross-sectional analysis was conducted to examine only a single period of the lives of individuals aged 10-18 years. In future studies, resilience levels can be examined by longitudinal studies in which individuals are following from childhood into adulthood and later life. Longitudinal studies can provide the information about the resilience in adulthood and even old age. This study has no control group. Future studies can conduct a similar research with a control group. A similar study may be

conducted with different risk groups, different age groups or with adding control groups.

In future cross-sectional studies, more detailed socio-demographic information can be obtained such as the name of the cities children and adolescents were living in pre-migration and parental education status. Also, detailed information about the experiences in migration and post-migration phases can be obtain from families of children and adolescents. Also, in this study only the relationship with mothers is included. Future studies could also include the relationship with fathers to understand parental relationships impact on resilience.

The results of this research indicate that perceived social support from family predicted higher levels of resilience. Because the impact of perceived social support from family is important for resilience, training programs can be arranged for families with children. Also, if the problems and challenges of Syrian families are well followed, and if families have support resources for their problems this may reduce displacement related stress and may enhance resilience of children indirectly.

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APPENDIX

APPENDIX 1

PSYCHOMETIC PROPERTIES of ASSESMENT MEASURES

1.1 Impact of Event Scale-Revised (IES-R; Weiss, 1997)

PTSD symptoms were measured using the validated Korean version of the Impact of Event Scale-Revised (Lim et al., 2009). This measure was originally developed by Weiss (2007) to assesses the experience of posttraumatic symptoms such as intrusion, avoidance, and hyper-arousal and consists of 22 items rated on a five-point Likert scale ranging from 0 (not at all) to 4 (extremely). The scores can range from 0 to 88. High levels of internal consistency reported for intrusion, avoidance, hyperarousal with Cronbach's alpha rated between .87 - .94, .84 - .87, .79 - .91, respectively.

1.2 Depression, Anxiety and Stress Scale (DASS-42; Lovibond and Lovibond, 1995)

The DASS-42 demonstrates high internal consistency, for depression, anxiety and stress scales with Cronbach's alpha was .96, .89, .93 respectively (Brown et al., 1997). The convergent validity of DASS-42 was established by examining correlations with other scales: Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock and Erbaugh, 1961) and Beck Anxiety Inventory (BAI; Beck, Epstein, Brown and Steer, 1988). Arabic version of the DASS-42 was developed in 2001 by Moussa, Lovibond and Laube. It is established in Australia with 220 immigrant sample. Arabic version of the DASS-42 demonstrated high internal consistency for the depression, anxiety and stress scales with Cronbahc's alpha .93, .90 and .93, respectively.

1.3 Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet and Farley, 1988)

Internal consistency of MSPSS, as demonstrated by Cronbach's alpha coefficient, was 0.88 which indicates high internal reliability. For the family, friends and significant other subscales Cronbach's alpha was .87, .85, .91 respectively (Zimet et al., 1988). Also, the test-retest reliability for the family, friends and significant other subscales was .85, .75 and .72. The readapted Arabic version of the MSPSS developed in 2012 by Merhi and Kazarian. It is established with 221 Lebanese sample. Internal consistency of Arabic MSPSS as demonstrated by Cronbach's alpha coefficient, was 0.87. For the family, friends and significant other, Cronbach's alpha was .82, .86 and .85, respectively.

1.4 Child and Youth Resilience Measure (CYRM-12; Liebenberg, Ungar, Leblanc, 2013)

Internal consistency of CYRM-12, as demonstrated by Cronbach's alpha coefficient, was 0.840. Arabic version of the CYRM-12 developed in 2017 by Panter-Brick, Dajani, Ager, Hadfield, Eggerman and Ungar. It is established in Jordan with 603 people consist of refugee and nonrefugee youth between the ages 11 and 18 years old. In Arabic version of the measure internal realiability was .75 for the nonrefugee sample, refugee sample and for total sample. The correlation coefficients for CYRM-12 Arabic was .93 which is indicating high inter-rater reliability. The convergent validity of CYRM-12 Arabic was established by examining correlations with other scales like Perceived Stress Scale, Human Distress Scale and Strengths and Difficulties Questionnaire.

1.5 Strengths and Difficulties Questionnaire (SDQ; Goodman, Meltzer and Bailey, 1998)

Internal consistency of the SDQ, as demonstrated by Cronbach's alpha coefficient, was 0.82. For the emotional symptoms, conduct problems, hyperactivity/inattention, peer relationships problems and prosocial behaviour, Cronbach's alpha was .75, .72, .69, .61 and .65, respectively (Goodman et al., 2013). Arabic version of the SDQ was

developed in 2006 by Alyahri and Goodman. It is established in Yemen with 187 children between ages 5-12 years old. 87 of children recruited from psychiatric clinics and 100 from the community. Internal consistency of SDQ examined with receiver operating characteristic (ROC) curves. For each subscale the area under the curve (AUC) was significantly greater than 0.5 (Alyahri et al., 2006).

1.6 Family Peer Relationship Questionnaire (FPRQ; Ellison, 1983)

Internal consistency of the FPRQ, as demonstrated by Cronbach's alpha coefficient, was ranged from .65 to .92 for family, friends and significant other scales. Arabic version of the FPRQ was developed in 2008 by Aroian, Hough, Templin and Kaskiri. It is established in Detroit with 645 Arab immigrant mother and child sample. Cronbach's alpha was higher than .80 for all three subscales of the Arabic FPRQ.

APPENDIX 2

SOCIO-DEMOGRAPHIC FORM

نموذج اجتماعي-ديموغرافي

الاسم:
التاريخ:

نرجو الإجابة على الأسئلة الموجودة في الأسفل بالشكل الذي ترونه مناسبا.

1. الجنس:

( )ذكر ( ) أنثى

2. تاريخ الميلاد (يوم/شهر/سنة)
3. هل تذهب للمدرسة؟

نعم ( )
لا ( )

4. منذ متى وانت تقيم في تركيا؟----------
5. هل ذهبتم للمدرسة قبل مجيئكم إلى هنا؟

نعم ( )
لا ( )

6. أين تعيش في سوريا؟

مدينة ( )
بلدة ( )
قرية ( )

7. هل والدك ووالدتك على قيد الحياة؟

الأم حية ( )
الأب حي ( )
الأب والأم أحياء ( )

8. كم عدد الأولاد في عائلتك ؟

1 ( )
2 ( )
3 ( )
4 ( )
5 ( )
6 ( )
7 ( )
8 ( )
9 ( )
10 ( )
+ 10 ( )

8. ما هو ترتيبك بين إخوتك؟

1 ( )
2 ( )
3 ( )
4 ( )
5 ( )
6 ( )
7 ( )
8 ( )
9 ( )
10 ( )

9. هل تعيش هنا مع عائلتك؟
نعم ( )
لا ( )
10. هل لديك أحد من أقربائكم يعيش هنا؟
نعم ( )
لا ( )
11. هل لديك أصدقاء هنا؟
نعم ( )
لا ( )
12. هل لديك أصدقاء أتراك؟

نعم ( )
لا ( )
13. هل لديك أصدقاء سوريين؟
نعم ( )
لا ( )

14. هل تتكلم اللغة التركية.؟
لا أتكلم اللغة التركية ( )
أتكلم قليلا ( )
أتكلم اللغة التركية ( )
أتكلم اللغة التركية بشكل جيد ( )
15. هل نعاني من أي أمراض حالياً؟
نعم ( )
لا ( )
16. هل عانيت من أي مرض نفسي سابقاً؟
نعم ( )
لا ( )
17. هل تعاني من أي مرض نفسي حالياً؟

نعم ( )
لا ( )
18. ما هي الظروف و الأحداث التي أثرت في حياتكم بشكل كبير او تعتبرونها قد أثرت على حياتكم بشكل سلبي نرجو اختيار حادثة أو أكثر من الأحداث المذكورة في الأسفل.
كارثة طبيعية ( )
التعرض للعنف الجسدي ( )

تدخل شخص في حياتي الخاصة من دون إذني ( )
فقد شخص محبوب و قريب ( )
مشاكل اقتصادية ( )
مشاكل الأصدقاء ( )
حادث سير كبير ( )
حادث جسدي كبير ( )
حريق ( )
حرب ( )
هل تم احتجازكم بالقوة؟ ( )

APPENDIX 3

Katılımcı Bilgilendirme ve Onam Formu

İletişim Bilgileri: sevde.kurt@ibnhaldun.edu.tr
Araştırma Başlığı: Türkiye'de Yaşayan Suriyeli Çocuk ve Ergenlerin Psikolojik Sağlamlığı

Giriş:

Bu araştırma, İbn Haldun Üniversitesi Sosyal Bilimler Enstitüsü Klinik Psikoloji Bölümü yüksek lisans tez araştırması kapsamında, Dr. Öğr. Üyesi Senem Eren danışmanlığında Psikolog Fatma Sevde Kurt tarafından yürütülmektedir. Çocuğunuzun araştırmaya katılmasını onaylamadan önce sağlıklı bir karar verebilmek adına metni okuyup araştırmanın amacı ve görüşmede izleyeceğimiz prosedür ile ilgili bilgi sahibi olmanız gerekmektedir. Eğer kabul ederseniz, çocuğunuzun araştırmamıza katılmasını onaylamış olacaksınız.

Araştırmanın Hedefi:

Araştırma kalem ve kağıt kullanılarak yapılacak olan testlerden oluşmaktadır. Amaç, çocuk ve ergenlerin değişime adapte olmalarını sağlayan faktörleri saptamak, uyum sağlamalarındaki yardımcı faktörleri belirlemektir.

İzlenilecek Yöntem:

Çocuklarınızın kalem ve kağıt kullanarak bazı testler doldurmalarını isteyeceğiz. Bu testlerde çocuklarınızın sosyal hayatı, arkadaşlık ilişkileri gibi bazı faktörlerle ilgili sorular olacaktır. Ortalama 40-45 dakika, maksimum bir saat sürecektir.

Katılımcı için olası riskler:

Araştırmada yapılması istenecek ölçeklerden herhangi birinin risk faktörü oluşturacağı düşünülmüyor. Buna rağmen çocuğunuzun araştırmadan çekilmesine karar verirseniz lütfen araştırmacıyı bilgilendiriniz. Araştırmacıya, araştırmadan çekilme sebeplerinizi söylemek zorunda değilsiniz. Kendinizi rahatsız hissettiğiniz

herhangi bir durumda lütfen Fatma Sevde Kurt ile iletişime geçiniz (e-mail: sevde.kurt@ibnhaldun.com.tr).

Araştırmanın katılımcıya faydaları:

Araştırmanın sonucunda, özellikle psikolojik dayanıklılık hakkında bilgi sağlanması ve dolaylı olarak daha geniş bir nüfusa fayda sağlanması ümit edilmektedir.

Kayıt altına alma ve gizlilik koşulları:

Araştırmayı yürüten kişilerden başka birisi bilgilere ulaşamaz. Bütün araştırma verileri gizli ve güvenli kilitli dosyalarda muhafaza edilecektir. Katılımcı isimleri tümüyle kaldırılıp kodlarla değiştirilecektir. Hukuk çerçevesinde tüm gizlilikler sağlanacaktır. Araştırmadan çıkacak akademik yayınların hiç birisinde kişisel bilgiler yer almayacaktır.

Araştırma veya katılımcı hakları hakkında daha detaylı bilgi almak için
Araştırmanın yürütücüsü Fatma Sevde Kurt ile iletişime geçebilirsiniz. (e-mail: sevde.kurt@ibnhaldun.edu.tr).

Araştırmaya katılımınız gönüllülük esasına dayanmaktadır:

Çocuğunuzun araştırmaya katılımını onaylamamanız herhangi bir yaptırım ya da hak mahrumiyetine yol açmayacaktır. Çocuğunuz araştırmadan istediğiniz zaman ayrılabilir. Ama ayrılması halinde araştırmaya katkısı yarım kalacaktır. Araştırmayı yürüten heyet araştırmayı iptal etme ve/veya erteleme hakkını saklı tutmaktadır.

Katılımcı Bilgilendirme ve Onam Formu

İletişim Bilgileri: sevde.kurt@ibnhaldun.edu.tr
Araştırma Başlığı: Türkiye'de Yaşayan Suriyeli Çocuk ve Ergenlerin Psikolojik Sağlamlığı

Bu formu imzalayarak; araştırma hakkında bilgilendirildiğinizi ve çocuğunuzun araştırmaya katılmasına rıza gösterdiğinizi onaylarsınız. Formu imzalamadan önce tüm sorularınıza cevap bulduğundan emin olunuz.

Ben (Ebeveyn ya da bakım veren kişi) ……

- Yukarıda yazılı olan notları okudum ve çalışmanın içeriğini anladım.
- Eğer ben veya çocuğum herhangi bir zaman diliminde bu araştırmaya katılmak istemediğimize karar verirsek, araştırmacıları bilgilendirebilir ve derhal geri çekebiliriz.
- Bu araştırmanın amaçları için çocuğumun kişisel bilgilerinin işlenmesine onay vermiş oluyorum.
- Çocuğumun bu çalışmaya katılmasını kabul ediyorum.

_____ _____

Çocuğun İsim ve Soyismi (düz yazı ile): Ebeveyn/Bakım Veren Kişinin İmzası

Tarih:_____

CURRICULUM VITAE

Personal Informatıon

Surname, Name: Kurt-Akkoyun, Fatma Sevde

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Educatıon

BS, Istanbul Sehir University, Psychology, 2012-2017

Internship Experience

July-October 2016, University College London, Research Assistant

July 2019-July 2020, Ibn Haldun University Psychotherapy Application and Research Center