REPUBLIC OF TURKEY
BOLU ABANT IZZET BAYSAL UNIVERSITY
INSTITUTE OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY
CLINICAL PSYCHOLOGY

POSTTRAUMATIC STRESS DISORDER AND POSTTRAUMATIC GROWTH IN REFUGEE ADOLESCENTS: RISKS AND PROTECTIVE FACTORS

MASTER THESIS

by
Hilal YEKEN

Supervisor
Assoc. Prof. Dr. Sait ULUÇ

BOLU 2019

To Institute of Social Sciences,

The study titled **"POSTTRAUMATIC STRESS DISORDER AND POSTTRAUMATIC GROWTH IN REFUGEE ADOLESCENTS: RISKS AND PROTECTIVE FACTORS"**, which belongs to **Hilal YEKEN**, was certified as fully adequate in scope and quality, and as a **thesis for the degree of Master of Science** by the examining committee members.

20.08. 2019

Examining Committee Members		**Signature**
Member (Supervisor)	: Assoc. Prof. Dr. Sait ULUÇ	.....
Member	: Assoc. Prof. Dr. Zeynep TÜZÜN	.....
Member	: Asst. Prof. Dr. Seçil KESKİN	.....

Approval of Institute of Social Sciences

Assoc. Prof. Dr. Yaşar AYYILDIZ

Director of Institute of Social Sciences

ETHICAL APPROPRIATENESS DECLERATION

I hereby declare that all information in this document titled **"Posttraumatic Stress Disorder and Posttraumatic Growth in Refugee Adolescents: Risks and Protective Factors",** 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.

Hilal YEKEN

20.08.2019

PREFACE

First and foremost, I would like to thank to all of those brave and strong youngsters who did not hesitate to help when asked and made this research possible to help us understand them, and also by giving us both a glimpse of hope and hopefully a strong slap to do what's on us.

Secondly, I would like to thank my supervisor Assoc. Prof. Sait ULUÇ for his guidance, kindness, for being extremely patient and helpful throughout this process perhaps even when I must have tested his patience. I appreciated his guidance from the beginning to the end and feel very grateful for him making this very stressful process a smooth sailing.

I would also like to thank jury members, Assoc. Prof. Zeynep TÜZÜN and Assist. Prof. Seçil KESKİN, for their constructive criticism and valuable insights.

I would like to thank to a very special someone, for his genuine love, kindness and endless support, Oktay, you clearly are the better half of this relationship.

I would like to thank to my friends, Elif and Nihan, both for their help academically and their encouragement whenever I felt like giving up. Also I thank my friend Taha, for being by my side in one of the most difficult times in my life, and for setting a good example on how to be compassionate and just.

Lastly, I would like to thank my family for being unapologetic, down to earth and a whole lot of fun. Their existence gives me strength and purpose every day. And they made me who I am, for better or for worse.

Hilal YEKEN

20.08.2019

Ananeme…

ABSTRACT

POSTTRAUMATIC STRESS DISORDER AND POSTTRAUMATIC GROWTH IN REFUGEE ADOLESCENTS: RISKS AND PROTECTIVE FACTORS

Hilal YEKEN

Master Thesis
Department of Psychology
Supervisor: Assoc. Prof. Dr.Sait ULUÇ
August 2019, 85 + xiii Pages

Present study was designed to explore the impact of social support, coping skills, resilience and postmigrational living difficulties on reugee mental health outcomes of posttraumatic growth and posttraumatic stress symptomology. 163 adolescents (aged 14-19) participated to the study. The correlations between variables and the impact of gender has been presented. The model including variables has been tested and showed good fit.

Key words: Posttraumatic Growth, Social Support, Resilience, Posttraumatic Stress, Coping Skills, Postmigrational Living Difficulties, Refugees, Adolescents

ÖZET

POSTTRAUMATIC STRESS DISORDER AND POSTTRAUMATIC GROWTH IN REFUGEE ADOLESCENTS: RISKS AND PROTECTIVE FACTORS

Hilal YEKEN

Yüksek Lisans Tezi
Psikoloji Anabilim Dalı
Danışman: Prof. Dr. Sait ULUÇ
Ağustos 2019, 82 + xiii Sayfa

Bu çalışma, sosyal destek, başetme becerileri, dayanıklılık ve göç sonrası zorlukların travma sonrası büyüme ve travma sonrası stres semptomatolojisi gibi mülteci ruh sağlığı unsurları üzerindeki etkisini incelemeyi amaçlamaktadır. Arastırmaya 163 mülteci ergen (14-19 yaşları arası) katılmıştır. Değişkenler arasındaki korelasyonlar ve cinsiyetin etkisi gösterilmiştir. Değişkenleri içeren model test edilmiş ve iyi uyum gösterdiği görülmüştür.

Anahtar kelimeler: Travma Sonrası Büyüme, Sosyal Destek, Başetme Becerileri, Dayanıklılık, Travma Sonrası Stres, Göç Sonrası Zorluklar, Mülteci, Ergen

TABLE OF CONTENTS

THESIS CONSENT ..... **ii**
ETHICAL APPROPRIATENESS DECLERATION ..... **iii**
PREFACE ..... **iv**
ABSTRACT ..... **vi**
ÖZET ..... **vii**
TABLE OF CONTENTS ..... **viii**
LIST OF TABLES ..... **xi**
LIST OF FIGURES ..... **xii**
ABBREVIATION LIST ..... **xiii**

CHAPTER I **1**
1. LITERATURE REVIEW **1**
1.1. Definitions and Legal Framework for Refugees 1
1.2. Refugees Around The World 2
1.3. Refugee Mental Health 3
1.3.1. Mental Health of Refugee Adolescent 4
1.3.2. Mental Health of Syrian Refugees in Turkey 6
1.4. War Trauma Outcomes and Associated Factors 8
1.4.1. Posttraumatic Growth 8
1.4.2. Trauma and Posttraumatic Stress Disorder 10
1.4.3. Resilience 12
1.4.4. Social Support 13
1.4.5.Coping Skills 14
1.4.6. Postmigrational Living Difficulties 15
1.5. Aim of the Present Study 17
1.6. Hypotheses of the Present Study 18

CHAPTER II

2. METHOD 21
2.1. Population and Sample 21
2.1.1. Participants 21
2.2. Instruments 22
2.2.1. Demographical Information Form 23
2.2.2. Exposure to War Stressors Questionnaire 23
2.2.3. Children Revised Impact of Events Scale 23
2.2.4. Posttraumatic Growth Inventory 24
2.2.5. Multidimentional Scale of Perceived Social Support Scale 24
2.2.6. Coping Scale for Children and Youth 24
2.2.7. Connor-Davidson Resilience Scale 25
2.3. Procedure 25

CHAPTER III

3. RESULTS 26
3.1. Descriptive Statistics of the Variables 26
3.2. Bivariate Correlations among Variables 28
3.3. Group Differences Based on Gender 32
3.4. Testing Impact and Growth Model 33

CHAPTER IV

4. DISCUSSION 39
4.1. Levels of PTSD, PTG and Resilience 39
4.2. Results of Bivariate Correlations 40
4.3. Gender Differences 43
4.4. Limitations 45
4.5. Clinical Implications 45
4.6. Further Studies 45
4.7. Conclusion 46

REFERENCES 47

APPENDICES

Appendix A: Arabic Battery 64
Appendix B: Demographical Information Form-Original 74
Appendix C: Exposure to War Stressors-Original 77
Appendix E: Posttraumatic Growth Inventory-Original 79
Appendix F: Coping Scale for Children and Youth-Original 81
Appendix G: Connor-Davidson Resilience Scale-Original 82
Appendix G: Informed Consent Form-Arabic 83
Appendix H: Informed Consent Form-Original 84

LIST OF TABLES

Table 2.1: Education Level of Participants and Their Parents..... 22
Table 3.1: Psychometric Parameters of Variables 27
Table 3.2: Bivariate Correlations among Variables..... 29
Table 3.3: Differences across Male and Female Participants 32
Table 3.4: Saturated Model Estimates 36
Table 3.5: Improved Model Estimates..... 38
Table 3.6: Fit Indices of Models 38

.

LIST OF FIGURES

Figure 3.1: Hypothesized Model 34
Figure 3.2: Saturated Model 35
Figure 3.3: Improved Model 37

ABBREVIATION LIST

ANOVA **:** Analysis of Variance

PTGI **:** Posttraumatic Growth Inventory

PTSD **:** Posttraumatic Stress Disorder

M **:** Mean

Max **:** Maximum

Min **:** Minimum

SD **:** Standard Deviation

CHAPTER I

1. LITERATURE REVIEW

1.1. Definitions and Legal Framework for Refugees

The word refugee comes from réfugié in French, a term given to over 400.000 Protestant Huguenots for being forced to flee France with the revoke of the law of Edict of Nantes which gave them rights and liberties (https://www.merriam-webster.com/words-at-play/origin-and-meaning-of-refugee, Accessed on 15.09.2019). The legal framework for refugees was first established on 1951 Geneva Convention on the Status of Refugees and Stateless Persons after the Universal Declaration of Human Rights in 1948 recognized the right of persons to seek asylum from persecution and went into force in 1954. The convention on 1951 only gave rights to individuals from Europe and fleeing from events before January 1951. On 1967, these limitations were abolished and individuals all around the world got rights to protection. Both the convention on 1951 and the Protocol on 1967 (p:1) defines refugees as the person who is:

> "…..owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it."

The document also has contracting states give certain rights and benefits to refugees including the right to employment, freedom of movement, public education,

providing housing and perhaps most importantly non-refoulment which is defined in Article 33(p:9): “No Contracting State shall expel or return (“refouler”) a refugee in any manner whatsoever to the frontiers of territories where his life or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion.”

Turkey only recognizes refugees as persons fleeing from Europe. Within “conditional refugee” term, Turkey accepts individuals as defined in the 1951 Convention but with a few difference, first individuals being outside Europe and second, individuals staying in Turkey temporarily until resettled into a third country(Öztürk 2017). However, after the war began in Syria, there was a flow of refugees, and since Turkey does not recognize non-Europeans as refugees and only recognize non-Europeans under the condition they are resettled into a third country, a new legislation was necessary. Therefore, in 2013 Law on Foreigners and International Protection has been established (Ministery of Internal Affairs 2013:30). According to law, Article 91:

> “(1) Temporary protection may be provided for foreigners who have been forced to leave their country, cannot return to the country that they have left, and have arrived at or crossed the borders of Turkey in a mass influx situation seeking immediate and temporary protection.”

Under this law refugees in Turkey, have been given the rights to health, public education, work and non-refoulment (Ministery of Internal Affairs 2013).

1.2. Refugees around the World

According to United Nations High Commissioner for Refugees statistics (“Figures at a Glance” https://www.unhcr.org/figures-at-a-glance.html, Accessed 15.09.2019), there are currently 70.8 million people worldwide who are forcibly displaced, with 41.3 million of which internally displaced, 25.9 million of refugees, about half of whom are under 18 years old, and 3.5 million asylum seekers. There are

also 138,600 unaccompanied and separated children seeking asylum individually as of 2018. Out of all 80% of displaced people reside in neighbouring countries and 57% of refugees come from 3 countries: Sudan (2.3 million), Afghanistan (2.7 million) and Syria (6.7 million). Also there are millions of stateless persons denied of nationality and basic human rights such as health, education and work (UNHCR 2018).

Around the world, four countries that host most refugees are Pakistan and Uganda with 1.4 million and 1.2 million respectively, Sudan and Germany with 1.1. million in each country and Turkey hosts most refugees with 3.6 million, most of whom fleeing Syria. While Turkey is the country that hosts most refugees, Lebanon is the country that hosts most refugees compared to its population with one in 6 people residing are refugees. The average people forced to flee its home was 37.000 a day in 2018. As of 2018, on in 108 people are forcibly displaced from their homes (UNHCR 2018).

1.3. Refugee Mental Health

Literature on refugee mental health has primarily focused on the negative effects of traumatic events for a very long time. Indeed refugees overall have been found to have high levels of psychopathology over decades, for example a meta-analytic study combining research of refugees in Western countries that included over 6000 refugees has found that 9% of which was diagnosed with PTSD, with the number increasing to 11% for children, which meant that refugees hadthe incidence of PTSD 10 times more than Westerners (Fazel, Wheeler and Danesh 2005). While this number is already very high compared to general statistics, higher numbers have been seen up to 63% of a study conducted with refugee minors in London (Heptinstall, Sethna and Taylor 2004).

Similarly high levels of depression and anxiety disorders were found in a meta-analysis comparing refugees and migrants that included 35 studies, with a total sample of 24,051 refugees, concluded that the rates of depression was 44% in refugees and %20 in migrants, and anxiety prevalence was 40% in refugees and 21% in migrants(Lindert

et al 2009). As for the course of mental health problems of refugees, a meta-analysis comprising of 29 studies and over 16.000 refugees, state that with a median of 9 years after displacement, rates of mental health disorders were still remarkably high with the rate of 20% and above (Bogic, Njoku and Priebe 2015) which suggests that refugee mental health seems to be comprised years after traumatic events.

1.3.1. Mental Health of Refugee Adolescent

Over half of world's refugee population constitutes children and adolescents under age 18 (UNHCR 2019). Therefore it is impossible to overlook the challenges faced by refugee minors.

Adolescence is a very important stage in child development where cognitive and social abilities are developed and a sense of self and identity emerges. Inability to use sophisticated coping responses compared to primitive ones, development of negative self-identity and peer influence may be the case for refugee adolescents whose development impacted from trauma (Blaustein and Kinniburgh 2010).

Refugee adolescents face many challenges both prior and post-migration, prior challenges may include trauma experience (Müller et al) while post-migration challenges may include financial difficulties (Heptinstall, Sethna and Taylor 2004); low individual resources, loss of social support systems and language difficulties (Müller et al. 2019), and discrimination from host community (Montgomery and Foldspang 2008) experiencing these problems early on may pose a challenge to their development and be disruptive.

According to a meta-analytic study risk factors were found to be pre-migration violence, female sex, being separated from parents, discrimination, post-migration violence, changes of residence in host country, parental exposure to violence, parental mental health problems, poor finances and single parent households, while protective resources were found to be parental support and cohesion of family, social support from friends and positive schooling experiences (Fazel et al. 2012).

The consequences of adversities and protective factors have been shown to impact mental health states of refugee adolescents, when looked into the literature a review study investigating psychiatric disorders in refugees residing in Europe revealed that; in adolescent/young adult refugees, the prevalence of major depression was found to be 12% and prevalence of post-traumatic stress disorder was found to be 35% (Fazel, Wheeler and Danesh 2005). Similarly another meta-analysis of refugee/asylum seeking minors revealed that about one third of refugee/asylum-seeking adolescents either had depression or anxiety disorder or other emotional/behavioral problem. Also, in the literature up to 50% prevalence rates of PTSD were shown for refugee/asylum seeking adolescents (Kien et al. 2018). When being accompanied or unaccompanied is taken into account, for posttraumatic stress symptomology, 64.7% of unaccompanied minors scored above the cut-off compared to 36.7% of accompanied minors, for depression 42.6% of unaccompanied minors compared to 30% of accompanied minors, and for anxiety 38.2% of unaccompanied minors compared to 23.3% of accompanied minors(Müller et al. 2019). As for the course of mental health problems of refugee adolescents, it was shown that even though symptomology relatively decreased over time it was still shown after 8 or 12 years (Kinzie et al. 1988).

Refugee adolescents have another potential risk factor to their mental health, which is their parents' mental health state which in turn effects them through parenting. A cohort study of refugees in Australia including 411 adult refugees and 660 children revealed that parental PTSD was associated with harsh parenting which had negative impact of children's mental state such as conduct problems, hyperactivity, emotional symptoms, and peer problems (Bryant et al. 2018). While the loss of social support and supervision from family may be diminished due to the state parents' mental health; it is further disruptive when separated from parents (Derluyn, Educ and Broekaert 2009).

To summarize, trauma may pose a significant threat refugee adolescent mental health due to the disruption on their development of cognitive/emotional abilities and sense of identity. The high levels of prevalence of mental disorders and risk factors associated, highlights the vulnerabilities of the population.

1.3.2. Mental Health of Syrian Refugees in Turkey

Due to the civil war in Syria, since April, 2011 Turkey has seen the biggest flow of migration in the country's history. Turkey now approximately hosts 3.6 million Syrian refugees with Temporary Protection status. Almost 140.000 of those reside in 13 temporary shelters in 8 cities, the rest live settled in cities around the country. The 10 cities that host most refugees are as follows: İstanbul, Şanlıurfa, Hatay, Gaziantep, Adana, Mersin, Bursa, İzmir and Kilis; the city that hosts the least refugees is Bayburt with 25 refugees. The cities that have least refugees proportionally are Erzincan and Giresun with 0.04% of their population, and the city that hosts most refugees proportionally is Kilis with refugees constituting of 81.65% of its population. Over 1.600.000 of Syrian refugees are children under age of 18 (https://www.goc.gov.tr/gecici-koruma5638, Accessed at 15.09.2019). Therefore, Turkey has become the country that hosts the most refugees with a rate of 4% of its population.

A few studies were conducted with Syrian refugees residing in Turkey as well, one of which was conducted (Cantekin 2014)with 111 adult asylum seekers residing in camps in Turkey with using both qualitative and quantitative methods. According to study, the most commonly experienced traumatic events were experiencing combat situations (97%), forced evacuation (97%), separation from family members (93%), being forced to hide(%91), destruction of property (75%), lack of food/water (70%), lack of shelter (61%), serious injury of family/friend (59%), family/friend's murder or death because of violence (52%). The overall exposure to trauma was very high. 33.3% of sample met criteria for PTSD and 37.8% met criteria for major depressive disorder, also 48.6% had scored above for emotional distress. The study also investigated post-migrational living difficulties and the most experienced among them were worries about the family at home (9%5), separation from family (88%), uncertainty of when to return home (87%), being away from home (87%), uncertainty about future (86%), unable to return home in case of emergency (79%). The results suggest that being young, female and single makes individuals more susceptible to mental health problems. For PTSD and depression, forced separation and loss of loved ones was found to be predictors. And loss of culture and support after migration was found to impact symptoms. Results

of the qualitative interviews show that individuals' report certain resources that help them cope including social support, religious faith, and being committed to a political cause of war.

A study conducted with 792 Syrian refugees in Turkey, assessed centrality of trauma, self-efficacy, posttraumatic stress and co-morbidity of psychiatric disorders and examined whether gender was a moderator. About half of the refugees resided in a refugee camp while the other half resided around town. The average age was 28 and majority of them (74%) completed secondary education. The mean time spent after fleeing Syria was close to 2 years, and the mean time spent in Turkey 18 months and % 59 has fled with their family members. Over half of participants met the cutoff point for PTSD. The participants meeting criteria for PTSD were more likely to witness civilians being executed or murdered and disappearance or kidnapping of family and friends. Also they were more likely to experience higher levels of trauma centrality, co-morbidity of psychiatric illnesses and feeling danger and anger. They also reported lower levels of self-efficacy. A couple of differences was observed between refugees residing in camp and residing in town was that the former reported higher level of trauma centrality, and refugees residing in the community setting reported higher levels of co-morbidity of psychiatric illnesses and losses with fleeing Syria. Age and feelings of one's life being in danger correlated with both distress outcomes, therefore they were controlled in analysis. Results revealed that centrality of trauma exhibited a positive and indirect effect on PTSD severity via self-efficacy which was not expected and the contrary (a negative relationship where higher centrality would predict lower self-efficacy) was hypothesized (Chung, AlQarni, Al Muhairi and Mitchel 2017).

Another study conducted with Syrian children residing in a refugee camp, included 311 refugee children between ages 12-18, collected data on traumatic events, social support, post-traumatic stress symptoms, depression and somatization. And children were asked to draw a person and pictures of war and peace. The trauma experiences were as follows, experiencing war (79%), someone close dying (74%), someone being in great danger (61%), one's own life being in danger (58%), seeing someone getting physically hurt (60%), drastic family changes in the past year (52%),

experiencing a disaster (38%), separation from family members (30%), getting physically hurt (30%). Results suggest that most of children reported supportive relationships, 45% score above cut off for PTSD, 54% of girls and 26% of boys reported depression in clinical level and psychosomatic problems were also common (65%). The data on human and war-peace drawings suggest 22% of children experience aggression (Özer, Şirin and Oppedal 2013).

1.4. War Trauma Outcomes and Associated Factors

While PTSD and the prevalence of traumatic experiences of traumatized people including refugees are widely studied, recently a more positive perspective to the effects of traumatic experiences has emerged(Tedeschi & Calhoun, 1995). It has been shown that not every individual that experienced traumatic events has to experience PTSD, depression, anxiety disorders and overall life dissatisfaction, but on the contrary some individuals get transformed with this experience and experience something called Posttraumatic Growth. Now, which factors affect how an individual will react to traumatic events and which individuals experience more adverse effects and perhaps clinical illnesses and which individuals will grow with the event and experience relatively positive outcomes is not exactly clear. However some links are found through recent research on the issue, that factors such as coping skills, social support, copingstrategies, resiliency and post-migrational living difficulties has some effect in determining what the outcome will be for the traumatized individual. These potential relationships will be tried to uncover here, and will provide a basis for the current study undertaken.

1.4.1. Posttraumatic Growth

Posttraumatic Growth is the relatively positive experience some individuals have after facing a traumatic event. It has been shown that not every individual that experienced traumatic events has to experience symptomology on the contrary they can see a wider range of opportunities, experience improvement in relationships, stronger

faith, perceive themselves to be stronger, and have a more purposeful life. This overall positive outlook in life, even though shocking regarding past research, has been engrained in many cultures and spiritual belief systems that one may go through extreme hardships in life and survive and be transformed with the experience.

In the academic field this concept has emerged at 90s although named differently by researchers such as thriving(Saakvitne, Tennen and Affleck 1998), stress-related growth(Park, Cohen and Murch 1996), benefit finding (Affleck and Tennen 1996)and posttraumatic growth (Tedeschi and Calhoun 1996). To this date posttraumatic growth has been studied with individuals going through a wide range of traumatizing events including having a diagnosis of pediatric leukemia (Best et al. 2001), having their partners' cancer diagnosis (Weiss 2004), having lost a child (Buchi et al. 2006) bombings (Maercker and Herrle 2003)and war (Powell et al. 2003).

As the study undertaken, many studies have investigated whether posttraumatic growth occur in war trauma survivors and if so which factors help foster it. To this date, war trauma research has explored relationships between PTG and both trauma variables such as trauma severity (Blair 2000), centrality of events (Groleau et al. 2013), and protective variables such as coping strategies (He, Xu and Wu 2013), emotional regulation strategies(Hussain and Bhushan 2011) social support (Cao et al. 2017), optimism (Sleijpen et al. 2016), resilience (Nishi, Matsuoka and Kim 2010) and also posttraumatic variables like postmigrational living difficulties (Earnest et al. 2015).

To examine the rates of PTSD and posttraumatic growth after one year since Wenchuan earthquake, and the risk factors impacting them, 2080 survivors of the earthquake from 19 countries was included in a study. Results revealed that the rate of PTSD was 40.1% and the rate of moderate posttraumatic growth was 51.1%, and coexistence rate was 19.6%. Symptom severity was positively related to posttraumatic growth, and the coexistence was more likely for individuals in the middle age group, living in temporary housing, who have lower income or less social support. It was suggested by the authors that income, better living conditions, and social support may help foster posttraumatic growth in individuals with PTSD (Wu, Xu and Sui 2016).

In a meta-analysis examining the relationship between PTSD and posttraumatic growth, and possibly the mediating role of trauma and age, 42 studies were included and analyzed. Results revealed a both linear and a stronger curvilinear relationship between the two. Also when taking age into account, it was shown that the relationship is stronger in children than adults. Also trauma type come into account effecting the relationship, where the relationship was stronger in natural disasters or civilians in combat compared to sexual assault and illnesses or secondary trauma in health professionals(Shakespeare-Finch and Lurie-Beek 2014). In a study that was conducted with 444 refugees concluded that religious commitment predicted posttraumatic growth, although when at a moderate level, whereas when religious commitment is high posttraumatic growth seemed to drop (Acquaye, Sivo and Jones 2017).

1.4.2. Trauma and Posttraumatic Stress Disorder

The term trauma comes from the word “wound” in Greek which only refered to physical wounds, however today it also includes emotional wounds (https://www.merriam-webster.com/dictionary/trauma, Accessed at 15.09.2019). Before having a final diagnosis, adverse reactions usually experienced by soldiers returning from combat were given different names such as soldier’s heart, shell shock, railway spine, Da Costa’s syndrome and traumatic neurosis(Stein, Friedman and Blanco 2011).

Even though DSM I (1952) and DSM II (1968) have very broadly include stress reactions, a first diagnosis of PTSD took place in the DSM-III. The core future of the PTSD in DSM III was the criteria of experiencing an event outside the range of usual human experience and that would significantly distress almost anyone (APA 1980). There were certain differences in DSM IV-TR in broadening of possible traumatizing events such as having a diagnosis of a life-threatening illness, child sexual abuse, hearingof unexpected death of a family member or close friend, or havingtheir child having a life-threatening illness; and classifying individuals’ reactions to said events as ‘intense fear, helplessness or horror’ (APA 2000). The categories were once again changed in the DSM V and the emotional reaction of intense fear, horror, helplessness were removed and it was stated that the individual must experience the event firsthand

either by directly experiencing or witnessing, learning about an event was valid only on the condition that learning of the death of someone who is a close friend or a relative and also the death must have been either violent or accidental (APA 2013).

Posttraumatic stress disorder is now categorized under Trauma and Stressor Related Disorders in DSM-5, categorized with symptoms under 4 factors: intrusions, avoidance, negative cognitions and moods, and arousal and reactivity (APA 2013).

For the prevalence rates, in a meta-analytic study, the estimated number of individuals who experienced wars between the years 1989-2015 was 1,471,401,246 around the world. According to this estimate, approximately %70 of people impacted were adults, while the remaining 432,146,933 were children and adolescents, the total number constituted almost 20% of whole world population, meaning nearly one in every 5 individuals were war survivors. The prevalence was found to be 23.81% for PTSD and for depression it was 23.37%, therefore there were about 242 million adults in post-war areas estimated to having PTSD and another 238 million from depression. When comorbidity is considered about 126 million individuals were thought to suffer from PTSD alone (Hoppen and Morina 2019).

PTSD has been found to impact more women than men across lifespan, and this relationship was attributed to women experiencing more traumatizing events such as sexual assault and interpersonal violence. Also several characteristics of individuals prior to trauma were found to be impactful regarding likelihood of PTSD such as younger age (for adults), low socioeconomic status, lower levels of education, prior trauma exposure, adverse childhood events, culture(being fatalistic etc.), minority racial status; and having family psychiatric history (APA 2013).

In addition to individual characteristics, characteristics of trauma exposure were also found to be impactful, for example, dose-response relationship has been established through several studies, where experiencing more traumatic events correlated with worse outcomes, one of which was conducted with 3.339 individuals living in West Nile region found a positive correlation between the number of experienced traumatic

events and symptoms of PTSD (Neuner et al. 2004). The type of events also were found to impact such as in a study conducted with Bosnian refugees, out of the 4 traumatic events clusters (human rights violations, dispossession and eviction, threat to life, traumatic loss); threat to life was found to be the stronger predictor of PTSD, its 3 symptom cluster and traumatic loss contributed to symptom severity and impairment in psychological functioning (Momartin et al. 2003). Centrality of events was also found to predict PTSD (Barton, Boals and Knowles 2013).

1.4.3. Resilience

Resiliency can be defined as a favorable outcome despite a risk to adaptation or development, according to this definition, in order to state that resiliency occurs both a serious threat must exists and also a relatively good adjustment must be present (Masten 2001). Looking in the literature, it can be seen that one of the first researchers to suggest a similar construct was Kobasa (1979) with “hardiness” as defined by him to be the resistance force for stress.

A study examining the evolution of the concept of resilience, defined resilience roughly as either a positive adaptation or maintaining the equilibrium in terms of mental health after facing a disruptive event. Across different conceptualizations, one of them was the definition of resilience as a personality trait, as first researchers focused on. Another was the impact of the systems of family, community and culture. And finally several other definitions included time and context bound nature of resilience. And the sources of resilience across different studies were found to be personal factors including; certain personality traits and demographics; systemic factors including social support from family and friends, attachment relationship, community and cultural factors; biological factors, and the interplay between each category (Herrman et al. 2011). To give an example, a review study that examined resilience studies conducted with refugee children stated that the factors that seemed to that promote resilience were stable living conditions, social support, sense of belonging, optimism, hope, attending school and achievements in school, also having continuous bonds with one’s culture and religion (Pieloch, McCullough and Marks 2016).

Later this concept has been studied by many, albeit named differently, and has been associated with many personality characteristics and other psychological constructs one of which is posttraumatic growth. The research on the relationship between PTG and resilience is complex. Through some articles it has been shown that there is a positive correlation between the two (Nishi, Matsuoka and Kim 2010; Oginska-Bulik 2015; Rzeszutek, Oniszczenko and Firlag-Burkacka 2017), while some find an inverse relationship (Levine et al. 2009; Moore, Cerel and Jobes 2015) To elaborate more on the issue, in a study that was conducted with Syrian refugees living in Turkey including 310 participants found out that 80% of the population had PTSD, and the participants that had PTSD had higher levels of growth. It was also concluded that resilience was moderately positively correlated with post-traumatic growth, and it was shown that resilience fosters growth especially in new possibilities personal strengths and appreciation of life domains (Cengiz, Ergün and Çakıcı 2018). Another study conceptualizing resilience as a personality trait, examined resilience, trauma exposure, PTSD and posttraumatic growth. And concluded with a model that trauma exposure both increased PTSD and posttraumatic growth, while resilience was only positively related to growth and negatively with PTSD (Bensimon 2012).

1.4.4. Social Support

In posttraumatic growth literature, social support is one of the most studied variables. The relationship between posttraumatic growth and social support has been shown in numerous studies, while most studies showed a positive relation between PTG and social support either directly or indirectly (Gul and Karancı 2017; Jia et al. 2015; Mo et al. 2014; Sattler, Claramita and Muskavage 2018; Yu et al. 2014). Some studies has found no relationship between the two (Schmidt et al. 2011). To further elaborate, in a study conducted after Wenchuan earthquake with 2080 adult survivors revealed correlations between social support, coping and posttraumatic growth, through further analysis it was shown that coping strategies mediated the relationship between social support and posttraumatic growth (He, Xu and Wu 2013). Another study conducted with 315 middle schoolers 6 months after the Yaan earthquake examined the effect of social support between severity of trauma and posttraumatic growth. The results

revealed that social support and PTG are positively correlated, with adolescents having higher support experienced more growth; also social support mediated the relationship between posttraumatic fear and PTG (Zhou et al. 2016).

In a national cohort study conducted with 2718 US military veterans concluded that along with gratitude, purpose in life, spirituality, having more close relationships and deeper social support predicted high and increasing PTG over time (Tsai and Pietrzak 2017). A study examining the effects of acculturation and social support in unaccompanied 895 young refugees seeking asylum in Norway who were on average 18.6 years old and have been in Norway for a mean 3.5 years, showed that the youth still experienced high levels of mental health problems, with over fifty percent experiencing intrusive symptoms related to prior traumatic events and the mean for depression was almost the same as the cut-off point. About half of participants reported having contact with their families. Having social contact with family abroad lead to increased levels of perceived social support and lower depression scores. (Oppedal and Idsoe 2015).

1.4.5. Coping Skills

The results of the studies exploring the relationship between PTG and coping are complex due to the nature of different coping mechanisms. A meta-analytic review exploring trauma coping strategies, has divided coping strategies into 4 namely: problem/behavioral approach, emotion/ cognitive approach, problem/behavioral avoidance, and emotion/cognitive avoidance (Littleton et al. 2007). In a meta-analysis, examining optimism, social support and coping has taken into account 4 coping strategies that are thought to be adaptive from a theoretical stand point: acceptance coping, reappraisal coping, religious coping and seeking social support coping and concluded that all 4 coping mechanisms are related to PTG (Prati and Pietrantoni 2009).

In a study examining coping strategies of refugees living in Jordan, out of all coping strategies, the most used was seeking social support with 88 percent of the population, 64.5% used avoidance coping and only 39.5% used problem solving. When

looked into related variables it was found that refugees who were employed used problem solving more, which can be explained with their extra financial resource that allows them to meet their basic needs, while unemployed refugees lacked those and used social support seeking. On a similar note, total income was found to impact use of problem solving, financial difficulties was found to be the most distressing event experienced and only %3.6 were satisfied with their income, therefore it can be inferred that as in the case of unemployment, loss of income can impact the usage of problem solving due to loss of resources. Gender was also found to be a predictor of coping strategies used by refugees, it was shown that males used problem solving more than females, whereas females used more social seeking then males, which was explained with traditional Syrian gender norms which expects men to take responsibility of the household financially and women to take care of the house (Alzoubi, Al-Smadi, and Gougazeh2017).

A study comparing refugees living in Turkey and Germany, found that refugees living in Turkey had worse mental health outcomes, also in the study it was found that diverse coping strategies were employed. It was revealed that refugees living in Germany employed more promotion focus along with higher levels of problem- focused coping and less maladaptive coping strategies. Problem focused coping was related to more problems for the sample living in Turkey, which was explained that in a situation where there is not much to do with the problem, where uncontrollability is high, it could be worse to focus on the problem and instead one could benefit from emotion focused coping (Woltin, Sassenberg and Albayrak 2018).

1.4.6. Postmigrational Living Difficulties

The last and the least studied is the post-trauma factors, which are the changes in individuals' lives after migration, whether remained in danger, or whether they could adapt to the new environment, whether they lost societal and financial status. Several studies has showed that refugees are subjected to a wide range of negative experiences after emigration including employment difficulties (Schweitzer et al. 2006), cultural bereavement (Eisenbruch 1991), language difficulties (Brown, Schale and Nilsson

2010), discrimination from host community (Pernice and Brook 1996) and difficulty adjusting to host culture (Schweitzer et al. 2006). Certain links were found through overall post-migratory experiences and mental health, for example, in a meta-analysis conducted by Porter and Haslam (2005) on refugee mental health published between 1959 and 2002, which overall included 59 reports and 67.294 participants, 22.221 of whom were refugees, yielded conclusions such as that settlement conditions was related with mental health, better outcomes was observed in refugees who lived individually compared to ones living institutions; the ones that had better economic opportunities (having right to work, access to employement, lack of socioeconomic status loss) compared to the ones that did not; externally displaced compared to internally displaced, whose conflict has ended compared to continuing conflicts, the ones in exile compared to those repatriated.

However few, the research has shown that post-migrational difficulties were associated with increased trauma psychopathology (Carswell, Blackburn and Barker 2011), increased risk of comorbidity and symptom severity (Teodorescu et al. 2012).

In a study conducted with Burmese refugees living in Australia, it was reported that %88 participants reported communication difficulties, 72% reported worries about family back, 16.2% reported employment difficulties, 14.7% reported difficulties with accessing health and welfare to a moderate or serious degree. The study revealed post-migration living difficulties correlated with and explaining additional variance in anxiety, depression and somatization (Schweitzer et al. 2011).

In a thesis conducted by Bertacco (2014) including 30 articles examining the effect of postmigrational stress on psychological outcomes, it was concluded that in most studies examining said effect, resettlement stress and traumatic experiences were both independent predictors of PTSD with trauma experiences having more effect. While for depression, in most studies examining said effect, resettlement stress and traumatic experiences were both independent predictors of depression with resettlement stress having more effect. When specific resettlement issues are considered, language difficulties, lack of social support, sense of belonging and acceptance were not found to

impact mental health outcomes and further research were thought to be necessary to elaborate on family issues. The factors that were found to have an impact on mental health were financial situation and unemployment where impact was negative. Also legal status was found to have a negative impact as well, temporary residence, asylum seeking rather than having a refugee status, and the lengthening of asylum seeking period were found to be a risk factor for worse mental health outcomes. Stated impact of legal status on mental health was found to be closely related to the impact of resettlement stress. The mental health problems seemed to increase over time, especially when asylum seeking status taking longer and PTSD symptoms. However, the impact of resettlement stress seemed to lessen over time while trauma experiences continue to be a strong predictor.

In a study conducted with refugees residing in Denmark, data of children at arrival and 9 years after immigration, both from their parents and later from children themselves was collected. According to results at 9 years later, %15.3 fell into clinical range for externalizing scale, and %18.3 for the internalizing scale. Through further analysis, it was revealed that witnessing attacks to others in Denmark increased externalizing while attending school or work decreased. And for internalizing behavior, experiencing more stressful or discriminating experiences in Denmark were found to increase internalizing behavior while male sex and number of Danish friends lead to a decrease. As a result, it is concluded that life in Denmark, including stressful experiences like discrimination and means of adaptation effected psychopathology after 9 years more so than traumatic experiences prior to immigration (Montgomery 2008).

1.5. Aim of the Present Study

It was aimed to examine the rates of posttraumatic stress symptomology and PTG in refugee adolescents, and explore what factors might contribute to the existence or lack thereof of PTG in refugee adolescents, including prior traumatic experiences, social support, coping skills, resilience and postmigrational living difficulties.

As shown above the variables have often been shown in relation with another, due to the complex nature of the concepts and to reveal the relationships between variables, a hypothesized model has been developed. Also, even though variables has been studied individually or a few of them together, no study to this date has included all of the study variables which is believed to be important since it has a potential to explore protective or restorative mechanisms arising after traumatic experiences spesifically about war and migration.

The present study also tries to examine possible protective and risk factors before/during or after war, which in turn might guide mental health practitioners, policy makers and stakeholders.

1.6. Hypotheses of the Present Study

The hypotheses of the research are as follows:

Hypothesis 1: There will be a significant positive relationship between trauma exposure and Posttraumatic Stress Symptomology.

Hypothesis 2: There will be a significant positive relationship between trauma exposure and Posttraumatic Growth.

Hypothesis 3: There will be a significant positive relationship between trauma exposure and Resilience.

Hypothesis 4: There will be a significant positive relationship between trauma exposure and Postmigrational Living Difficulties.

Hypothesis 5: There will be a significant positive relationship between posttraumatic stress symptomology and Postmigrational Living Difficulties.

Hypothesis 6: There will be a significant positive relationship between Posttraumatic Stress Symptomology and PTG.

Hypothesis 7: There will be a significant positive relationship between Posttraumatic stress symptomology and Behavioral Avoidance Coping.

Hypothesis 8: There will be a significant positive relationship between posttraumatic Stress Symptomology and Cognitive Avoidance Coping.

Hypothesis 9: There will be a significant positive relationship between social support and Posttraumatic Growth.

Hypothesis 10: There will be a significant positive relationship between Assistance Seeking Coping and Posttraumatic Growth.

Hypothesis 11: There will be a significant positive relationship between Problem Solving Coping and Posttraumatic Growth.

Hypothesis 12: There will be a significant positive relationship between Resilience and Posttraumatic Growth.

Hypothesis 13: There will be a significant positive relationship between Resilience and Assistance Seeking Coping.

Hypothesis 14: There will be a significant positive relationship between Resilience and Problem Solving Coping.

Hypothesis 15: There will be a significant negative relationship between Postmigration Living Difficulties and PTG.

Hypothesis 16: Male and female participants will differ in terms of Exposure to War Stressors scores.

Hypothesis 17: Male and female participants will differ in terms of posttraumatic stress symptomology scores.

Hypothesis 18: Male and female participants will differ in terms of PTGI scores.

Hypothesis 19: Male and female participants will differ in terms of Social Support scores.

Hypothesis 20: Male and female participants will differ in terms of Assistance Seeking Coping scores.

Hypothesis 21: Male and female participants will differ in terms of Problem Solving Coping scores.

Hypothesis 22: Male and female participants will differ in terms of Cognitive Avoidance Coping scores.

Hypothesis 23: Male and female participants will differ in terms of Behavioral Avoidance Coping scores.

Hypothesis 24: Male and female participants will differ in terms of Resilience scores.

Hypothesis 25: Male and female participants will differ in terms of Postmigration Living Difficulties scores.

Hypothesis 26: A model will be present revealing that Social Support, Resilience, Assistance Seeking Coping and Problem Solving Coping in a positive relationship with PTG.

Hypothesis 27: A model will be present revealing that War Stressors, Postmigrational Living Difficulties, Cognitive Avoidance Coping and Behavioral Avoidance Coping in a positive relationship with Posttraumatic Stress Symptomology.

CHAPTER II

2. METHOD

In this chapter, information on participants, measurements and data collection of the present study will be explained in detail.

2.1. Population and Sample

The target population of this study is Syrian refugee adolescents living in Turkey. According to the most up to date data of Ministery of Turkey Directorate General of Migration Management (https://www.goc.gov.tr/gecici-koruma5638, Accessed at 15.09.2019), there is currently 272.877 adolescents aged 15-18 living in Turkey. As the research includes adolescents between ages 14 and 19, the study population is expected to be above that number.

2.1.1. Participants

Participants of this study were Syrian refugee adolescents between 14 and 19 years old, residing in various cities of Turkey such as Sakarya, Mardin and Hatay. A total of 176 adolescents participated in this survey. And after both themselves and their parents/guardians signed the informed consent form, they took a battery made of self-report questionnaires. They were then thanked for their participation and given contact information in case they want to reach out about a matter relating to the procedure. Due to the reason of high levels of missing answers, 13 participants were removed from the analysis. %37 of the participants was male and %63 was female with a mean age of 16. When asked where they spent most of their life %53.9 choose Syria whereas %45.4

chose Turkey and %0.7 indicated another country.When asked their fluency level of Turkish language %5.6 stated that their level was beginner, %32.9 intermediate, %41.6 advanced, %19.9 excellent. When asked about whether they had friends from the host community, %72.9 stated they did, %27.1 stated they did not. The mean number of siblings was 5 and the mean birth order was 3. Education level of participants and their parents summarized at Table 2.1.

Table 2.1: Education Level of Participants and Their Parents

	Illiterate	Literate	Primary School Graduate	Middle School Graduate	High School Graduate	College Graduate
Participants	-	% 3.1	%6.8	%24.8	%65.2	-
Mother	%10.6	%10.6	%9.9	%26.7	%22.4	%19.9
Father	%3.8	%7	%10.2	% 19.1	%28.7	%19.9

When asked about monthly income, %55.4 stated they had below 1000 TL, %37.5 between 1000-2000 TL, %1.8 2000-3000 TL, %0.9 3000-4000 TL, %4.5 above 4000 TL. %92 stated they do not work.

2.2. Instruments

In the current study, in the Demographic Information Form that included detailed questions about participants and their parents/guardians (age, gender, education, income, number of child, and living conditions), and questions about possible obstacles experienced in Turkey after migration were asked. Moreover five statistically reliable and valid scales were used. These scales were Exposure to War Stressors Questionnaire, Posttraumatic Growth Inventory (PTGI), Cries-13, Multidimentional Scale of Perceived Social Support Scale (MSPSS), Coping Scale for Children and Youth (CSCY) and Connor-Davidson Revised Scale of Resilience (CD-RISC). Arabic battery of all questionnaires is presented in Appendix A, and the original Turkish or English forms are also presented consequently.

2.2.1. Demographical Information Form

Demographic Information Form was designed to obtain information about age, gender, education, education of parents, family income, and possible obstacles experienced in Turkey after migration. The Demographical Information Form was translated into Arabic by a Syrian translator who was also fluent in Turkish.

2.2.2. Exposure to War Stressors Questionnaire

Predecessor of this scale is Childhood War Trauma Questionnaire (CWTQ) which was developed for Lebanese youth suffering from internal conflict in Lebanon. It consists of two sections, first of which collects information on demographics, the second part collects information on whether a list of traumatic events happened and if happened what was the age of children when it happened and how many times it happened (Macksoud,1988, as cited in Macksoud 1992:2).After Bosnian war based on this scale a new instrument has been modified (UNICEF 1993, as cited in: Smith et al. 2002:149). The new version is named Exposure to War Stressors Questionnaire (EWSQ) and includes 28 yes/no questions of possible traumatic events the children may go through and total score of experienced events give an indication of trauma severity. The Arabic version of the new verson was used prior (Barron et al. 2015) and with the permission of its authors it was included in the study. In the original study had high level of internal consistency (.94). In this study the Cronbach alpha value was $\alpha = .85$.

2.2.3 Children Revised Impact of Events Scale

The Impact of Events Scale was developed by (Horowitz, Wilner& Alvarez, 1979) to test whether individuals undergo stress experience intrusion and avoidance as clinically hypothesized. Original 15 item scale included items on intrusion and avoidance plus 2 items related to emotional numbness. Even though the scale was developed for adults, it has been used with children and the researchers found out that 2 items were mostly misunderstood by children. For that reason a new 8 item version of the measure was created for children, using a cut off of 17 the scale was found to

indicate posttraumatic stress symptomalogy in children (Dyredgov and Yule 1995, as cited in: Dyregrov, Gjestad and Raundalen 2002: 60). Later, as the clinical view has shifted on the diagnosis of PTSD, additional 5 items relevant to hyperarousal was added to the scale, Cronbachs's alpha was 0.80 for the entire measure and for additional arousal items it was .60. However the arousal items did not clearly belong to an additional factor but rather loaded onto intrusion (Smith et al. 2003). This 13 item version had been used for our study. The Arabic version of the scale was developed by (Thabet et al. 2008) and included after obtaining permission from author. In our study, Cronbach's alpha value for the 13 item version was .84.

2.2.4. Posttraumatic Growth Inventory

The term posttraumatic growth was first used by Tedeschi and Calhoun (1995), later Posttraumatic Growth Inventory (PTGI) was developed and first tested on (Tedeschi and Colhoun 1996). The scale was translated into Arabic by Dr. Thabet (Thabet et al. 2015) and had high internal consistency (.86) and included after obtaining permission from author. In our study, Cronbach's alpha value for the PTGI was .90.

2.2.5. Multidimentional Scale of Perceived Social Support Scale

Multidimentional Scale of Perceived Social Support Scale (MSPSS) was developed (Zimet et al.1988) as a measure of social support comprising of 12 items and 3 factors including Family, Friend and Significant Other. The Arabic version of the scale was developed by Merhi and Kazarian (2012) and showed high internal consistency (.87), it was included after obtaining permission from authors. In our study, Cronbach's alphas for Family, Friend and Significant Other were .83 and .84, .89 respectively.

2.2.6. Coping Scale for Children and Youth

Coping Scale for Children and Youth (CSCY) was developed by Brodzinsky and colleagues (1992), at first it was tested as 44 items, later 15 item were dismissed and

remaining 29 items yielded a 4 factor structure namely Assistance Seeking, Cognitive-Behavioral Problem Solving, Cognitive Avoidance and Behavioral Avoidance. The Arabic version of this scale was tested in another study and included with the permission of its author (Aroian et al. 2009). In our study, Cronbach's alphas Assistance Seeking, Cognitive-Behavioral Problem Solving, Cognitive Avoidance and Behavioral Avoidance were .55 and .83, .83, .73 respectively.

2.2.7. Connor-Davidson Resilience Scale

Connor-Davidson Resilience Scale (CD-RISC) was developed originally on 2003 comprising of 25 items, later a shorter version was created Campbell-Sills and Stein (2007) by choosing 10 of the 25 items using factor analysis, and showed good reliability with .85. An authorized Arabic version had already existed prior to research, after communicating with authors; permission to use the scale was obtained. The scale was both previously used in adolescents and refugee population. In our study, Cronbach's alpha value for the 10 item version was .87.

2.3. Procedure

After both participants and their parents/guardians signed the informed consent form, participants took a battery made of self-report questionnaires, totaling of 129 questions including demographics. The help of a translator was only acquired for the translation of demographical form including postmigratory questions, since the questionnaires were in Arabic and self-report, and the population was highly fluent in Turkish they were approached without the assistance of a translator. The snowball sampling was exercised and the participants filled out questionnaires in settings as convenient for them such as their homes, workplaces or public places. The researcher was present in all of them and provided necessary information and obtained parent’s and participant’s permission.

CHAPTER III

3. RESULTS

After data cleaning, univariate and bivariate analysis were performed. After assumption of normality, descriptive and correlation analysis are completed. SPSS 21 was used through analysis and for Path Analysis AMOS Software was used.

3.1. Descriptive Statistics of the Variables

The psychometric parameters regarding valuables and subdimensions are presented in Table 3.1.

Table 3.1: Psychometric Parameters of Variables

Variable	Mean	Standard Dev.	Min.	Max	Range
EWSQ	9,20	5,20	0	26	26
Cries8	16,70	9,41	0	40	40
CriesIntrusion	2,02	1,40	0	5	5
CriesAvoidanc	2,32	1,44	0	5	5
CriesArousal	2,01	1,53	0	6,25	6,25
PTGI	2,17	,77	0	4	0
PTGIRelating	1,80	,94	0	4	4
PTGINewPos	2,32	,90	0	4	4
PTGIPersStr	2,27	,94	0	4	4
PTGISpi	2,84	1,06	0	4	4
PTGIAppre	2,23	,97	0	4	4
MSPSS	4,80	1,36	1	7	6
MSPSSSigOth	4,94	1,94	1	7	6
MSPSSFamily	5,38	1,46	1	7	6
MSPSSFriend	4,06	1,68	1	7	6
CSCYasse	1,44	,73	0	3	3
CSCYps	1,74	,70	0	3	3
CSCYcog	1,40	,65	0	2,91	2,91
CSCYbeh	1,40	,71	0	3	3
Resilience	23,20	9,01	0	40	40
PMLD	57,30	11,21	21	90	69

EWSQ: Exposure to War Stressors Questionnaire; **CRIES-8:** Children Revised Impact of Events Scale; **CriesIntrusion**: Children Revised Impact of Events Scale-Intrusion Subscale; **CriesAvoid**: Children Revised Impact of Events Scale-Avoidance Subscale; **CriesArousal**: Children Revised Impact of Events Scale- Avoidance Subscale; **PTGI:** Posttraumatic Growth Inventory; **PTGIRelating**: Posttraumatic Growth Inventory-Relating to Others Subscale; **PTGINewPos**:Posttraumatic Growth Inventory-New Possibilities Subscale; **PTGIPersStr**: Posttraumatic Growth Inventory-Personal Strength Subscale; **PTGISpi**: Posttraumatic Growth Inventory-Spirituality Subscale; **PTGIAppre**: Posttraumatic Growth Inventory-Appreciation of Life Subscale,MSPSS: Multidimentional Scale of Perceived Social Support; MSPSSSigOth: Multidimentional Scale of Perceived Social Support-Significant Other Subscale; MSPSSFamily: Multidimentional Scale of Perceived Social Support-Family Subscale; MSPSSFriend: Multidimentional Scale of Perceived Social Support-Friend Subsscale; **CSCY-1**: Assistance Seeking; **CSCY-2:** Cognitive-Behavioral Problem Solving; **CSCY-3**: Cognitive Avoidance; **CSCY-4**: Behavioral Avoidance; **CD-RISC:** Connor-Davidson Resilience Scale; **GSZ**: Postmigrational Living Difficulties.

The most experienced traumatizing events and their percentages are as follows: Having forced to leave town or village %73, having ones home shelled %55.8, experiencing shooting at a very close distance %57.7, experiencing shelling at a very close distance %70.6, staying in basement for a long time due to shelling %52.1, being so cold that makes one think they could die % 44.8, seeing people who were recently injured %57.1, seeing someone being killed %46, seeing a dead body %55.2, and being in a situation where one thinks they might die %60.7.The least experienced two were seeing someone being raped or sexually abused and being used as a human shield during war with %4.3.

3.2. Bivariate Correlations among Variables

Bivariate correlations were conducted in order to investigate relationships between PTG and exposure to war stressors, postmigrational difficulties, social support, posttraumatic stress symptomology, resilience and coping skills and resuts are presented in Table 3.2.

Table 3.2: Bivariate Correlations among Variables

	EWSQ	Cries8	CriesIntrusion	CriesAvoidance	CriesArousal	PTGI	PTGIRelating	PTGINewPos	PTGIPersStr	PTGISpi	PTGIAppre	MSPSS	MSPSSSigOth	MSPSSFamily	MSPSSFriend	CSCY-1	CSCY-2	CSCY-3	CSCY-4	CDRISC	GSZ
EWSQ	1	,415**	,387**	,379**	,217**	,099	,051	,126	,037	,086	,135	,005	,024	,140	-,137	,119	,108	-,147	,072	,214**	,297**
Cries8		1	,853**	,773**	,715**	,195*	,133	,093	,160*	,221**	,272**	-,068	-,143	,112	-,098	,010	,055	,110	,320**	,008	,346**
CriesIntrusion			1	,489**	,675**	,158*	,092	,080	,151	,241**	,174*	-,111	-,155*	,060	-,145	,001	,053	,072	,299**	-,081	,295**
CriesAvoidanc				1	,349**	,262**	,201**	,178*	,174*	,161*	,389**	,033	-,056	,176*	-,008	,096	,056	,111	,234**	,143	,301**
CriesArousal					1	,056	,020	-,006	,100	,130	,051	-,216**	-,258**	-,068	-,170*	-,039	,020	,147	,303**	-,121	,198*
PTGI						1	,822**	,888**	,836**	,634**	,791**	,357**	,295**	,342**	,232**	,242**	,227**	,080	,075	,342**	-,025
PTGIRelating							1	,605**	,497**	,326**	,501**	,363**	,343**	,183*	,330**	,211**	,037	,005	,016	,149	-,091
PTGINewPos								1	,728**	,545**	,685**	,263**	,200*	,305**	,143	,218**	,235**	,115	,099	,422**	,009
PTGIPersStr									1	,591**	,676**	,248**	,202**	,310**	,101	,168*	,282**	,087	,083	,284**	-,051
PTGISpi										1	,454**	,186*	,076	,404**	,013	,143	,184*	,034	,086	,209**	,064
PTGIAppre											1	,306**	,244**	,323**	,182*	,213**	,317**	,118	,054	,394**	,073
MSPSS												1	,874**	,742**	,782**	,483**	,180*	,028	-,009	,374**	-,111
MSPSSSigOth													1	,513**	,527**	,381**	,104	-,034	-,113	,263**	-,144
MSPSSFamily														1	,343**	,351**	,207**	-,042	,026	,339**	,036
MSPSSFriend															1	,432**	,139	,145	,086	,312**	-,136
CSCY-1																1	,178*	,077	,020	,283**	,052
CSCY-2																	1	,252**	,297**	,374**	-,058
CSCY-3																		1	,492**	,161*	,095
CSCY-4																			1	,110	,293**
CDRISC																				1	-,073
GSZ																					1

EWSQ: Exposure to War Stressors Questionnaire; **CRIES-8:** Children Revised Impact of Events Scale; **CriesIntrusion**: Children Revised Impact of Events Scale-Intrusion Subscale; **CriesAvoid**: Children Revised Impact of Events Scale-Avoidance Subscale; **CriesArousal**: Children Revised Impact of Events Scale- Avoidance Subscale; **PTGI:** Posttraumatic Growth Inventory; **PTGIRelating**: Posttraumatic Growth Inventory-Relating to Others Subscale;**PTGINewPos**:Posttraumatic Growth Inventory-New Possibilities Subscale; **PTGIPersStr**: Posttraumatic Growth Inventory-Personal Strength Subscale; **PTGISpi**: Posttraumatic Growth Inventory-Spirituality Subscale; **PTGIAppre**: Posttraumatic Growth Inventory-Appreciation of Life Subscale,MSPSS: Multidimentional Scale of Perceived Social Support; MSPSSSigOth: Multidimentional Scale of Perceived Social Support-Significant Other Subscale; MSPSSFamily: Multidimentional Scale of Perceived Social Support-Family Subscale; MSPSSFriend: Multidimentional Scale of Perceived Social Support-Friend Subsscale; **CSCY-1**: Assistance Seeking; **CSCY-2:** Cognitive-Behavioral Problem Solving; **CSCY-3**: Cognitive Avoidance; **CSCY-4**: Behavioral Avoidance; **CD-RISC:** Connor-Davidson Resilience Scale; **GSZ**: Postmigrational Living Difficulties. * p< 0.05 level, ** p< 0.01

Analysis results showed that Exposure to War Stressors were significantly correlated with Posttraumatic Stress Symptomology (*r* = ,*42, p*< .01.), to specify Traumatic Intrusions (*r* = ,*39, p*< .01.), Traumatic Avoidance (*r* = ,*38, p*< .01.) and Arousal (*r* = ,*22, p*< .01.), Resilience (*r* = ,*21, p*< .01.), Post Migrations Living Difficulties (*r* = ,*30, p*< .01.).

Posttraumatic Stress Symptomology were significantly correlated with PTGI (*r*=,*20, p*< .05.), to specify Personal Strength (*r* = ,*16, p*< .05.), Spirituality (*r* = ,*22, p*< .01.), Appreciation of Life (*r* = ,*27, p*< .01.), Behavioral Avoidance Coping (*r* = ,*32, p*< .01.), Post Migrations Living Difficulties (*r* = ,*35, p*< .01.).

Traumatic Intrusions were significantly correlated with PTGI (*r* = ,*16, p*< .05.),to specify Spirituality (*r* = ,*24, p*< .01.), Appreciation of Life (*r* = ,*17, p*< .01.), Significant Other Support (*r* = ,*16, p*< .05.), Behavioral Avoidance Coping (*r* = ,*30, p*< .01.), Post Migrations Living Difficulties (*r* = ,*30, p*< .01.).

Traumatic Avoidance were significantly correlated with PTGI(*r* = ,*26 p*< .01.),to specify Relating to Others(*r* = ,*20, p*< .01.), New Possibilities(*r* = ,*18, p*< .05.), Personal Strength(*r* = ,*17, p*< .05.), Spirituality(*r* = ,*16, p*< .05.), Appreciation of Life(*r* = ,*39, p*< .01.), Family Support(*r* = ,*18, p*< .05.), Behavioral Avoidance Coping(*r* = ,*23, p*< .01.), Post Migrations Living Difficulties(*r* = ,*30, p*< .01.).

Traumatic Arousal were significantly correlated with Social Support(*r* = ,*22, p*< .01.), to specify Significant Other Support(*r* = ,*26, p*< .01.), Friend Support(*r* = ,*17, p*< .05.), Behavioral Avoidance Coping(*r* = ,*30, p*< .01.), Post Migrations Living Difficulties(*r* = ,*20, p*< .05.).

Posttraumatic Growth Inventory Total Scores were significantly correlated with Social Support(*r* = ,*36, p*< .01.), to specify Significant Other Support(*r* = ,*30, p*< .01.), Family Support(*r* = ,*34, p*< .01.), and Friend Support(*r* = ,*23, p*< .01.), Assistance Seeking Coping(*r* = ,*24, p*< .01.), Problem Solving Coping(*r* = ,*23, p*< .01.), Resilience(*r* = ,*34, p*< .01).

Relating to Others were significantly correlated with Social Support(*r* = ,*36, p*< .01.), to specify Significant Other Support(*r* = ,*34, p*< .01.), Family Support(*r* = ,*18, p*< .05.), and Friend Support(*r* = ,*33, p*< .01.), Assistance Seeking Coping(*r* = ,*21, p*< .01.).

New Possibilities were significantly correlated with Social Support(*r* = ,*26, p*< .01.), to specify Significant Other Support(*r* = ,*20, p*< .05.), Family Support(*r* = ,*31, p*< .01.), and Friend Support(*r* = ,*22, p*< .01.), Assistance Seeking Coping(*r* = ,*24, p*< .01.), Problem Solving Coping(*r* = ,*24, p*< .01.), Resilience(*r* = ,*42, p*< .01.).

Personal Strength were significantly correlated with Social Support(*r* = ,*25, p*< .01.), to specify Significant Other Support(*r* = ,*20, p*< .01.), Family Support(*r* = ,*31, p*< .01.), Assistance Seeking Coping(*r* = ,*17, p*< .05.), Problem Solving Coping(*r* = ,*28, p*< .01.), Resilience(*r* = ,*29, p*< .01).

Spirituality were significantly correlated with Social Support(*r* = ,*19, p*< .05.), to specify Family Support(*r* = ,*40, p*< .01.), Problem Solving Coping(*r* = ,*18, p*< .05.), Resilience(*r* = ,*21, p*< .01.).

Appreciation of Life were significantly correlated with Social Support(*r* = ,*31, p*< .01.), to specify Significant Other Support(*r* = ,*24, p*< .01.), Family Support(*r* = ,*32, p*< .01.), and Friend Support(*r* = ,*18, p*< .05.), Assistance Seeking Coping(*r* = ,*21, p*< .01.), Problem Solving Coping(*r* = ,*32, p*< .01.), Resilience(*r* = ,*39, p*< .01).

Social Support were significantly correlated with Assistance Seeking Coping(*r* = ,*48, p*< .01.), Problem Solving Coping(*r* = ,*18, p*< .05.), Resilience(*r* = ,*37, p*< .01.).

Significant Other Support were significantly correlated with Assistance Seeking Coping(*r* = ,*38, p*< .01.), Resilience(*r* = ,*26, p*< .01.).

Family Support were significantly correlated with Assistance Seeking Coping(*r* = ,*35, p*< .01.), Problem Solving Coping(*r* = ,*21, p*< .01.), Resilience(*r* = ,*34, p*< .01.).

Friend Support were significantly correlated with Assistance Seeking Coping(*r* = ,*43, p*< .01.), Resilience(*r* = ,*31, p*< .01.).

Assistance Seeking Coping was significantly correlated with Problem Solving Coping(*r* = ,*18, p*< .05.), Resilience(*r* = ,*28, p*< .01.).

Problem Solving Coping were significantly correlated with Cognitive Avoidance Coping(*r* = ,*25, p*< .01.), Behavioral Avoidance Coping(*r* = ,*30, p*< .01.), Resilience(*r* = ,*37, p*< .01.).

Cognitive Avoidance Coping were significantly correlated with Behavioral Avoidance Coping(*r* = ,*50, p*< .01.), Resilience(*r* = ,*16, p*< .05.).

Behavioral Avoidance Coping were significantly correlated with Post Migrations Living Difficulties(*r* = ,*29, p*< .01.).

3.3. Group Differences Based on Gender

An independent-samples t-test was conducted to compare each variable in male and female conditions. Results are presented in Table 3.3.

Table 3.3: Differences across Male and Female Participants

	Male (67)		**Female (96)**		
	Mean	**SD**	**Mean**	**SD**	**P**
EWSQ	10.76	5.45	8.10	4.74	.01
CRIES-13:	17.00	9.01	16.47	9.73	NS
PTGI	2.18	0.85	2.17	0.72	NS
MSPSS	5.07	1.33	4.61	1.36	NS
CD-RISC	25.08	10.33	21.87	7.75	.05
PMLD	56.96	11.59	57.55	11.00	NS
CSCY-1	1.64	0.67	1.30	0.75	.01
CSCY-2	1.80	0.68	1.69	0.71	NS
CSCY-3	1.35	0.63	1.44	0.67	NS
CSCY-4	1.31	0.77	1.47	0.66	NS

EWSQ: Exposure to War Stressors Questionnaire; **CRIES-13:** Children Revised Impact of Events Scale; **PTGI:** Posttraumatic Growth Inventory; **CD-RISC:** Connor-Davidson Resilience Scale; **PMLD**: postmigrational living difficulties; **MSPSS:** Multidimentional Scale of Perceived Social Support Scale **CSCY-1**: Assistance Seeking; **CSCY-2:** Cognitive-Behavioral Problem Solving; **CSCY-3**: Cognitive Avoidance; **CSCY-4**: Behavioral Avoidance.

There was a significant difference in the Exposure to War Stressors Questionnaire scores for male (M=10.76, SD=5.45) and female (M=8.10 SD= 4.74) conditions; t (161)= 3.31 , p = .001. These results suggest that Gender really does have an effect on amount of exposure to travmatic events. Specifically, our results suggest that males were experience more war stress than women.

Secondly, there was a significant difference in the Assistance Seeking Coping Style scores for male (M=1,64 SD=0.67) andfemale (M=1,30 SD= 0.75) conditions; t (161)= 2.97 , p = .001.

A third difference is found in resilience values. There was a significant difference in the Resilience Scale scores for male (M=25.08 SD=10.33) and female (M=21.87 SD= 7.75) conditions; t (161)= 2.26 , p = .05.

Male and female participants did not differsignificantly on other scales scores (CRIES-13, PTGI, PMLD, MSPSS, Assistance Seeking, Cognitive-Behavioral Problem Solving, Cognitive Avoidance, and Behavioral Avoidance scores).

3.4. Testing Impact and Growth Model

Hypothesized model was tested using AMOS Software. The model where the impact of perceived social support, resilience, exposure to war stressors and postmigrational living difficulties on posttraumatic stress reactions and posttraumatic growth directly and through coping styles were examined with path analysis. The hypothesized model is shown below on Figure 1.

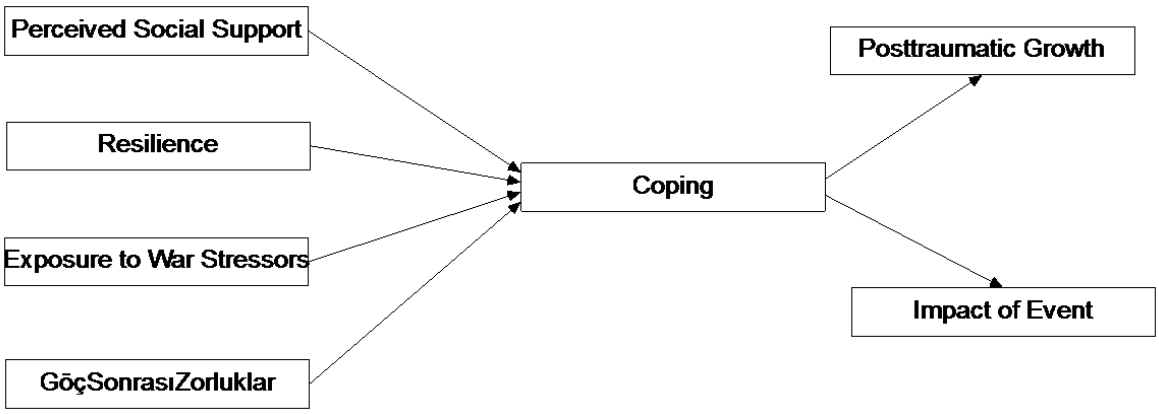

Figure 3.1: Hypothesized Model

Primary Model

In primary model, all paths that go from perceived social support, resilience, exposure to war stressors and post migrational living difficulties to coping and final outcomesa nd from coping skills to final outcomes were placed into model and the saturated model was tested in Figure 2.

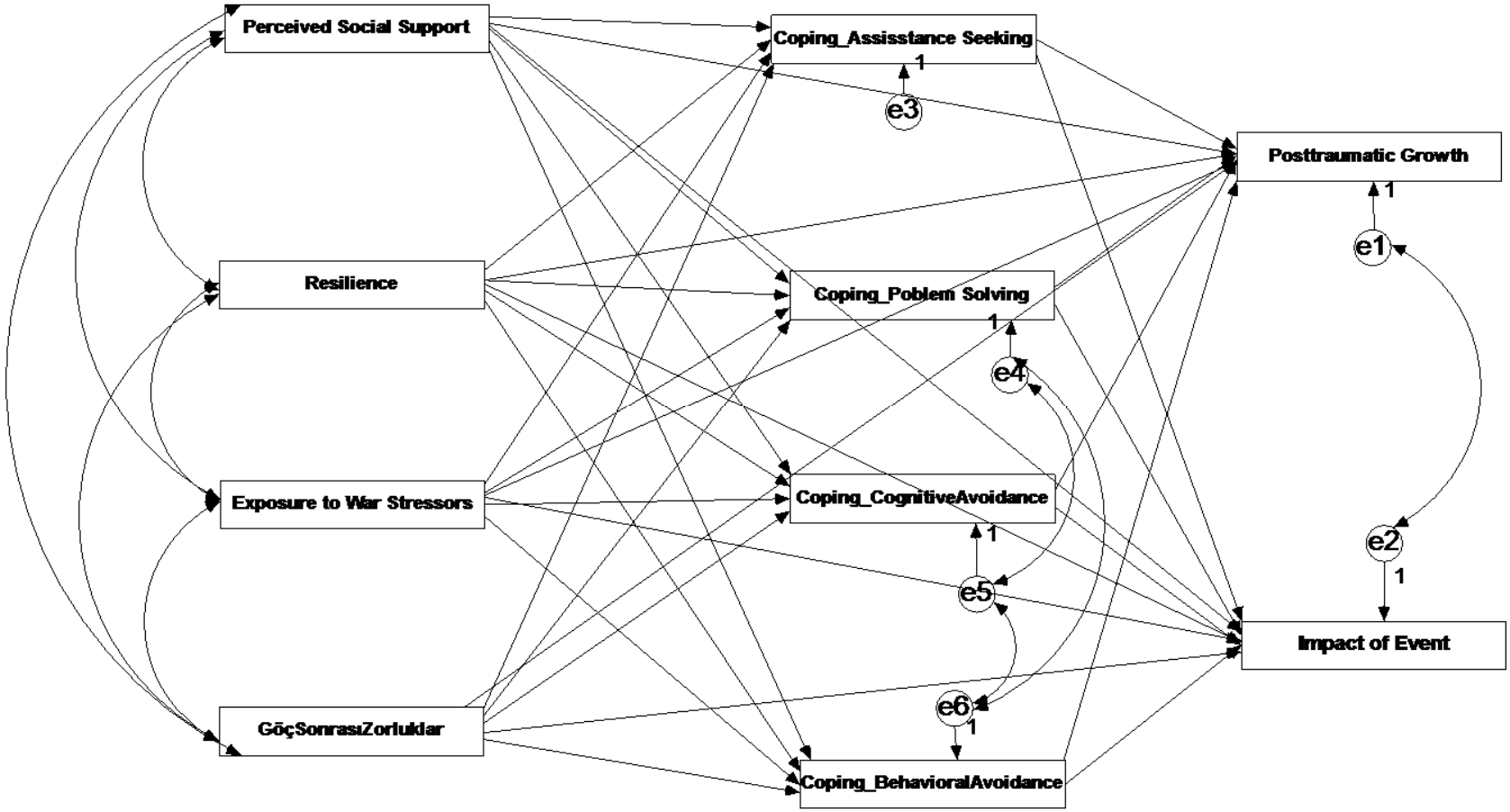

Figure 3.2: Saturated Model

Table 3.4: Saturated Model Estimates

			Estimate	S.E.	C.R.	P
Problem_Solving	**<---**	**Resilience**	**,027**	**,006**	**4,243**	***
Coping_Assisstance_Seeking	**<---**	**Social_Support**	**,244**	**,039**	**6,193**	***
Coping_CognitiveAvoidance	**<--**	**War_Stressors**	**-,032**	**,010**	**-3,135**	**,002**
Coping_BehavioralAvoidance	**<--**	**PostmigrationalDifficulties**	**,020**	**,005**	**4,026**	***
Poblem_Solving	<--	Social_Support	,024	,040	,597	,550
Coping_BehavioralAvoidance	<--	Social_Support	-,017	,042	-,399	,690
Coping_CognitiveAvoidance	<--	Social_Support	-,020	,039	-,505	,613
Coping_Assisstance_Seeking	<--	Resilience	,009	,006	1,405	,160
Coping_CognitiveAvoidance	**<--**	**Resilience**	**,018**	**,006**	**2,921**	**,003**
Coping_BehavioralAvoidance	**<--**	**Resilience**	**,012**	**,007**	**1,892**	**,058**
Coping_Assisstance_Seeking	<--	War_Stressors	,009	,010	,915	,360
Poblem_Solving	<--	War_Stressors	,006	,011	,596	,551
Coping_BehavioralAvoidance	<--	War_Stressors	-,008	,011	-,696	,487
Coping_Assisstance_Seeking	<--	PostmigrationalDifficulties	,006	,005	1,259	,208
Poblem_Solving	<--	PostmigrationalDifficulties	-,003	,005	-,540	,589
Coping_CognitiveAvoidance	**<--**	**PostmigrationalDifficulties**	**,011**	**,005**	**2,319**	**,020**
Posttraumatic_Growth	**<--**	**Resilience**	**,016**	**,007**	**2,249**	**,024**
Impact_of_Event	**<--**	**War_Stressors**	**,697**	**,135**	**5,173**	***
Impact_of_Event	**<--**	**Coping_BehavioralAvoidance**	**3,149**	**1,084**	**2,905**	**,004**
Impact_of_Event	**<--**	**PostmigrationalDifficulties**	**,125**	**,063**	**1,997**	**,046**
Impact_of_Event	<--	Social_Support	-,053	,552	-,095	,924
Impact_of_Event	<--	Resilience	-,083	,083	-1,006	,314
Posttraumatic_Growth	<--	War_Stressors	,006	,012	,542	,588
Posttraumatic_Growth	<--	Coping_Assisstance_Seeking	,049	,087	,570	,569
Impact_of_Event	<--	Coping_Assisstance_Seeking	-,268	,988	-,271	,786
Posttraumatic_Growth	<--	Poblem_Solving	,099	,089	1,114	,265
Impact_of_Event	<--	Poblem_Solving	-,376	1,017	-,370	,711
Posttraumatic_Growth	<--	Coping_CognitiveAvoidance	,015	,100	,154	,878
Impact_of_Event	<--	Coping_CognitiveAvoidance	,828	1,146	,722	,470
Posttraumatic_Growth	<--	Coping_BehavioralAvoidance	,021	,095	,217	,828
Posttraumatic_Growth	<--	PostmigrationalDifficulties	,000	,005	-,003	,998
Posttraumatic_Growth	**<--**	**Social_Support**	**,140**	**,048**	**2,896**	,004

Through analysis saturated model were determined as significant. Overall all fit indices showed that model has satistactory fit. The fit indices of the primary model were presented in Table 8. After model showed satisfactory fit, whether the predictive powers of variables were significant was analysed and presented in Table 3.5.

In the next stage, the model is improved by removing insignificant paths; the improved model is presented in Figure 3.

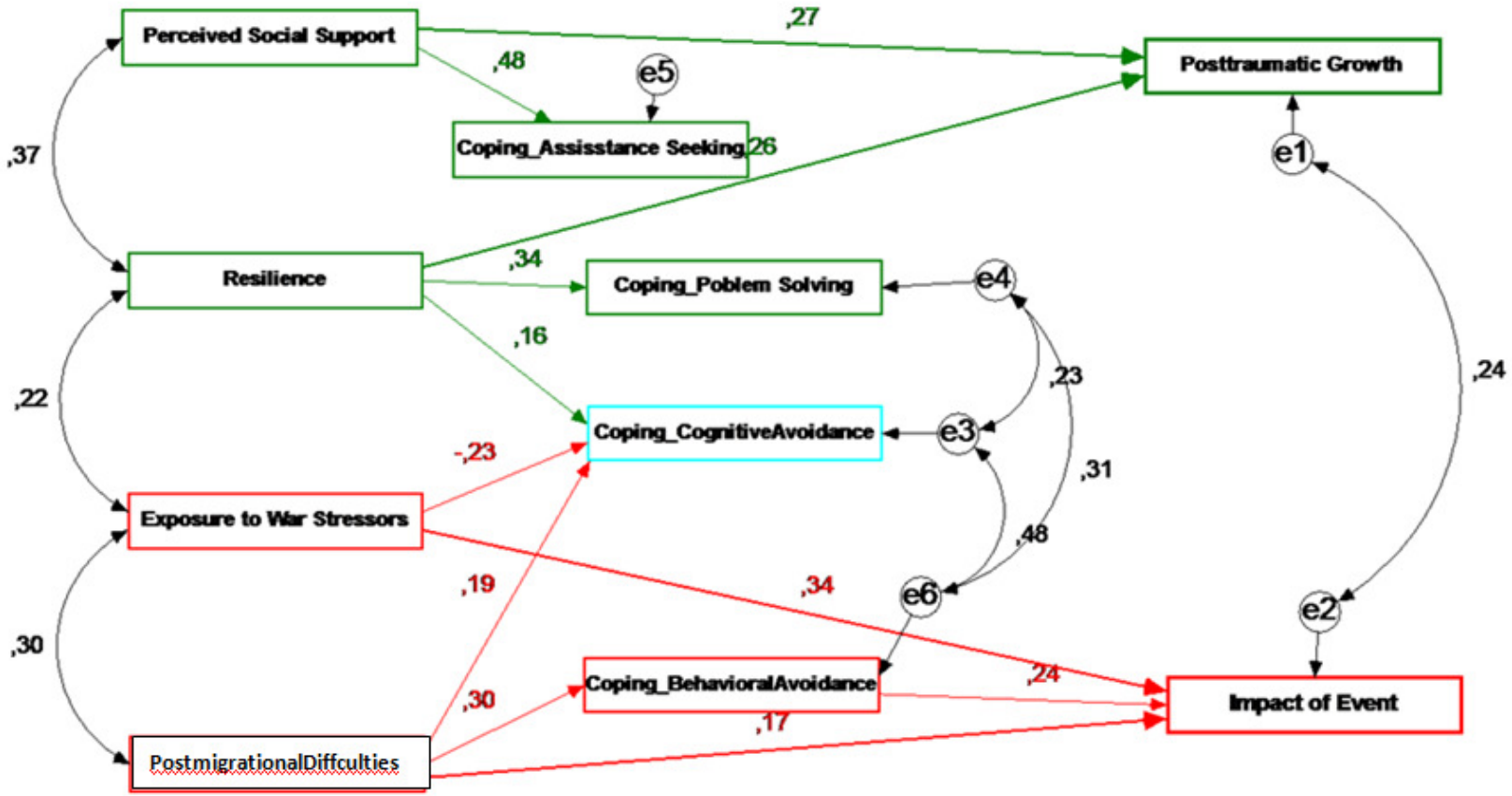

Figure 3.3: Improved Model

Table 3.5: Improved Model Estimates

			Estimate	S.E.	C.R.	P
Poblem_Solving	<---	Resilience	,026	,005	4,825	***
Coping_Assisstance_Seeking	<---	Social_Support	,260	,037	7,024	***
Coping_CognitiveAvoidance	<---	War_Stressors	-,029	,009	-3,273	,001
Coping_BehavioralAvoidance	<---	PostmigrationalDifficulties	,019	,005	4,240	***
Coping_CognitiveAvoidance	<---	Resilience	,012	,005	2,352	,019
Coping_CognitiveAvoidance	<---	PostmigrationalDifficulties	,011	,004	2,406	,016
Posttraumatic_Growth	<---	Resilience	,019	,007	2,773	,006
Impact_of_Event	<---	War_Stressors	,651	,126	5,158	***
Impact_of_Event	<---	Coping_BehavioralAvoidance	3,186	1,062	2,999	,003
Impact_of_Event	<---	PostmigrationalDifficulties	,135	,060	2,251	,024
Posttraumatic_Growth	<---	Social_Support	,138	,047	2,924	,003

The predictive powers of variables in the model are presented in Table 3.5. The fit indices of improved model are presented in Table 3.6.

Table 3.6: Fit Indices of Models

Model	Δχ2	p	sd	Δχ2/sd	RMSEA	GFI	CFI
Primary Model	1,979	,577	3	,660	,000	,998	1,000
Model with significant relationships	21,059	,784	27	,780	,000	,975	1,000

CHAPTER IV

4. DISCUSSION

Present study was designed to explore the impact of social support, coping skills, resilience and postmigrational living difficulties on reugee mental health outcomes of posttraumatic growth and posttraumatic stress symptomology. Results of bivariate correlations and group differences have been discussed in the light of the literature. Later the model including variables has been tested. Finally, limitations and implications of the study and suggestions for further research have been mentioned.

4.1. Levels of PTSD, PTG and Resilience

According to present results, %51 were considered to show posttraumatic stress symptomology, similar results were observed in the literature, for example, in a study conducted with refugee children in Turkey with the prevalence of %45(Özer, Şirin and Oppedal 2013) and another study with adults with a rate of %52(Chung et al. 2017).

For posttraumatic growth, there are no clinically determined cut-off points as present (Steffens and Andrykowski 2015) however certain researchers deem a mean of 1 to 3 as low, and 3 as a cut-off for moderate response (Jansen et al. 2011) Mean in this study is 2.17 which can be deemed as low according to that assumption, also it is slightly over the response "= I experienced this change to a small degree as a result of my crisis." in the response set, corresponding 2.

When looked into the literature it can be seen that adolescents and adults have shown various levels of resilience depending on the circumstances, for example, former

child surviors(11-17) had a mean of 22.7(sd:8.3)(Klasen et al. 2010), earthquake survivors who have PTSD(20.8, s.d:20.8) who don't have PTSD(26.8, s.d:6.3)(Wang et al. 2010), university students who have PTSD and who experience PTG (25.5, s.d:4.9)(Duan et al. 2015), school children aged 10-15 (29.3)(Skrzypiec 2018). However one inference can be made about resilience, which is that overall psychiatrically healty individuals report higher resilience then psychiatric patients and primary care patients. Also, young people and minors scoring lower and studies conducted with non-US adults expressing less resiliency might explain levels of resilience in this population(Davidson 2019). It is also theorized that culturally grounded measures including communal resilience could be helpful investigating resilience in non-Western cultures (Alemi et al. 2018). When all these factors, collectivistic nature of Syrian culture, young age of participants, high levels of posttraumatic stress symptomology helps explain not so high levels of resilience in this population.

4.2. Results of Bivariate Correlations

Bivariate correlations will be presented in the order of vulnerability factors such as trauma exposure and postmigration difficulties with protective factors of social support and resilience, and also coping mechanisms in relation with outcome variables and one another.

Exposure to war stressors has shown positive correlation with posttraumatic stress symptomology in our study, which is in line with previous findings suggesting a dose-response relationship between the number of experienced traumatic events and increased PTSD (Neuner et al. 2004). A similar relationship also exists with resilience and exposure to war stressors, which is in line with the findings of İkizer (2014)'s doctoral dissertation examining resilience after Van earthquake, where exposure severity correlated with resilience.

Exposure to war stressors has also showed correlation with postmigration living difficulties(r = ,*30,* p< .001.), which is in line with the literature, albeit few there are

studies has shown this relationship including (Dunlavy 2010) showing post-migration stress increaing with prior traumatic events, which was explained by the impact of traumatic events on mental health leading to having more problems in adapting into new environment and coping with stress.

Postmigration living difficulties has been found to be correlated with posttraumatic stress symptomology in present study(r = ,*35,* p< .001.) which is also the case with studies mentioned above (Bertacco 2014)(Carswell, Blackburn and Barker 2011) explaining post-migratory difficulties in relationship with posttraumatic stress symptomology. Even though the direction of the relationship is not addressed in present study, it can be argued that with an addition of current difficulties, the impact of traumatizing events might be highlighted or that resources of individuals' to cope with said events may have been limited.

Active coping skills are believed to be a factor that promotes resilience, which includes the likelihood to ask for help and support in hard situations which in turn possibly aid the social relationships an individual has (Iacoviello and Charney 2014). This notion is helpful in explaining study results in which the coping skills that can be regarded as active (assistance seeking and problem solving) has both been positively correlated with social support and resilience. Also in line with the literature PTG correlated with both problem solving coping (Linley and Joseph 2004) and assistance seeking coping (Baghjari, Esmaeilinasab and Shahriari-Ahmadi 2017).One seemingly unusual finding is that cognitive avoidance coping which can be classified as passive coping mechanism has also positively correlated with resilience. This is somewhat conflicting in the literature, while it has been theorized the contrary, research has found out denial has a role in protecting mental health of children (Punamaki, Muhammed and Abdulrahman 2004). This is also in line with the conceptualization of avoidance as a means of processing traumatic events. Certain studies has found links between repressive coping and resilience(Coifman et al. 2007) which is a concept quite similar to cognitive avoidance, the study has conceptualized repressive coping as an involuntary emotional regulation response rather than deliberate avoidant behavior. With this conceptualization it can be explained, why only cognitive avoidance coping is related

with resilience, an adaptive process and not with posttraumatic stress symptomology, and why behavior avoidance is correlated with posttraumatic stress symptomology and postmigrational living difficulties (r = ,*32, p*< .001.) and not with resilience. It has been shown prior that young adults use avoidance coping more compared to older adolescents and adults(Diniz and Zanini 2010; Yoon, Lee, Lee, Cho and Lee 2014) and was discussed to be due to the uncontrollability of stressors for adolescents(Yoon, Lee, Lee, Cho and Lee 2014) and it was argued prior that adolescent stressors are related to situations outside of their range of control, and that the cognitive abilities of adolescents are still in development and not in the realm of adults(Ryan-Wenger 1992). When the experiences of adolescent refugees are considered it can be hypothesized that the stressors they face are even further uncontrollable compared to general population and that their cognitive abilities may have been hindered.

For the protective resource variables, resilience has been found to be correlated with posttraumatic growth (r = ,*34, p*< .001) which is in line with previous findings(Bensimon 2012). Also, in the present study resiliency has found to be correlated with coping mechanisms, the finding that assistance seeking and problem solving correlating with resiliency is supported in the literature by İkizer's (2014) doctoral dissertation examining resilience after Van earthquake.

Another resource variable, social support has also been correlated in present study and in the literature, with posttraumatic growth (Hu, Xu and Wu 2013) (Zhou et al. 2016) and resilience (Hu et al. 2018).

For the outcome variables, even though literature shows conflicting examples on this issue, two outcome variables posttraumatic growth and posttraumatic stress symptomology has shown positive correlation in present study(r = ,*20, p*< .05.), which is supported by Snape(1997) which is explained by the author that both intrusion and avoidance symptoms of posttraumatic stress symptomology and posttraumatic growth are aiding in processing of the traumatizing event.

4.3. Gender Differences

Male participants were found to experience a higher number of traumatic events compared to female participants, which is true for other studies conducted in Gaza, which was explained by gender norms enabling boys to be more active in everyday life while girls mostly stayed at home (Thabet, Elheloub and Vostanis 2015; Thabet and Thabet 2014). The same notion is thought to apply to participants in present study with gender norms requiring boys to involve in outside activities, while girls tented to be involved more in family life.

Another difference is that male participants scored higher in Assistance Seeking, which is contradictory with literature with women using reporting higher use of coping mechanisms especially seeking support, however most of the studies reporting a gender difference also reveals that women reporting higher stressor severity (Tamres, Janicki and Helgeson 2002) which has not been the case for present study, where males reported more experienced stressors, therefore if the gender difference is rooted in stress severity driving coping (Tamres, Janicki and Helgeson 2002), it can explain how male participants have scored higher in Assistance Seeking and no difference in other coping subscales contrary to females scoring higher in use of all coping mechanisms in the literature.

Even though results are conflicting in the literature, according to results male participants reported significantly higher resilience compared to female participants, and it is believed it can also be explained with gender norms participants grew into leading them to report higher with the need to appear stronger (Campbell-Sills, Forde and Stein 2009).

4.4. Model Testing

When the model is observed, it can be seen that a relatively positive outcome and the path leading to it can be observed. First, it has been shown that positive personal

resources of refugees such as perceived social support and resilience has an impact of posttraumatic growth.

Secondly, it is observed that the adversities both experienced prior and after migration has a negative impact on refugee mental health in this case exhibiting posttraumatic stress symptomology.

When the model is perceived as risks and protective resources leading to either negative and positive impact after trauma, one element of the model that can be viewed as challenging is coping mechanisms. On one hand, cognitive avoidance is an important component of posttraumatic stress symptomology however in our study there no relationship has been found between the two variables, on the contrary it seems that being resilient has an impact on cognitive avoidance coping, although confusing, this relationship has been observed before in terms of cognitive avoidance leading to a relatively positive adaptation (Coifman et al. 2007). A greater impact of resilience has been on problem solving, which is concurrent with expectations due to the conceptualization of resilience in present instrument partly being in one's perceived ability deal with life's difficulties. One of the most significant relationships is the impact of perceived social support on assistance seeking coping, which in the instrument is presented in asking someone for help or advice when faced with a problem which is understandably connected to having individuals ready for support when a problem arises. Findings of the study is in line with the conceptualization of social support impacting coping strategies resulting with increase in use of approach coping and leading to growth(Schaefer and Moos 1998: 110).

Postmigrational living difficulties appear to be linked to both cognitive avoidance and behavioral avoidance directly, also has an indirect effect on posttraumatic stress symptomology through behavioral avoidance. One possible explanation of the effect of postmigrational living difficulties on coping mechanisms, is that postmigrational living difficulties, for example loss of social support networks, loss of income and social status, intercepts with one's ability and resources to deal with problems effectively. Problems refugees face hardly arise out of nowhere and most of

the time they are either related with or stems from said difficulties, therefore it can be expected to interfere with the ability to cope, resulting in the increased use of avoidance coping mechanisms.

4.4. Limitations

The self-report nature of questionnaires may pose a limitation to the study. Another possible limitation of the study is the geographical limitation even though the cities the data was collected are from different regions of Turkey, the sample might still not be as representative of all refugees residing in different cities of Turkey.

4.5. Clinical Implications

The exploration of variables impacting refugee mental health including social support, coping mechanisms, gender and postmigrational living difficulties can be beneficial in aiding refugee mental health practice. The present knowledge, especially the impact of and postmigrational living difficulties can guide government officials, international organizations, mental health practitioners and all stakeholders towards practice. Also, the adversities faced by refugees after migration can and should be prevented by hosting countries and other stakeholders mentioned above, considering it is the most controllable risk factor that has been showed to be detrimental to refugee mental health.

4.6. Further Studies

Even though present study reveals relationships between variables relevant to refugee mental health, the mediating and moderating roles of variables have not been explored; further research may focus on revealing said relationships.

4.7. Conclusion

Present research has examined the impact of social support, coping skills, resilience and postmigrational living difficulties on mental health outcomes such as posttraumatic growth and posttraumatic stress symptomology, the relationships between variables has been presented and discussed in the light of the literature.

The issue has been handled from a vulnerability and resource perspective, with resilience and social support being positive resources that is protective for refugee youth's mental health versus exposure to war stressors and postmigrational living difficulties being vulnerability factors that results in a worse outcome for example higher posttraumatic stress symptomology scores and coping mechanisms being influenced from those vulnerability and resource factors. The only unexpected coping influence has been the relationship of cognitive avoidance and adaptive variables such as resilience which has been supported by research albeit few as conceptualized as aiding in processing of traumatizing events. Gender has been found to be influential, by boys being more resilient, reporting higher social support and exposure to a higher number of traumatizing events. Results have been discussed in the light of the literature.

REFERENCES

Acquaye, Hannah. E., Sivo, Stephen and Jones, Dayle (2018). Religious commitment's moderating effect on refugee trauma and growth. *Counseling and Values*, *63*(1), 57- 75.

Affleck, Glenn and Tennen, Howard (1996). Construing benefits from adversity: Adaptational significance and dispositional underpinnings. 64(4), 899-922.

Alemi, Qais, Stempel, Carl, Koga, Patrick Marius, Montgomery, Susanne, Smith, Valerie, Sandhu, Gagandeep, Villegas, Bianca and Requejo, Jessica (2018). Risk and protective factors associated with the mental health of young adults in Kabul, Afghanistan. *BMC Psychiatry*, *18*(1). doi: 10.1186/s12888-018-1648-4

Alzoubi, Fatmeh Ahmad, Al-Smadi, Ahmed Mohammad and Gougazeh, Yazeed Mohammad (2017). Coping Strategies Used by Syrian Refugees in Jordan. *Clinical Nursing Research*, *28*(4), 396-421. doi: 10.1177/1054773817749724

American Psychiatric Association. (1980). *Diagnostic and Statistical Manual of Mental Disorders (2nd ed.).* American Psychiatric Press: Washington, DC.

American Psychiatric Association. (1987). *Diagnostic and Statistical Manual of Mental Disorders(3rd ed.).* American Psychiatric Press: Washington, DC.

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental* Disorders (4th ed.). American Psychiatric Press: Washington, DC.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (4th ed.).* Washington, DC.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders.* Washington, DC.

Aroian, Karen, Hough, Edythe S., Templin, Thomas N., Kulwicki, Anahid, Ramaswamy, Vidya and Katz, Anne (2009). A model of mother–child adjustment in Arab Muslim immigrants to the US. *Social Science & Medicine*, *69*(9), 1377-1386. doi: 10.1016/s9999-9994(09)20431-4

Barron, Ian, Dyregrov, Atle, Abdallah, Ghassan, and Jindal-Snape, Divya (2015). Complicated Grief in Palestinian Children and Adolescents. *Journal of Child And Adolescent Behaviour*, *03*(03). doi: 10.4172/2375-4494.1000213

Barton, Sarah, Boals, Adriel, and Knowles, Laura (2013). Thinking about Trauma: The Unique Contributions of Event Centrality and Posttraumatic Cognitions in Predicting PTSD and Posttraumatic Growth. *Journal of TraumaticStress*, *26*(6), 718-726. doi: 10.1002/jts.21863

Bensimon, Moshe (2012). Elaboration on the association between trauma, PTSD and posttraumatic growth: The role of trait resilience. *Personality and Individual Differences*, *52*(7), 782-787. doi: 10.1016/j.paid.2012.01.011

Bertacco, Marilena (2014). *Review and empirical study of mental health in forced migrants in the context of trauma and resettlement stress* (Hochschulschrift (Diplomarbeit). University of Vienna.

Best, M., Streisand, Randi, Catania, Lisa, and Kazak, Anne E. (2001). Parental distress during pediatric leukemia and posttraumatic stress symptoms (PTSS) after treatment ends. *Journal of pediatric psychology*, 26(5), 299-307.

Blair, Robert (2000). Risk factors associated with PTSD and major depression among Cambodian refugees in Utah. *Health & Social Work*, 25(1), 23-30.

Blaustein, Margaret, and Kinniburgh, Kristine (2010). Treating traumatic stress in children and adolescents: How to foster resilience through attachment, self-regulation, and competency. New York, NY, US: Guilford Press.

Bogic, Marija, Njoku, Anthony and Priebe, Stefan (2015). Long-term mental health of war-refugees: A systematic literature review. *BMC International Health and Human Rights*, 15(29), 1-41. doi:10.1186/s12914-015-0064-9

Bryant, Richard, Edwards, Ben, Creamer, Mark , O'donnell, Meaghan, Forbes, David, Felmingham, Kim, Silove, Derrick, Steel, Zachary, Nickerson, Angela, Mcfarlane, Alexander, Hooff, Miranda, Hadzi-Pavlovic, Dusan. (2018). The effect of post-traumatic stress disorder on refugees' parenting and their children's mental health: a cohort study. *The Lancet*. 3:249–58. 10.1016/S2468-2667(18)30051-3..

Brodzinsky, David, Elias, Maurice, Steiger, Cynthia, Simon, Jennifer, Gill, Maryann and Hitt, Jennifer Clarke. (1992). Coping Scale for Children and Youth: Scale Development and Validation. *Journal of Applied Developmental Psychology 13(2):195-214.*

Brown, Chris, Schale, Codi, and Nilsson, Johanna (2010). Vietnamese Immigrant and Refugee Women's Mental Health: An Examination of Age of Arrival, Length of Stay, Income, and English Language Proficiency. *Journal of Multicultural Counseling and Development*, *38*(2), 66-76. doi:10.1002/j.2161-1912.2010.tb00115.x

Buchi, Stefan, Hanspeter, Mörgeli., Schnyder, Ulrich, Jenewein, Joseph, Urs, Hepp, Jina, Eveline, Neuhaus, Rachel, Fauchere, Jean-Claude, Bucher, Hans Ulrich, Sensky, and Tom (2007). Bereavement and posttraumatic growth in parents two to six years after death of their extremely premature baby. *Journal of Psychosomatic Research*, 76, 106-114.

Campbell-Sills, Laura, and Stein, Murray (2007). Psychometric analysis and refinement of the Connor–Davidson resilience scale (CD-RISC): Validation of a 10-item measure of resilience. *Journal of Traumatic Stress*, *20*(6), 1019-1028. doi: 10.1002/jts.20271

Campbell-Sills, Laura, Forde, David and Stein, Murray (2009). Demographic and childhood environmental predictors of resilience in a community sample. Journal of Psychiatric Research, 43(12), 1007-1012. doi: 10.1016/j.jpsychires. 2009.01.013

Cantekin, Duygu (2014). Mental Health of Syrian Asylum Seekers Residing in Camps: Risk and Protective Factors with a Mixed-Method Study. Doctoral Thesis, Middle East Technical University.

Carswell, Kenneth, Blackburn, Pennie, and Barker, Chris (2011). The Relationship between Trauma, Post-Migration Problems and the Psychological Well-Being of Refugees and Asylum Seekers. *International Journal of Social Psychiatry*, *57*(2), 107-119. doi: 10.1177/0020764008105699

Cengiz, Ibrahim; Ergün, Deniz, and Çakıcı, Ebru (2018). Posttraumatic stress disorder, posttraumatic growth and psychological resilience in Syrian refugees: Hatay, Turkey. *Anatolian Journal Of Psychiatry*, (0), 1. doi: 10.5455/apd.4862

Chung, Man Cheung, AlQarni, Nowf, Al Muhairi, Shamsa, and Mitchell, Britt (2017). The relationship between trauma centrality, self-efficacy, posttraumatic stress and psychiatric co-morbidity among Syrian refugees: Is gender a moderator? *Journal of Psychiatric Research*, 94, 107-115. doi:10.1016/j.jpsychires. 2017.07.001

Coifman, Karin, Bonanno, George, Ray, Rebecca, and Gross, James (2007). Does repressive coping promote resilience? Affective-autonomic response discrepancy during bereavement. *Journal of Personality and Social Psychology*, *92*(4), 745-758. doi: 10.1037/0022-3514.92.4.745

Connor, Kathryn, and Davidson, Jonathan (2003). Development of a new resilience scale: The Connor-Davidson Resilience Scale (CD-RISC). *Depression and Anxiety*, *18*(2), 76-82. doi: 10.1002/da.10113

Davidson, Jonathan RT. Connor-Davidson Resilience Scale (CDRISC) Manual. Unpublished. 08-19-2018, accessible at www.cdrisc.com.

DINIZ, Simon Santana and ZANINI, Daniela S..(2010). Relação entre fatores de personalidade e estratégias de coping em adolescentes. *Psico-USF (Impr.),15*, (1)pp.71-80.ISSN1413-8271.

Duan, Wenjie, Guo, Pengfei, and Pei, Gan (2015). Relationships among trait resilience, virtues, posttraumatic stress disorder, and post-traumatic growth. *PLoS ONE* 2015; DOI:10.1371/journal.pone.0125707.

Dunlavy, A. (2010). *The Impact of Acculturation, Trauma, and Post-Migration Stressors on the Mental Health of African Immigrants and Refugees in Sweden* (Master of Public Health). University of Pittsburgh.

Dyregrov, Atle, and Yule, William (1995). Screening measures-the development of the UNICEF screening battery. Paper presented at the Fourth European Conference on Traumatic Stress. Paris

Dyregrov, Atle, Gjestad, Rolf, and Raundalen, Mansi (2002). Children exposed to warfare: A longitudinal study. *Journal of Traumatic Stress*, *15*(1), 59-68. doi:10.1023/a:1014335312219

Earnest, Jaya, Mansi, Ruth, Bayati, Sara, Earnest, Joel Anthony, and Thompson, Sandra C. (2015). Resettlement experiences and resilience in refugee youth in Perth, Western Australia. *BMC research notes*, *8*(1), 236.

Eisenbruch, Maurice (1991). From post-traumatic stress disorder to cultural bereavement: Diagnosis of Southeast Asian refugees. *Social Science&Medicine*, *33*(6), 673-680. doi: 10.1016/0277-9536(91)90021-4

Fazel, Mina, Wheeler, Jeremy, and Danesh, John (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review. *The Lancet*, 365(9467), 1309-1314. doi:10.1016/s0140-6736(05)61027-6

Fazel, Mina, Reed, Ruth, Panter-Brick, Catherine and Stein, Alan (2011). Mental health of displaced and refugee children resettled in high income countries: Risk and protective factors. *The Lancet 379*, 266-82. 10.1016/S0140-6736(11)60051-2.

Groleau, Jessica M., Calhoun, Lawrence G., Cann, Arnie, & Tedeschi, Richard G. (2013). The role of centrality of events in posttraumatic distress and posttraumatic growth. *Psychological Trauma: Theory, Research, Practice, and Policy*, 5(5), 477.

Gul, Ervin, and Karanci, Nuray A. (2017). What Determines Posttraumatic Stress and Growth Following Various Traumatic Events? A Study in a Turkish Community Sample. *Journal of Traumatic Stress*, *30*(1), 54-62. doi: 10.1002/jts.22161

He, Lili, Xu, Jiuping, and Wu, Zhibin (2013). Coping Strategies as a Mediator of Posttraumatic Growth among Adult Survivors of the Wenchuan Earthquake. *Plos ONE*, *8*(12), e84164. doi: 10.1371/journal.pone.0084164

Heptinstall, Ellen, Sethna, Vaheshta, and Taylor, Eric (2004). PTSD and depression in refugee children. *Eur Child Adolesc Psychiatry*, 13(6), 373-380.

Herrman, Helen, Stewart, Donna, Diaz-Granados, Natalia, Berger, Elena L., Jackson, Beth, and Yuen, Tracy (2011). What is Resilience? *The Canadian Journal of Psychiatry*, 56(5), 258–265. https://doi.org/10.1177/070674371105600504

Hoppen, Thole and Morina, Nexhmedin (2019). The prevalence of PTSD and major depression in the global population of adult war survivors: a meta-analytically informed estimate in absolute numbers *European Journal of Psychotraumatology*. 10(1): 1578637.

Horowitz, Mardi, Wilner, Nancy, and Alvarez, William (1979). Impact of Event Scale: A Measure of Subjective Stress. *Psychosomatic Medicine*, *41*(3), 209-218. doi:10.1097/00006842-197905000-00004

Hu, Tingjie, Xiao, Jian, Peng, Juan, Kuang, Xiao, and He, Bixiu (2018). Relationship between resilience, social support as well as anxiety/depression of lung cancer patients: A cross-sectional observation study. *Journal of Cancer Research and Therapeutics,* 2018;14(1):72.

Hussain, Dilwar, and Bhushan, Braj (2011). Posttraumatic stress and growth among Tibetan refugees: The mediating role of cognitive-emotional regulation strategies. *Journal of Clinical Psychology*, *67*(7), 720-735.

Iacoviello, Brian, and Charney, Dennis (2014). Psychosocial facets of resilience: implications for preventing posttrauma psychopathology, treating trauma survivors, and enhancing community resilience. *European Journal of Psychotraumatology*, *5*(1), 23970. doi: 10.3402/ejpt.v5.23970

İçişleri Bakanlığı Göç İdaresi Genel Müdürlüğü. (2019). Geçici Koruma İstatistikleri (Accessed at 15.09.2019) https://www.goc.gov.tr/gecici-koruma5638

İçişleri Bakanlığı. (2013). *Yabancılar ve Uluslararası Koruma Kanunu*.

Ikizer, Gözde (2014). Factors Related to Psychological Resilience Among Survivors of The Earthquakes in Van, Turkey Doctor of Philosophy. Middle East Technical University.

Jansen, Lina, Hoffmeister, Michael, Chang-Claude, Jenny, Brenner, H., and Arndt, Volker (2011). Benefit finding and post-traumatic growth in long-term colorectal cancer survivors: prevalence, determinants, and associations with quality of life. *British Journal of Cancer*, *105*(8), 1158-1165. doi: 10.1038/bjc. 2011.335

Xuji, Jia, Ying, Liuhua, Zhou, Xiao, Wu, Xinchun, and Lin, Chongde (2015). The Effects of Extraversion, Social Support on the Posttraumatic Stress Disorder and Posttraumatic Growth of Adolescent Survivors of the Wenchuan Earthquake. *PLOS ONE*, *10*(3), e0121480. doi: 10.1371/journal.pone.0121480

Klasen, Fionna, Oettingen, Gabriele, Daniels, Judith, Post, Manuela, Hoyer, Catrin, and Adam, Hubertus (2010). Posttraumatic resilience in former Ugandan child soldiers. *Child Development* 81:1096-1113.

Kien, Christina, Sommer, Isolde, Faustmann, Anna, Gibson, Lacey, Schneider, Martha, Krczal, Eva, Jank, Robert, Klerings, Irma, Szelag, Monika, Kerschner, Bernd, Brattström, Petter, and Gartlehner, Gerald (2018). *European Child & Adolescent Psychiatry* 1-16https://doi.org/10.1007/s00787-018-1215-z

Kobasa, Suzanne C. (1979). Stressful life events, personality, and health: An inquiry into hardiness. *Journal of Personality and Social Psychology, 37*(1), 1-11.

Levine, Stephen Zvi, Laufer, Avital, Stein, Einat, Hamama-Raz, Yaira, and Solomon, Zahava (2009). Examining the relationship between resilience and posttraumatic growth. *Journal Of Traumatic Stress*, *22*(4), 282-286. doi: 10.1002/jts.20409

Lindert, Jutta, von Ehrenstein, Ondine S., Priebe, Stefan, Mielck, Andreas and Brähler, Elmar (2009). Depression and anxiety in labor migrants and refugees–a systematic review and meta-analysis. *Social Science & Medicine*, 69(2), 246-257.

Littleton, Heather, Horsley, Samantha, John, Siji, and Nelson, David (2007). Trauma coping strategies and psychological distress: A meta-analysis. *Journal Of Traumatic Stress*, *20*(6), 977-988. doi: 10.1002/jts.20276

Macksoud, Mona(1992) Assessing War Trauma in Children: A Case Study of Lebanese Children, *Journal of Refugee Studies*,5(1), 1–15, https://doi.org/10.1093/jrs/5.1.1

Maercker, Andreas, and Herrle, Johannes (2003). Long-Term Effects of the Dresden Bombing: Relationships to Control Beliefs, Religious Belief, and Personal Growth. *Journal of traumatic stress*, 16(6), 579-587. doi:10.1023/B:JOTS.0000004083.41502.2d

Masten, Ann (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, *56*(3), 227-238. doi: 10.1037/0003-066x.56.3.227

Merhi, Rana and Kazarian, Shahe (2012). Validation of the Arabic translation of the Multidensional Scale of Social Support (Arabic MSPSS) in a Lebanese community sample. *Arab Journal of Psychiatry*. 23. 159-168.

Mo, Phoenix Kit Han, Lau, Joseph Tak Fai, Yu, Xionan, and Gu, Jing (2014) The role of social support on resilience, posttraumatic growth, hopelessness, and depression among children of HIV-infected parents in mainland China, *AIDS Care,* 26:12, 1526-1533, DOI: 10.1080/09540121.2014.923810

Momartin, Shakeh, Silove, Derrick, Manicavasagar, Vijaya, and Steel, Zachary. (2003). Dimensions of trauma associated with posttraumatic stress disorder (PTSD) caseness, severity and functional impairment: a study of Bosnian refugees resettled in Australia. *Social Science & Medicine*, *57*(5), 775-781. doi: 10.1016/s0277-9536(02)00452-5

Montgomery, Edith (2008). Long-term effects of organized violence on young Middle Eastern refugees' mental health. *Social Science & Medicine*, *67*(10), 1596-1603. doi: 10.1016/j.socscimed.2008.07.020

Montgomery, Edith, Foldspang, Anders (2008) Discrimination, mental problems and social adaptation in young refugees*, European Journal of Public Health*, *18*(2) 156–161, https://doi.org/10.1093/eurpub/ckm073

Moore, Melinda, Cerel, Julie, and Jobes, David (2015). Fruits of Trauma? *Crisis*, *36*(4), 241-248. doi: 10.1027/0227-5910/a000318

Müller, Lauritz Rudolf Floribert, Büter, Karl Philip, Rosner, Rita, & Unterhitzenberger, Johanna (2019). Mental health and associated stress factors in accompanied and unaccompanied refugee minors resettled in Germany: a cross-sectional study. *Child and Adolescent Psychiatry and Mental Health*, 13(1), 8. doi:10.1186/s13034-019-0268-1

Neuner, Frank, Schauer, Maggie, Karunakara, Unni, Klaschik, Christine, Robert, Christina, and Elbert, T. (2004). Psychological trauma and evidence for enhanced vulnerability for posttraumatic stress disorder through previous trauma among West Nile refugees. *BMC Psychiatry*, *4*(1). doi: 10.1186/1471-244x-4-34

Nishi, Daisuke, Matsuoka, Yutaka, and Kim, Yoshiharu (2010). Posttraumatic growth, posttraumatic stress disorder and resilience of motor vehicle accident survivors. *Biopsychosocial Medicine*, *4*(1), 7. doi: 10.1186/1751-0759-4-7

Ogińska-Bulik, Nina (2015). The Relationship between Resiliency and Posttraumatic Growth Following the Death of Someone Close. OMEGA - *Journal of Death and Dying, 71(3), 233–244*. https://doi.org/10.1177/0030222815575502

Oppedal, Brit and Idsoe, Thormod (2015). The role of social support in the acculturation and mental health of unaccompanied minor asylum seekers. *Scandinavian Journal of Psychology* 56 (2): 203-211. doi:10.1111/sjop.12194.

Özer, Serap, Şirin, Selçuk, and Oppedal, Brit (2013). Bahçeşehir Study of Syrian Refugee Children in Turkey. Retrieved from https://www.fhi.no/globalassets/dokumenterfiler/studier/ungkul/bahcesehir-study-report.pdf

Öztürk, Neva Övünç (2017). Geçici korumanın uluslararası koruma rejimine uyumu üzerine bir inceleme. *Ankara Üniversitesi Hukuk Fakültesi Dergisi*, *66*(1), 201-263. doi: 10.1501/hukfak_0000001891

Park, Crystal, Cohen, Lawrence , & Murch, Richard (1996). Assessment and prediction of stress-related growth. *Journal of personality* 64(1), 71-105.

Pernice, Regina, and Brook, Judith (1996). Refugees' and immigrants; mental health: Association of demographic and post-immigration factors. *The Journal of Social Psychology*, 136(4), 511-519. http://dx.doi.org/10.1080/00224545.1996.9714033

Pieloch, Kerrie, McCullough, Mary Beth, and Marks, Amy (2016). Resilience of children with refugee statuses: A research review. *Canadian Psychology/Psychologie Canadienne, 57*(4), 330-339.

Porter, Matthew, and Haslam, Nick (2005). Predisplacement and Postdisplacement Factors Associated With Mental Health of Refugees and Internally Displaced Persons. *JAMA*, *294*(5), 602. doi: 10.1001/jama.294.5.602

Powell, Steve, Rosner, Rita, Butollo, Willi, Tedeschi, Richard, and Calhoun, Lawrence (2003). Posttraumatic growth after war: A study with former refugees and displaced people in Sarajevo. *Journal of Clinical Psychology,* 59(1), 71-83.

Prati, Gabriele, & Pietrantoni, Luca (2009). Optimism, Social Support, and Coping Strategies As Factors Contributing to Posttraumatic Growth: A Meta-Analysis. *Journal of Loss And Trauma*, *14*(5), 364-388. doi: 10.1080/15325020902724271

Punamäki, Raija Lena., Muhammed, Abbas Hedaiyet, and Abdulrahman, Hemen Ahmed (2004). Impact of traumatic events on coping strategies and their effectiveness among Kurdish children. International Journal of Behavioral Development, 28(1), 59-70. http://dx.doi.org/10.1080/01650250344000271

Ryan-Wenger, Nancy (1992). A Taxonomy of Children's Coping Strategies: A Step toward Theory Development. *American Orthopsychiatric Association, 62*(2), 256-263.

Rzeszutek, Marcin, Oniszczenko, Wlodzimiers, and Firląg-Burkacka, Ewa (2017). Journal of *Behavioral Medicine*, 40: 942-954. https://doi.org/10.1007/s10865-017-9861-z

Saakvitne, Karen, Tennen, Howard, and Affleck, Glenn (1998). Exploring thriving in the context of clinical trauma theory: Constructivist self development theory. *The Society for the Psychological Study of Social Issues,* 54(2), 279-299.

Sattler, David N., Claramita, Nora, and Muskavage, Brett (2018). Natural Disasters in Indonesia: Relationships Among Posttraumatic Stress, Resource Loss, Depression, Social Support, and Posttraumatic Growth, *Journal of Loss and Trauma*, 23:5, 351-365, DOI: 10.1080/15325024.2017.1415740

Schmidt, Steven, Blank, Thomas, Bellizzi, Keith, Park, Crystal (2011). The relationship of coping strategies, social support, and attachment style with posttraumatic growth in cancer survivors. *Journal of Health Psychology*,17(7):1033-40 10.1177/1359105311429203.

Schweitzer, Robert, Brough, Mark, Vromans, Lyn, & Asic-Kobe, Mary (2011). Mental Health of Newly Arrived Burmese Refugees in Australia: Contributions of Pre-Migration and Post-Migration Experience. *Australian & New Zealand Journal of Psychiatry*, *45*(4), 299-307. doi: 10.3109/00048674.2010.543412

Schweitzer, Robert, Melville, Fritha, Steel, Zachary, and Lacherez, Philippe (2006). Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. *Australian And New Zealand Journal of Psychiatry*, *40*(2), 179-188. doi: 10.1111/j.1440-1614.2006.01766.x

Shakespeare-Finch, Jane, and Lurie-Beck, Janine (2014). A meta-analytic clarification of the relationship between posttraumatic growth and symptoms of posttraumatic distress disorder. *Journal of Anxiety Disorders*, 28(2), 223-229.

Skrzypiec, Grace, Askell-Williams, Helen, Zhao, Xueqin, Du, Wenping, Cao, Fei, and Xing, Lihong (2018). Predictors of Mainland Chinese students' wellbeing. *Psychology in the Schools,* 55: 539-554.

Sleijpen, Marieke, Haagen, Joris, Mooren, Trudy, and Kleber, Rolf (2016). Growing from experience: an exploratory study of posttraumatic growth in adolescent refugees. European Journal of Psychotraumatology, 7, 1-10.doi:10.3402/ejpt.v7.28698.

Smith, Patrick, Perrin, Sean, Dyregrov, Atle, and Yule, William (2003). Principal components analysis of the impact of event scale with children in war. *Personality and Individual Differences*, *34*(2), 315-322. doi: 10.1016/s0191-8869(02)00047-8

Smith, Patrick, Perrin, Sean, Yule, William, Hacam, Berima, and Stuvland, R. (2002). War exposure among children from Bosnia-Hercegovina: Psychological adjustment in a community sample. *Journalof Traumatic Stress, 15(2), 147-156.*doi:10.1023/a:1014812209051

Snape, Melanie (1997). Reactions to a traumatic event: The good, the bad and the ugly?. *Psychology,Health&Medicine*, *2*(3), 237-242. doi:10.1080/13548509708400 581

Steffens, Rachel, and Andrykowski, Michael (2015). Posttraumatic Growth Inventory: Overview. *Comprehensive Guide to Post-Traumatic Stress Disorder*, 1-14. doi: 10.1007/978-3-319-08613-2_12-1

Stein, D. J., Friedman, M., & Blanco, C. (Eds.). (2011). Post-traumatic stress disorder (Vol. 26). Wiley-Blackwell: Oxford, 2011.

Tamres, Lisa, Janicki, Denise, and Helgeson, Vicki (2002). Sex Differences in Coping Behavior: A Meta-Analytic Review and an Examination of Relative Coping. *Personality and Social Psychology Review*, *6*(1), 2-30. doi:10.1207/ s15327957pspr0601_1

Tedeschi, Richard, and Calhoun, Lawrence (1995). Trauma and transformation: Sage.

Tedeschi, Richard, and Calhoun, Lawrence (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*(3), 455-472.

Tedeschi, Richard, and Calhoun, Lawrence (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress* 9(3), 455-471.

Tedeschi, Richard, Park, Crystal, and Calhoun, Lawrence (1998). Posttraumatic Growth: Positive Changes in the Aftermath of Crisis (p. 110). New Jersey: Lawrence Erlbaum Associates.

Teodorescu, Dinu-Stefan, Heir, Trond, Hauff, Edward, Wentzel-Larsen, Tore, and Lien, Lars (2012). Mental health problems and post-migration stress among multi-traumatized refugees attending outpatient clinics upon resettlement to Norway. *Scandinavian Journal of Psychology*, *53*(4), 316-332. doi: 10.1111/j.1467-9450.2012.00954.x

Thabet, Abdelaziz, and Thabet, Sana Sabah (2014). Stress, trauma, psychological problems, quality of life, and resilience of Palestinian Families in the Gaza Strip. Report published in July 2014.

Thabet, Abdelaziz Mousa, Elhelou, Mohammed, and Vostanis, Panos (2015). Exposure to war traumatic experiences, post traumatic growth and resilience among university students in Gaza. *American Journal of Advanced Medical Sciences 1*(1): 1-8.

Thabet, Abdelaziz Mousa, Tawahina, Abu, El Sarraj, Eyad, and Vostanis, Panos (2008). Exposure to war trauma and PTSD among parents and children in the Gaza strip. *European Child & Adolescent Psychiatry*, *17*(4), 191-199. doi: 10.1007/s00787-007-0653-9.

Tsai, Jack, and Pietrzak, Robert (2017). Trajectories of posttraumatic growth among US military veterans: a 4-year nationally representative, prospective cohort study. *Acta Psychiatrica Scandinavica*, *136*(5), 483-492. doi: 10.1111/acps.12800

UNHCR (2018). Global Trends Forced Displacement in 2018. Annual Report.

UNHCR(2019). "Figures at a Glance" (https://www.unhcr.org/figures-at-a-glance.html/ Accessed at September, 15, 2019).

Wang, Li, Shi, Jeffrey, Zhang, Yuqing and Zhang, Zhen(2010). Psychometric properties of the 10-item Connor-Davidson Resilience Scale in Chinese earthquake victims. *Psychiatry and Clinical Neurosciences*, *64*: 499-504.

Weiss, Tzipi (2004). Correlates of posttraumatic growth in married breast cancer survivors. *Journal of Social Clinical Psychology*, *23*(5), 733-746.

Woltin, Karl-Andrew, Sassenberg, Kai, and Albayrak, Nihan (2018). Regulatory focus, coping strategies and symptoms of anxiety and depression: A comparison between Syrian refugees in Turkey and Germany. *PLOS ONE*, *13*(10), e0206522. doi: 10.1371/journal.pone.0206522

Wu, Zhibin, Xu, Jiuping, and Sui, Yan (2016). Posttraumatic stress disorder and posttraumatic growth coexistence and the risk factors in Wenchuan earthquake survivors. *Psychiatry Research*, *237*, 49-54.

Yoon, Jae Ho, Lee, Ji Hae, Lee, Chae Yeon, Cho, Minhee and Lee,Sang Min (2014). Suppressor effects of coping strategies on resilience. *Asia Pacific Educ. Rev. 15*:537–545

Yu, Yongju, Peng, Li, Chen, Long, and Wang, Tao (2014). Resilience and social support promote posttraumatic growth of women with infertility: The mediating role of positive coping. *Psychiatry Research*, *215*(2), 401-405. doi:10.1016/j. psychres.2013.10.032

Zhou, Xiao, Wu, Xinchun, Li, Xin, and Zhen, Rui (2016). The role of posttraumatic fear and social support in the relationship between trauma severity and posttraumatic growth among adolescent survivors of the Yaan earthquake. *International Journal Of Psychology*, *53*(2), 150-156. doi: 10.1002/ijop.12281

Zimet, Gregory, Dahlem, Nancy, Zimet, Sara, and Farley, Gordon (1988). The Multidimensional Scale of Perceived Social Support. *Journal of Personality Assessment, 52*(1), 30-41. doi:10.1207/s15327752jpa5201_2

APPENDICES

Appendix A: ARABIC BATTERY

التاريخ :..... رمز المشترك: .....

معلومات الديموغرافية

نطلب منكم قبل البدء بالاجابة على الأسئلة ملء القسم المتعلق بالمعلومات الشخصية.

1. الجنس انثى ( ) ذكر ( )

2. العمر :.....

3. عدد الاخوة.....

4.ما هو ترتيبك بين الاخوة.....

5. مستوى الدراسي:

امي	تقرىء و كاتب	ابتدائي	اعدادي	ثانوي
( )	( )	( )	( )	( )

6.وضع العمل : يعمل ( ) لا يعمل ( )
اذا كنت تعمل فما هو مجال العمل

عند صاحب عمل	معمل-ورشة	عامل فصلي	متجول	غير
( )	( )	( )	( )	( )

7.مستوى الدخل الشهري :

اقل من 1000	2000-1000	3000-2000	4000-3000؟	اكثر من 4000
( )	( )	( )	( )	( )

8.في أي بلد قمت بالعمل مدة : .....
9.مستوى التعليمي لوالدتك: .....

امية	تقرا و تكتب	ابتدائي	اعدادي	ثانوي	خريجة جامعة
( )	( )	( )	( )	( )	( )

10 مستوى التعليمي لوالدك :.....

امي	يقرا و يكتب	ابتدائي	اعدادي	ثانوي	خريج جامعة
( )	( )	( )	( )	( )	( )

11.هل تتكلم اللغة التركية و ما هو مستواك: مبتدئ ( ) متوسط ( ) جيد ( ) ممتاز ( )

12.هل لديك أصدقاء محليين في المحافظة التي تعيش فيها: نعم ( ) لا ( )

		أوافق قطعا	أوافق	متردد	لا أوافق	لا أوافق ابدا
1	أواجه صعوبة في تكلم و فهم اللغة التركية					
2	يواجه الكبار في عائلتي (امي-ابي) اي صعوبة في فهم و تكلم اللغة التركية					
3	اشتاق لبلدي					
4	اشعر بالوحدة هنا					
5	اشتاق لاقرباني،أصدقائي و اهلي المتواجدين في بلدي					
6	اشعر بصعوبة في التأقلم هنا					
7	أواجه عائلتي صعوبات مادية اكثر من ما كانت عليه في بلدي					
8	لا يعطى اهتمام و تقدير لعائلتي مثل قبل					
9	واجهت تفرقة في المدرسة بسبب الطابع العرقي الذي انا عليه					
10	واجهت تفرقة في العمل بسبب الطابع العرقي الذي انا عليه					
11	واجهت تفرقة في الشارع بسبب الطابع العرقي الذي انا عليه					
12	أخاف من ترحيلي الى بلدي					
13	لا اظن ان لي مستقبل في هذا البلد					
14	المستقبل يخيفني /يربكني					
15	مستوى دخل عائلتي لا يلبي احتياجاتنا					
16	يجب علي ان اعمل من اجل تلبية الاحتياجات					
17	انا افضل من يتكلم اللغة التركية في عائلتي					
18	اذا لم اترجم لعائلتي فلن يستطيعوا تلبية احتياجاتهم					

EWSQ

.1	هل أجبرت على مغادرة قريتك أو بلدتك؟	نعم	لا
.2	هل تم طردك من منزلك؟	نعم	لا
.3	هل قام الجنود أو المسلحين باقتحام منزلك بالقوة؟	نعم	لا
.4	هل قصف منزلك؟	نعم	لا
.5	هل تم فصلك عن عائلتك خلال الحرب؟	نعم	لا
.6	هل انفصل والديك عن بعضهما البعض بسبب الحرب؟	نعم	لا
.7	هل كان أحد أفراد عائلتك في معسكر الاعتقال خلال الحرب؟	نعم	لا
.8	هل ذهب أي فرد من أفراد عائلتك إلى الخط الأمامي للقتال؟	نعم	لا
.9	هل أصيب أحد أفراد عائلتك خلال الحرب؟	نعم	لا
.10	هل قتل أي من أفراد عائلتك أثناء الحرب؟	نعم	لا
.11	هل واجهت اطلاق النار على مسافة قريبة جدا؟	نعم	لا
.12	هل سبق لك إطلاق النار من قبل القناصة؟	نعم	لا
.13	هل عانيت من القصف على مسافة قريبة جدا؟	نعم	لا
.14	هل كان عليك البقاء في القبو لفترة طويلة بسبب القصف؟	نعم	لا
.15	هل كنت باردة جدا فظننت أنك ستموت؟	نعم	لا
.16	هل كنت جائعا من أي وقت مضى كنت تعتقد أنك سوف تموت؟	نعم	لا
.17	هل رأيت أشخاصا أصيبوا مؤخرا؟	نعم	لا
.18	هل رأيت شخصا يقتل؟	نعم	لا
.19	هل رأيت جثة ميتة؟	نعم	لا
.20	هل ساعدت في نقل الجرحى أو القتلى؟	نعم	لا
.21	هل سبق لك أن احتجزت في معسكر اعتقال أثناء الحرب؟	نعم	لا
.22	هل رأيت شخصا ما يتعرض للتعذيب؟	نعم	لا
.23	هل رأيت شخصا يتعرض للاغتصاب أو الإساءة الجنسية أثناء الحرب؟	نعم	لا
.24	هل رأيت الكثير من الناس يقتلون في نفس الوقت؟	نعم	لا
.25	هل جرحت خلال الحرب؟	نعم	لا
.26	هل سبق لك أن استعملت كدرع بشري أثناء الحرب؟	نعم	لا
.27	هل هددك أحد مباشرة بقتلك خلال الحرب؟	نعم	لا
.28	هل كنت في أي وقت تظن أنك ستقتل فيه؟	نعم	لا

C-RIES 13

فيما يلي قائمة بالتعليقات التي أدلى بها الناس بعد وقوع أحداث شاقة. يرجى وضع علامة على كل عنصر يوضح مدى تكرار هذه التعليقات بالنسبة لك خلال الأيام السبعة الماضية. إذا لم يحدث ذلك خلال ذلك الوقت ، يرجى وضع علامة في المربع "لا على الإطلاق"

	0	1	3	5
خلال الأيام أربع عشرة الماضية	أبدا	نادرا	احيانا	غالبا
1. هل تفكر بالأحداث الصادمة دون قصد ؟				
2. هل تفكر في إزالة الأحداث الصادمة من ذاكرتك ؟				
3. هل لديك صعوبات في التركيز و الانتباه؟				
4. هل تنتابك موجات من المشاعر الشديدة الخاصة بالأحداث الصادمة؟				
5. هل تستثار بسهوله أو تشعر بأنك متوتر أكثر بعد الأحداث الصادمة؟				
6. هل تحاول تجنب الأماكن و الأشخاص الذين يذكروك بالأحداث الصادمة؟				
7. هل تحاول تجنب الحديث عن الأحداث الصادمة؟				
8. هل تفاجئ عقلك صور خاصة بالأحداث الصادمة؟				
9. هل هناك أشياء أخرى تذكرك بالأحداث الصادمة؟				
10. هل تحاول عدم التفكير بالأحداث الصادمة؟				
11 . هل تستثار بسهوله؟				
12. هل تشعر بأنك متحفز و مترقب لشيء غير متوقع				
13. هل لديك مشاكل في النوم (بسبب صور أو أفكار متعلقة بالأحداث الصادمة)				

4

PTGI

عزيزي/ عزيزتي

فيما يلي مجموعة من الأسئلة التي تتناول القوة و التطور للأشخاص الذين يتعرضون لأزمات و صدمات نفسية مثل الحرب و العنف، والحوادث المختلفة. يرجاء وضع علامة (√) في الخانة التي تراها تناسبك. علما بأن الاجابات هي على النحو التالي:

0 = لا 1= لقد جربت ذلك بطريقة بسيطة بعد الازمة , 2= لقد جربت ذلك بطريقة متوسطة بعد الازمة, 3= لقد جربت ذلك بطريقة كبيرة بعد الازمة, 4= لقد جربت ذلك بطريقة كبيرة جدا بعد الازمة.

البنود	لا	بدرجة بسيطه	بدرجة متوسطة	بدرجة كبيرة	بدرجة كبيرة جدا
1. تغيرت أهدافي في الحياة بعد الحرب مقارنة بما هي عليه قبل الحرب					
2. اقدر قيمة حياتي أكثر من الأول					
3. بدأت اهتم بأشياء جديدة في الحياة					
4. أصبحت ثقتي في نفسي أكثر من قبل					
5. أصبحت أتفهم الأمور الروحية و الدينية أفضل من قبل					
6. عرفت بأنني استطيع الاعتماد على الآخرين حولي عندما أقع في مشكلة					
7. اخترت طريق (مسار) جديد في حياتي					
8. أشعر بالقرب من الآخرين					
9. أصبحت قادرا على التعبير عن مشاعري أكثر من قبل الحرب					
10. أعرف بأنني أصبحت قادرا بطريقة أفضل على التعامل مع مشاكلي					
11. أستطيع أن أفعل الأشياء في حياتي بطريقة جيدة بعد الحرب					
12. أقبل بشكل أفضل ما انتهت إليه الأمور بعد الحرب					
13. اقدر كل يوم جديد في حياتي أكثر من الأول					
14. أصبحت لدي فرص جديدة في الحياة لم تكن موجودة من قبل					
15. أصبحت لدي عاطفة و حب تجاه الآخرين					
16. أحاول أن أقيم أفضل العلاقات الاجتماعية مع الآخرين					
17. أحاول أن أقرر الأشياء في الحياة التي تحتاج للتغيير					
18. أصبح إيماني أعمق بالله					
19. اكتشفت بأنني أكثر قوة مما كنت أعتقد					
20. تعلمت كثيراً كيف أن الناس حولي رائعين					
21. تقبلت أكثر من قبل بأنني أحتاج الناس من حولي					

مقياس التطور الايجابي بعد الصدمات النفسية-

MSPSS

إرشادات :ق بالدعم الإجتماعي. إستعمل المقياس أدناه من ق ق يتضمن هذا الإستفتاء عدد من الإقتراحات التي تتعل 1 إلى 7 لتقييم كل بند من البنود من خلال وضع دائرة حول الرقم المناسب

1	2	3	4	5	6	7
اعترض ب	أعترض	اعترض	حيادي	أوافق	اوافق	أوافق

بشدة	باعتدال	قليل	قليل	باعتدال	شدة
1.هناك شخص مميز بجانبي عندما احتاجه					7 6 5 4 3 2 1
2هناك شخص مميّز استطيع ان اشارك أفراحي و أحزاني معهم					7 6 5 4 3 2 1
3. تحاول عائلتي مساعدتي					7 6 5 4 3 2 1
4.أتلقى مساعدة عاطفية ودعم من عائلتي					7 6 5 4 3 2 1
.5. هناك شخص مميّز هو/هي مصدر حقيقي للراحة لي.					7 6 5 4 3 2 1
6.اصدقائي ىحـــاولون مساعدتي					6 5 4 3 2 1
7					
. ق 7- ق بامكاني الإعتماد على أ صدقائي عندما تجري بشكل سيء					7 6 5 4 3 2 1
8. بامكاني التحدث عن مشاكلي مع عائلتي					7 6 5 4 3 2 1
9.عندي اصدقاءي استيطيع ان أشارك احزاني و افراحي معهم					7 6 5 4 3 2 1
10-هناك شخص مميّز في حياتي يهتم بمشاعري					7 6 5 4 3 2 1.
11.ترغب عائلتي بمساعدتي لاتخاذ القرارات					-7 6 5 4 3 2 1
12.استطيع التحدث عن مشاكلي مع أصدقائي					7 6 5 4 3 2 1

CSCY

عند كل الأطفال والمراهقون بعض المشاكل التي يجدونها صعبة للتعامل معها وذلك يز عجهم ويقلقهم. نحن مهتمين لايجاد ما الذي يجب ان تفعله عندما تحاول التعامل مع مشكلة صعبة. فكر في المشكلة التي از عجتك او اقلقتك في الشهور الماضية. يمكن ان تكون مشكلة مع شخص، صديق، او اي شيئ آخر. صف باختصار ما هي المشكلة:

_____

_____

_____

_____

_____

_____

_____

_____

أداه هذاك بعض الطرق التي يجربها الاطفال والمراهقين للتعامل مع مشاكلهم. الرجاء اخبارنا فيما اذا كان كل من هذه البيانات صحيحة بالنسبة لك عندما تعاملت مع المشكلة الموصوفة في أداه.

	3	2	1	0
	3=في أغلب الأخيان	2= غالبا	1= أحيانا	0= أبدا

Ass. Se.

1. طلبت المساعدة من أحد أعضاء العائلة لحل المشكلة.....	0	1	2	3
2. نصحني شخص عما يجب أن أفعل.....	0	1	2	3
3. شاركت شعوري عن المشكلة مع شخص آخر.....	0	1	2	3
4. احتفظت مشاعري لنفسي.....	0	1	2	3

CBPS

3	2	1	0	1. فكرت بالمشكلة وحاولت ان اتصور ما يمكن ان أفعل بشأنها.....
3	2	1	0	2. خاطرت وحاولت طريقة جديدة لحل المشكلة.....
3	2	1	0	3. وضعت خطة لحل المشكلة ومن ثم تابعت الخطة.....
3	2	1	0	4. راجعت في فكري بعض الاشياء التي يمكن فعلها لحل المشكلة .....
3	2	1	0	5. فكرت بحل المشكلة بطريقة جديدة حتى لا تسبب ازعاجي.....
3	2	1	0	6. تعلمت طريقة جديدة لمواجهة او معاملة المشكلة.....
3	2	1	0	7. حاولت ان اتصور كيف شعرت تجاه المشكلة.....
3	2	1	0	8. تصورت ما الذي يجب ان أفعله ومن ثم فعلته.....

Cog. Avo.

3	2	1	0	1. حاولت عدم التفكير في المشكلة.....
3	2	1	0	2. تصرّفت كأنه لم يحصل شيئ.....
3	2	1	0	3. تظاهرت كأن المشكلة لم تكن ذات أهمية كبيرة بالنسبة لي.....
3	2	1	0	4. كنت اعلم ان لدي شعور كبير بالمشكلة، ولكن لم اعط اهتماما لها .....
3	2	1	0	5. حاولت ان ابتعد عن المشكلة لوهلة وذلك بعمل اشياء اخرى .....

3	2	1	0

0= أبدا 1= أحيانا 2= غالبا 3= في أغلب الأحيان

3	2	1	0	6. تظاهرت بأنّ المشكلة لا علاقة لي بها.....
3	2	1	0	7. تظاهرت بان المشكلة لم تحصل.....
3	2	1	0	8. تمنيت ان تسير الامور بشكل ما، اذًا لم افعل شيئا.....
3	2	1	0	9. حاولت ان ادعي ان المشكلة لم تكن حقيقية.....
3	2	1	0	10. ادركت بانه ليس هناك شيئا يمكن ان افعله. فقط انتظرت ان تنتهي .....
3	2	1	0	11. أبعدت المشكلة عن فكري.....

Bh. Avo.

3	2	1	0	1. ابتعدت من الاشياء التي كانت تذكرني عن المشكلة.....
3	2	1	0	2. حاولت ان لا اشعر شيئا بداخلي. اردت ان أفقد الحس .....
3	2	1	0	3. ذهبت الى النوم حتى لا علي ان افكر عنها (اي المشكلة).....
3	2	1	0	4. عندما كنت منزعجا من المشكلة، كنت لئيما تجاه شخص حتى لو لم يستحقه.....
3	2	1	0	5. حاولت ان لا اكون مع اي شخص الذي يذكرني عن المشكلة.....
3	2	1	0	6. قررت ان ابتعد من الناس واكون لوحدي .....

الرجاء الإشارة الى أي مدى تنطبق العبارات التالية عليك خلال الثلاثين يوما الماضية. إذا لم يحدث موقف معين مؤخرا، اجب وفقا لاعتقادك كيف كنت ستشعر تجاه ذلك الموقف فيما لوحدث.

		ليس صحيحا على الإطلاق (0)	نادرا ما صحيح (1)	أحيانا صحيح (2)	غالبا صحيح (3)	صحيح كل الوقت تقريبا (4)
١	أستطيع التأقلم عند ما تحدث تغييرات	☐	☐	☐	☐	☐
٢	أستطيع التعامل مع أي شيء يطرأ في حياتي	☐	☐	☐	☐	☐
٣	أحاول أن أرى الجانب الهزلي من المشاكل عندما اواجهها	☐	☐	☐	☐	☐
٤	اضطراري للتعامل مع التوترو قد يجعلني شخص أقوى	☐	☐	☐	☐	☐
٥	أميل إلى استعادة توازني بعد مرض أو إصابة، أو غيرها من الصعوبات	☐	☐	☐	☐	☐
٦	أؤمن بأنني أستطيع تحقيق أهدافي حتى مع وجود عقبات	☐	☐	☐	☐	☐
٧	تحت الضغط، استطيع التركيز والتفكير بوضوح	☐	☐	☐	☐	☐
٨	الفشل لا يسبب لي الاحباط بسهولة	☐	☐	☐	☐	☐
٩	أعتبر نفسي شخص قوي عند التعامل مع تحديات وصعوبا ت الحياة	☐	☐	☐	☐	☐
١٠	أنا قادر على التعامل مع مشاعر غير سارة أو مؤلمة مثل الحزن والخوف والغضب	☐	☐	☐	☐	☐

Appendix B: Demographical Information Form-Original

Sizden, diğer ölçekleri cevaplandırmadan önce öncelikle aşağıda kişisel bilgilerinizle ilgili olan soruları cevaplandırmanızı rica ediyoruz.

1. Cinsiyetiniz: □ Kadın □ Erkek

2. Yaşınız:……..

3. Kaç kardeşsiniz:……

4. Kaçıncı çocuksunuz: ……

5. Eğitim durumunuz:

Okuryazar değil	Okuryazar	İlkokul mezunu	Ortaokul mezunu	Lise mezunu
( )	( )	( )	( )	( )

6. Çalışma Durumunuz: ( ) Çalışıyor ( ) Çalışmıyor
Çalışıyor iseniz: Çalıştığınız ortam

Bir usta yanında	Fabrika- atölye	Mevsimlik işçi	Seyyar	Diğer
( )	( )	( )	( )	( )

7. Ailenizin toplam aylık geliri:

1000 TL'den az	1000-2000	2001-3000	3001-4000	4000 TL'den fazla
( )	( )	( )	( )	( )

8. Bugüne kadar en uzun yaşadığınız yer:……

9. Annenizin eğitim durumu:……

Okuryazar değil	Okuryazar	İlkokul mezunu	Ortaokul mezunu	Lise mezunu	Üniversite
( )	( )	( )	( )	( )	( )

10. Babanızın eğitim durumu:

Okuryazar değil	Okuryazar	İlkokul mezunu	Ortaokul mezunu	Lise mezunu	Üniversite
( )	( )	( )	( )	( )	( )

11. Türkçe biliyorsanız düzeyi: □ **Başlangıç** □ **Orta** □ **İyi** □ **Çok İyi**

12. Bulunduğunuz şehirde yerel halktan arkadaşlarınız var mı? □ Evet □ Hayır

	Kesinlikle Katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle Katılıyorum
Türkçeyi anlamakta ve konuşmakta zorluk çekiyorum.					
Büyüklerim (Anne-babam) Türkçeyi anlamakta ve konuşmakta zorluk çekiyor					
Ülkeme özlem duyuyorum.					
Burada kendimi yalnız hissediyorum.					
Ülkemde kalan akraba, arkadaş, ailemi özlüyorum.					
Buradaki yaşama uyum sağlamakta güçlük çekiyorum.					
Ailem maddi olarak kendi ülkemdekine göre daha kötü durumda.					
Ailem sosyal açıdan eskisi kadar değer/saygı görmüyor.					
Etnik kökenim nedeniyle okulda ayrımcılığa uğradım.					
Etnik kökenim nedeniyle işyerinde ayrımcılığa uğradım.					
Etnik kökenim nedeniyle sokakta ayrımcılığa uğradım.					
Ülkeme geri gönderilmekten korkuyorum.					
Bu ülkede bir geleceğim olabileceğini düşünmüyorum.					
Gelecek beni endişelendiriyor/ korkutuyor.					
Ailemin geliri ihtiyaçlarımızı karşılamak için yeterli değil.					

Ailemi geçindirmek için çalışmak zorundayım.					
Ailemde Türkçeyi en iyi konuşabilen kişi benim.					
Ben çevirmenlik yapmazsam ailem ihtiyaçlarını anlatamaz.					

Appendix C: Exposure to War Stressors-Original

Exposure to War Stressors Questionnaire

	Yes	No
Were you forced to leave your village or town?		
Were you expelled from your home?		
Did soldiers or armed man forcibly enter your home?		
Was your home shelled?		
Were you seperated from from your family during the war?		
Were your parents separated from each other because of the war?		
Was any member of your family in concentration camp during the war?		
Did any member of your family go to the front line to fight?		
Was any member of your family injured during the war?		
Was any member of your family killed during the war?		
Did you experience shooting at a very close distance?		
Were you ever shot at by snipers?		
Did you experience shelling at a very close distance?		
Did you have to stay in a basement for a long time because of shelling?		
Were you ever so cold you thought you would die?		
Were you ever so hungry you thought you would die?		
Did you see people who had been recently injured?		
Did you see someone being killed?		
Did you see a dead body?		
Did you help to carry wounded or dead people?		
Were you ever held in a detention camp during the war?		
Did you see someone being tortured?		
Did you see someone being raped or sexually abused during the war?		
Did you see many people someone being killed at once?		
Were you injured during the war?		
Were you ever used as a human shield during the war?		
Did anyone directly threaten to kill you during the war?		
Were you ever in a situation where you thought you would be killed?		

Appendix D: Revised Child Impact of Event Scale-Original

Revised Child Impact of Event Scale

Below is a list of comments made by people after stressful life Event. Please tick each item showing how frequently these comments were true for you *during the past seven days.* If they did not occur during that time please tick the 'not at all' box.

Office use only

		Not at all	Rarely	Some-times	Often	In	Av	Ar
1.	Do you think about it even when you don't mean to?	[ ]	[ ]	[ ]	[ ]			
2.	Do you try to remove it from your memory	[ ]	[ ]	[ ]	[ ]			
3.	Do you have difficulties paying attention or concentrating	[ ]	[ ]	[ ]	[ ]			
4.	Do you have waves of strong feelings about it	[ ]	[ ]	[ ]	[ ]			
5.	Do you startle more easily or feel more nervous than you did before it happened?	[ ]	[ ]	[ ]	[ ]			
6.	Do you stay away from reminders of it (e.g. places or situations)	[ ]	[ ]	[ ]	[ ]			
7.	Do you try not talk about it	[ ]	[ ]	[ ]	[ ]			
8.	Do pictures about it pop into your mind?	[ ]	[ ]	[ ]	[ ]			
9.	Do other things keep making you think about it?	[ ]	[ ]	[ ]	[ ]			
10.	Do you try not to think about it?	[ ]	[ ]	[ ]	[ ]			
11.	Do you get easily irritable	[ ]	[ ]	[ ]	[ ]			
12.	Are you alert and watchful even when there is no obvious need to be?	[ ]	[ ]	[ ]	[ ]			
13.	Do you have sleep problems?	[ ]	[ ]	[ ]	[ ]			

Appendix E: Posttraumatic Growth Inventory-Original

Posttraumatic Growth Inventory

Indicate for each of the statements below the degree to which this change occurred in your life as a result of your crisis [**or researcher inserts specific descriptor here**], using the following scale.

0= I did not experience this change as a result of my crisis.

1= I experienced this change to a very small degree as a result of my crisis.

2= I experienced this change to a small degree as a result of my crisis.

3= I experienced this change to a moderate degree as a result of my crisis.

4= I experienced this change to a great degree as a result of my crisis.

5= I experienced this change to a very great degree as a result of my crisis.

1. I changed my priorities about what is important in life. (V)
2. I have a greater appreciation for the value of my own life. (V)
3. I developed new interests. (II)
4. I have a greater feeling of self-reliance. (III)
5. I have a better understanding of spiritual matters. (IV)
6. I more clearly see that I can count on people in times of trouble. (I)
7. I established a new path for my life. (II)
8. I have a greater sense of closeness with others. (I)
9. I am more willing to express my emotions. (I)
10. I know better that I can handle difficulties. (III)
11. I am able to do better things with my life. (II)
12. I am better able to accept the way things work out. (III)
13. I can better appreciate each day. (V)
14. New opportunities are available which wouldn't have been otherwise. (II)
15. I have more compassion for others. (I)
16. I put more effort into my relationships. (I)
17. I am more likely to try to change things which need changing. (II)
18. I have a stronger religious faith. (IV)
19. I discovered that I'm stronger than I thought I was. (III)
20. I learned a great deal about how wonderful people are. (I)
21. I better accept needing others. (I)

Appendix E: Multidimensional Scale of Perceived Social Support

Multidimensional Scale of Perceived Social Support

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you **Very Strongly Disagree**
Circle the "2" if you **Strongly Disagree**
Circle the "3" if you **Mildly Disagree**
Circle the "4" if you are **Neutral**
Circle the "5" if you **Mildly Agree**
Circle the "6" if you **Strongly Agree**
Circle the "7" if you **Very Strongly Agree**

1. There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2. There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3. My family really tries to help me.	1	2	3	4	5	6	7
4. I get the emotional help & support I need from my family.	1	2	3	4	5	6	7
5. I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6. My friends really try to help me.	1	2	3	4	5	6	7
7. I can count on my friends when things go wrong.	1	2	3	4	5	6	7
8. I can talk about my problems with my family.	1	2	3	4	5	6	7
9. I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
10. There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11. My family is willing to help me make decisions.	1	2	3	4	5	6	7
12. I can talk about my problems with my friends.	1	2	3	4	5	6	7

Appendix F: Coping Scale for Children and Youth-Original

Coping Scale for Children and Youth

All children and teenagers have some problems they find hard to deal with and that upset them or worry them. We are interested in finding out what you do when you try to deal with a hard problem. Think about some problem that has bothered you or upset you in the past few months. It could be a problem with homework, teachers, parents, other kids, or anything else. Briefly describe what the problem is in the space below.

……

……

How much has this problem bothered you. Circle one of the answers.

1	2	3
A little bit	a medium amount	a great deal

Listed below are some ways that children and teenagers try to deal with their problems. Please tell us how often you have used these behaviors when you tried to deal with the problem you described.

	Never	Sometimes	Often	Very Often
I asked someone in my family for help.	1	2	3	4
I tried not thinking about the problem.				
I went on with my usual activities as if nothing was wrong.				
I thought about the problem and tried to figure out what I could do about it.				
I stayed away from things that reminded me about the problem.				
I tried not to feel anything inside me. I wanted to feel numb.				
I pretended the problem wasn't very important to me.				
I knew I had lots of feelings about the problem, but I just didn't pay any attention to them.				
I took a chance and tried a new way to solve the problem.				
I tried to get away from the problem for a while by doing other things.				
I made a plan to solve the problem and then I followed the plan.				
I pretended the problem had nothing to do with me.				
I went over in my head some of the things I could do about the problem.				
I thought about the problem in a new way so that it didn't upset me as much.				

Appendix G: Connor-Davidson Resilience Scale-Original

Connor-Davidson Resilience Scale 10 (CD-RISC-10) ©

*Please indicate how much you agree with the following statements as they apply to you over the last **month**. If a particular situation has not occurred recently, answer according to how you think you would have felt.*

		not true at all (0)	rarely true (1)	sometimes true (2)	often true (3)	true nearly all the time (4)
1.	I am able to adapt when changes occur.	☐	☐	☐	☐	☐
2.	I can deal with whatever comes my way.	☐	☐	☐	☐	☐
3.	I try to see the humorous side of things when I am faced with problems.	☐	☐	☐	☐	☐
4.	Having to cope with stress can make me stronger.	☐	☐	☐	☐	☐
5.	I tend to bounce back after illness, injury, or other hardships.	☐	☐	☐	☐	☐
6.	I believe I can achieve my goals, even if there are obstacles.	☐	☐	☐	☐	☐
7.	Under pressure, I stay focused and think clearly.	☐	☐	☐	☐	☐
8.	I am not easily discouraged by failure.	☐	☐	☐	☐	☐
9.	I think of myself as a strong person when dealing with life's challenges and difficulties.	☐	☐	☐	☐	☐
10.	I am able to handle unpleasant or painful feelings like sadness, fear, and anger.	☐	☐	☐	☐	☐

Add up your score for each column **0** + ____ − ____ + ____ + ____

Add each of the column totals to obtain CD-RISC score = _____

"

01-01-19

Appendix G: Informed Consent Form-Arabic

استمارة متطوع لاعلام ولي الامر

يقمم بهذا البحث الباحثة المرشدة النفسية هلال يكان في نطاق رسالة ماجستير علم النفس السريري في جامعة أبانت عزت بايسال من فرع كلية العلوم والآداب في قسم علم النفس بإشراف الدكتور الأستاذ سعيد اولوج . يمكنكم التواصل على عنوان البريد الالكتروني hilalyeken@hotmail.com

في هذا البحث ، سيتم التحقيق في العوامل ذات الصلة بمستويات النمو ما بعد الصدمة بين المراهقين من اللاجئين.و انت ولي الطفل إذا كنت تقبل مشاركة طفلك في ملء استبيانات فسوف يطلب منك للرد على أسئلة عن الماضي والحياة الحاضرة . ستكون المشاركة في هذا البحث بشكل تطوعي. لا يتعين على الطفل الذي أن يجيب على الأسئلة التي لا يريدها ، لجمع بيانات صحية من المهم ألا يترك / تترك أكبر قدر ممكن من الأسئلة والرد على الأسئلة بصدق. إذا كان لديك أي أسئلة حول البحث أو عند ملء المقاييس ، يرجى مشاركتها مع الباحث. سيتم الرد على جميع الأسئلة التي تطرحها من قبل الباحث. بالإضافة إلى ذلك ، يمكن سحب طفلك في أي وقت دون إبداء أي سبب. إذا انسحب من الدراسة ، فلن يواجه أي عقوبات. سيتم أخذ معلومات الهوية الشخصية التي شاركها طفلك خلال التطبيق برقم الكود وسيتم تسجيلها دون أي تحديد معلومات عن مجري المقابلة. سيتم تحليل نتائج البحث بالطرق الإحصائية وسيتم تقديم المعلومات التي تم الحصول عليها إلى لجنة تحكيم الرسالة.

تمت مراجعة هذا البحث والموافقة عليه من قبل لجنة أخلاقيات البحوث بجامعة أبانت عزت بايسال. إذا كان لديك أي مخاوف أو أسئلة بخصوص هذه الدراسة ، فإن مستشار الرسالة هو الدكتور سعيد اولوج و هذا هو عنوان البريد الالكتروني الخاص به او يمكنك الاتصال المرشدة النفسية هلال يكان

(hilalyeken@hotmail.com). أو (psysait@hacettepe.edu.tr).

إذا كنت ترغب في مشاركة طفلك في هذه الدراسة ، فالرجاء قراءة نموذج الموافقة وتوقيعه على الصفحة الخلفية.

انا والد الطفل أوافق بمشاركة طفلي في بحث الدكتور سعيد اولوج و المرشدة النفسية هلال يكان. لقد قرأت نص تأكيد المعلومات وأريد أن أسأل الباحث نفسه أو مساعده عن الأسئلة التي أود طرحها حول الانضمام إلى هذه الدراسة ، وأعلم أنه يمكن سحب طفلي من الدراسة في أي مرحلة دون تحديد أي سبب. في نفس الوقت ، تم إخباري بأن هذه الدراسة تمت الموافقة عليها من قبل لجنة أخلاقيات جامعة أبانت عزت بايسال.

إذا كنت ترغب في المشاركة في البحث وفقًا لهذه المعلومات ، يرجى توقيع نسختين من نموذج الموافقة والحفاظ على نسخة من هذا النموذج بنفسك.

التاريخ:

الاسم و الكنية:

العنوان:

رقم الموبايل:

التوقيع:

Appendix H: Informed Consent Form-Original

GÖNÜLLÜ KATILIMCI VELİ BİLGİLENDİRME FORMU

Bu araştırma araştırmacı Psikolog Hilal YEKEN tarafından, Abant İzzet Baysal Üniversitesi Fen – Edebiyat Fakültesi Psikoloji Bölümü Klinik Psikoloji Yüksek Lisans Tezi kapsamında Doç. Dr. Sait ULUÇ danışmanlığında yürütülmektedir. İletişim Bilgileri: e-mail: hilalyeken@hotmail.com

Çalışmada mülteci ergenlerin travma sonrası büyüme düzeyleriyle ilgili faktörler araştırılmaktadır. Velisi olduğunuz çocuğun katılmasını kabul etmeniz halinde velisi olduğunuz çocuğun verilen anketleri doldurması ve geçmiş ve şimdiki yaşantısıyla ilgili soruları cevaplaması istenecektir. Çalışmaya katılım gönüllülük esasına dayanmaktadır. . Velisi olduğunuz çocuk ölçeklerde istemediği sorulara cevap vermek zorunda değildir, ancak araştırmada sağlıklı veriler toplanabilmesi için mümkün olduğu kadar eksik soru bırakmaması ve sorulara içtenlikle cevap vermesi önemlidir. Eğer araştırma ile ilgili şimdi veya ölçekleri doldururken herhangi bir soru aklınıza gelirse lütfen bunu araştırmacı ile paylaşınız. Sorduğunuz bütün sorular araştırmacı tarafından cevaplandırılacaktır. Ayrıca velisi olduğunuz çocuğunuz bu çalışmadan herhangi bir neden belirtmeksizin, istediği an çekilebilir. Çalışmadan çekilmesi durumunda herhangi bir yaptırımla karşılaşmayacaktır.

Velisi olduğunuz çocuğunuzun uygulama esnasında paylaştığı kişisel kimlik bilgileri, kod numarası ile alınacak olup, kimliği belirtilmeden kayıt altına alınacaktır. Araştırma sonuçları, istatistiksel yöntemlerle analiz edilecek ve elde edilen bilgiler rapor halinde Tez Jürisine sunulacaktır.

Bu araştırma Abant İzzet Baysal Üniversitesi Araştırma Etik Komisyonu tarafından incelenmiş ve onaylanmıştır. Bu çalışma ile ilgili herhangi bir endişeniz veya sorunuz olursa tez danışmanı Doç. Dr. Sait ULUÇ (psysait@hacettepe.edu.tr) veya Psikolog Hilal Yeken (hilalyeken@hotmail.com) ile iletişim kurabilirsiniz.

Eğer çocuğunuzun bu çalışmaya katılmasını istiyorsanız, lütfen arka sayfadaki onam formunu okuyarak imzalayınız.

Velisi olduğum çocuğun Doç. Dr. Sait Uluç ve Psikolog Hilal Yeken tarafından yürütülmekte olan bu çalışmaya katılmasını kabul ediyorum. Bilgi-Onam metnini

okudum ve bu çalışmaya katılmakla ilgili olarak sormak istediğim soruları araştırmacının kendisine veya yardımcısına sorarak öğrenme fırsatım olduğunu ve velisi olduğunuz çocuğumun çalışmadan herhangi bir neden belirtmeksizin istediği her aşamada çekilebileceğini biliyorum. Aynı zamanda bu çalışmanın Abant İzzet Baysal Üniversitesi Etik Komisyonu tarafından onaylandığı bilgisi benimle paylaşıldı.

Eğer bu bilgiler doğrultusunda araştırmaya katılmak istiyorsanız lütfen Onam Formunun iki kopyasını da imzalayınız ve bu formun bir kopyasını kendiniz için saklayınız.

Tarih:

Adınız-Soyadınız:

Adres:

Tel:

İmza: