

## Psychosocial Sequels of Syrian Conflict

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### Abstract

**Background:** Victims of political violence and genocide survivors are highly vulnerable to mental and psychological distress. The aim of this study is to explore the level of psychological distress and mental health disorders including depression, anxiety, and post-traumatic stress disorder (PTSD) amongst Syrian Refugees in South Turkey and to investigate their association with socio-demographic variables.

**Methods:** A cross-sectional survey wherein three hundred questionnaires were distributed in four Syrian Refugee Camps located in South Turkey. Surveys included demographic data, Impact of Event Scale-Revised (IES-R), and Hospital Anxiety and Depression Scale (HADS). Snowball sampling method was utilized. Surveys missing any item were excluded. Data were processed and analyzed using SPSS v.16.

**Results:** Surveys were returned by 178 (59.3%) respondents of which 83 were incomplete. Therefore 95 (31.6%) of total responded questionnaires were analyzed. Mean age of respondents was  $34.2 \pm 11.9$  years and 85.3% of them were males. IES-R concluded PTSD among 58 (61.1%). Moreover HADS estimated pathologic anxiety among 50 (52.6%) and borderline anxiety among 18 (18.9%), whereas pathologic depression 26 (27.4%) and borderline depression 37 (37.9%) were the other disorders. HADS anxiety was strongly associated with PTSD ( $p < 0.001$ ), while PTSD and Depression did not bear significant difference. Anxiety, depression, and PTSD were not significantly associated with age, gender or marital status.

**Conclusions:** The political violence in Syria resulted in a high level of psychological distress and traumatization within civilians. This is characterized by the high level of PTSD amongst Syrian refugees. This requires a prompt crisis intervention campaign and urgent psychological support. Further research is required to explore the issue on a larger scale.

**Keywords:** SIRA; Syrian conflict; PTSD; Psychological traumas; Refugees mental health

### Background

The psychological consequences of combat exposure had been well documented throughout the history of war under various labels, including "soldier's heart", "shell shock" and "war neurosis" [1]. Additionally, political violence is implicated in a range of mental health outcomes, including PTSD, depression, and anxiety [2].

Research suggests that asylum seekers and displaced persons worldwide report high rates of pre-migration trauma (e.g. Sinnerbrink, Silove, Field, & Manicavasagar, 1997) [3]. Elevated rates of mental distress have been recorded amongst diverse adult populations that have experienced war. This can manifest in more general problems of mental health, [4] or specific conditions of which the most commonly researched tend to be post-traumatic stress disorder (PTSD) and depression [5,6].

The more common mental health diagnoses associated with refugee populations include post-traumatic stress disorder (PTSD), major depression, generalized anxiety, panic attacks, adjustment disorder, and somatization. The incidence of diagnoses varies with different populations and their experiences. Different studies have shown rates of PTSD and major depression in settled refugees to range from 10-40% and 5-15%, respectively. Children and adolescents often have higher levels of disorders with various investigations revealing rates of PTSD from 50-90% and major depression from 6-40% [7].

The Syrian conflict has turned out to be more challenging as the country is still politically unstable and economically impoverished given the longevity and severity of the war and displacement of the general population. The ability of the government to meet the basic needs, safety and security of the refugee population is limited. From a

health perspective, the refugee camps have extremely high health needs and limited health service provision [8].

While living in their home country, refugees often experience traumatic events and adverse situations such as sexual violence, genocide, torture, political persecution, the loss of loved ones, and forced child soldiering, which frequently prompt them to escape from their country of origin [9].

The often traumatic reasons for leaving the home country as well as the potentially long and hazardous journey and process of resettlement increase the risk for refugees to suffer from a variety of mental health issues [9].

Moreover, the stresses of everyday life at a refugee camp are known to negatively impact health, and the daily hassles seem to be reliable predictors of distress among war-affected populations and promising targets for interventions [10]. Lastly, when refugees leave the camps, they often are resettled and sent to a foreign country where they have to endure new stressful experiences, such as the everyday struggles of living in a new country, mourning the loss of loved ones, and coming to terms with their cultural identity [11].

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When refugees have witnessed and experienced many traumatic events, as well as multiple and chronic adversities, they have a high risk of developing mental health problems and have a higher prevalence of psychological disorders, in particular depression and post-traumatic stress disorder (PTSD) [12]. PTSD is a stress disorder which often occurs after witnessing or experiencing an event that is personally threatening. A survey conducted among Sudanese refugees living in northern Uganda found that PTSD was prevalent among 50.5% of the refugees [13]. PTSD and depression are particularly problematic because they have such long lasting effects: "even two decades after the trauma experienced in Cambodia, studies show that 62% of adult refugees still suffer from PTSD and 51% suffer from depression" [14]. In addition, refugees frequently mention being plagued by feelings of hopelessness, fear, sadness, anger, aggression and worry [15].

The Crisis in Syria began in March 2011. The conflict initially began as a civil uprising, evolved from initially minor protests, as a response to the Arab Spring, human rights abuses. It began in the southern city of Daraa, sometimes called the "Cradle of the Revolution", and later spread nationwide [16].

The government responded to the protests with large arrests, torture of prisoners, police brutality, and suppression of events. Few months later, protests could not appear in the streets any more due to bombs and explosions targeted directly towards civilians. Snipers, again targeting civilians, are distributed all over the streets in the areas that undergo peaceful protests. Clashes and tragedy continue till this moment. As a result, hundreds of thousands of Syrians were killed. Eight million were either displaced inside Syria or fled as refugees in the neighboring countries [17].

The pervasive negative impact of human rights violations (HRVs) on psychological functioning has been well documented. There is limited research, however, investigating the mechanisms that mediate the link between exposure to HRVs and various mental and behavioral health outcomes.

An estimated 8 million Syrians have fled their homes since the outbreak of civil war in March 2011, taking refuge in neighboring countries or within Syria itself. According to the United Nations High Commissioner for Refugees (UNHCR), about 2.5 million have fled to Syria's immediate neighbors Turkey, Lebanon, Jordan and Iraq. Besides; 6.5 million are internally displaced within Syria. Meanwhile, fewer than 100,000 have declared asylum in Europe with a small number offered resettlement by countries such as Germany and Sweden [18].

A considerable amount of research has examined how political violence is implicated in a variety of poor outcomes related to mental health, including PTSD, depression, and anxiety [19-21]. WHO, for example, estimates that between one-third to one half of people exposed to political violence will endure some type of mental distress, including PTSD, depression or anxiety (World Health Organization) [2].

The objective of the study is:

- To measure PTSD anxiety and depression in the displaced Syrian population
- To investigate the association of demography, displacement, and trauma exposure variables (past and recent) on PTSD anxiety and depression.

## Methods

The study was conducted in three main refugee camps in Turkey for

Syrian refugees (Reyhanl, Yayladağı and Bakhsheem) which are located in Hatay province in Southern Turkey near the Syrian borders. The camps are different in their shelter type, size, health and other support services [22,23].

## Selection of study groups

The data collection was done during the joint field visit of Physicians Across Continents (PAC) and Syrian Expatriate Medical Association (SEMA) in January 2012. Cross-sectional study design with snowball sampling method was used in order to achieve a more representative picture of the psychological effects of war on the communities exposed to war violence. The refugees were asked to come to their usual gathering area where study objectives were explained. The voluntary nature of participation was explained prior to survey administration and was clearly stated in the printed surveys. Verbal consent was obtained from participants. Surveys in participants' language (Arabic) including demographic data, Impact of Event Scale-Revised (IES-R), and The Hospital Anxiety and Depression Scale (HADS), were distributed. Participants were advised to distribute extra survey forms to friends and acquaintances with a similar trauma experience. This "snowballing" process continued until the targeted sample size of 300 was achieved.

## Instruments for assessment of mental health

**For depression and anxiety symptoms:** Hospital Anxiety and Depression scale (HADS) has been established by Zigmond & Snaith in 1983 [24]. This 14-item questionnaire has two subscales: anxiety and depression. Each question has four possible answers indicating that symptoms are either not present in the past week or occurred at three levels of severity. The validity of the HADS is widely proved [25]. The validated Arabic version [26] of HADS was used for the survey.

**For Posttraumatic stress symptoms:** The Impact of Event Scale-Revised: IES-R [27] was included at both assessments to measure the participants' level of posttraumatic stress symptoms during the previous two weeks. The IES-R consists of 22 items with five response alternatives of degree of distress (0=not at all, 1=a little, 2=moderately, 3=quite a bit, 4=extremely).

The psychometric properties of the IES-R have been extensively evaluated and deemed acceptable. The IES-R has also been found to have acceptable reliability in a Norwegian non-clinical sample [28]. Additionally; IES has shown good validity and internal consistency [29]. IES measures intrusion and avoidance symptoms relating to the experience of any specific stressful event and the revised version also measures hyper arousal [30].

A validated Arabic version of IES-R was utilized in the study (Development of the Arabic versions of the Impact of Events Scale Revised and the Posttraumatic Growth Inventory to assess trauma) [31].

Institutional Review Board (IRB) at King Fahad Medical City, Riyadh Saudi Arabia granted permission for this study. A questionnaire containing a covering letter explaining the confidentiality, anonymity, reasons for undertaking the study and information about completing the questionnaire, was used.

The approval for accessing the refugee camps facilities was granted, upon our request, by the Turkish authorities.

## Statistical analysis

Data was described as Mean  $\pm$  S.D and percentages. Inferences

were drawn by application of Pearson's Chi-square test and Odds Ratio at 95% confidence interval. SPSS version 16 and Microsoft Excel 2010 software were used for data analysis. Surveys lacking demographic data or vital information for scoring of mental health issues were excluded from analysis.

### Results

Total Responses were 178 (59.33%). Surveys missing any item were excluded. After Exclusion of incomplete surveys the remaining responses were 95 (31.67%). Mean age of respondents was 34.2 ± 11.9 years and 85.3% of them were male (Table 1).

Anxiety within the refugees was pathological in 50 (52.6%) and borderline in 18 (18.9%), whereas depression was pathological in 26 (27.4%) and borderline in 37 (37.9%). PTSD was present in 58 (61.1) survey subjects (Tables 2 and 3).

HADS Normal Score for Anxiety was attained by 27 (28.4%) subjects of which 10(37.0) had PTSD. PTSD was determined in 39(78.0) of the Pathologic Anxiety (Abnormal) subjects and its occurrence was 6.0 (1.93 to 19.42) times more than the Normal cases that sustain a significant correlation ( $p < 0.05$ ). Moreover; the significant increase in PTSD across Anxiety predicted strong association ( $p < 0.05$ ).

PTSD was observed among 10 (52.6) Non-depressed cases while its occurrence was assessed in 15 (60.0) Borderline Abnormal (Depression) subjects. Likelihood of PTSD among Borderline Abnormal (Depression) subjects was 1.4 (0.34 to 5.36) times more than the Normal Subjects. PTSD was present among 33 (64.7) Pathologic Depression subjects which was 1.7 (0.50 to 5.47) times more likely than the Normal Cases. The respective associations were insignificant ( $p > 0.05$ ). Overall association of PTSD with Depression was insignificant. Anxiety, depression, and PTSD had not significant associations with age, gender or marital status.

Characteristics	Categories	n (%)
Gender	Male	81 (85.3)
	Female	14 (14.7)
Education level	Uneducated	5 (5.3)
	Junior high	37 (37.9)
	High school	26 (27.4)
	University	11 (11.6)
	Chose not to answer	16
Marital Status	Single	30 (31.6)
	Married	52 (54.7)
	Chose not to answer	13
Job categories	General worker	31 (32.6)
	Engineering	5 (5.3)
	Teaching	10 (10.5)
	Military	5 (5.3)
	Service worker	4 (4.2)
	Housewife	4 (4.2)
	Student	2 (2.1)
	Worker	9 (9.5)
	Unemployed	2 (2.1)
Age (year)		34.2±11.8
Anxiety score of HAD		10.5±4.5
Depression score of HAD		10.9±4.4

Table 1: Socio Demographic characteristics of the respondents

Hospital Anxiety & Depression	Levels	n (%)
Anxiety (HADS)	Normal	27 (28.4)
	Borderline Abnormal	18 (18.9)
	Abnormal	50 (52.6)
Depression (HADS)	Normal	19 (20)
	Borderline Abnormal	25 (26.3)
	Abnormal	51 (53.7)
PTSD (IES Revised Cut off 33)	Absent	37 (38.9)
	Present	58 (61.1)

Table 2: Anxiety, Depression and PTSD among refugees.

Hospital Anxiety and Depression (HADS)	IES revised cut off 33		OR (95% CI)	'p' value	
	No PTSD	PTSD			
Anxiety	Normal	17 (63.0)	10 (37.0)	-	0.001 (Sig)
	Borderline abnormal	9 (50.0)	9 (50.0)	1.7 (0.43 to 6.82)	
	Abnormal	11 (22.0)	39 (78.0)	6.0 (1.93 to 19.42)	
Depression	Normal	9 (47.4)	10 (52.6)	-	0.649 (NS)
	Borderline abnormal	10 (40.0)	15 (60.0)	1.4 (0.34 to 5.36)	
	Abnormal	18 (35.3)	33 (64.7)	1.7 (0.50 to 5.47)	

Table 3: Association between psychological distress components.

39 participants (41.1%) had both pathologic depression and pathologic anxiety, 30 participants (31.6%) had pathological depression, pathological anxiety, and PTSD.

### Discussion

#### Rational for conducting the study to explore the psychological stresses among refugees

Many studies have demonstrated that political violence, intense conflict or mass displacement can lead to different mental health problems, including PTSD, depression, and anxiety. The WHO, for instance, estimates that almost one-third to one-half of people exposed to political violence will endure some type of mental distress, including PTSD, depression or anxiety (World Health Organization) [2].

Our study revealed an obvious evidence of high levels of psychological disturbance amongst Syrian refugees. A significant number of Syrian refugees score high for anxiety disorder, depressive disorder and post-traumatic stress disorder. Table 2 explains: Anxiety, Depression and PTSD among Refugees.

Up to the investigator knowledge, this is the first study tackling the psychosocial distress of Syrian refugees as a sequel of Syrian conflict.

It is worth mentioning that, the extreme human suffering, such as the expulsion, experience chaos in the country of origin, and a threat to hazardous conditions and life-threatening, may results in a spectrum of mental health problems. The loss of culture and support systems in addition to application process for asylum and detention, are all counted as risk factors [9].

#### Ethno religious and sectarian issues

“Levant” or Bilad al-Sham has been distinguished as a complex

ethnoreligious diverse historical region in the Middle East. Syria is part of a larger region called the "Levant" or Bilad al-Sham (the country on the left). Syria is at the heart of the Levant. Though all the Syrian neighbor countries are from the same ethnoreligious background, i.e. Arabic, mainly Muslim Sunnis (75 percent) and Christians (10 percent), in addition to Alawites (less than 12 percent), Druze (less than 3 percent) and Isma'ilis (1%), they are diverse in their governmental political system and religious sects [32].

Cultural issues were noticed in the refugees inside the refugee camps and outside them. First: Most refugees are able to communicate through Arabic language only, and the Turkish people, including camp administrators, speak Turkish, creating language barriers at times. Second: It is well known that there are cultural differences between how distress is conceptualized and expressed, that is related to Resilience- the successful recovery from or adaptation to adversity [33,34] at the individual or community level is a considerable factor has a strong link to culture and religiosity that play as deterrent reaction to psychological traumas. Third: contrary to the most researcher belief including the author, some theorist speculated that PTSD is a pseudo condition especially in some non-western societies [35].

Although the sample included individuals from a range of refugee populations however, some social difficulties were faced during data collection due to the hectic nature of the living situation and adversity in the tent living with a full of negative emotions, frustrations, full of revenge and anger which resulted in research negligence and indifference hence data missing.

The prevalence of depression was about 52% ( $\pm 2$ ) exceeding other studies where the rate of major depression in settled refugees ranged from 5-50% [9]. It was noted that the prevalence of anxiety very similar (50%).

PTSD was significantly high (64%) in our study as compared to other studies 10-40% [9]. In the present study, we found a statistical significant association between individuals who suffer from PTSD and anxiety, whereas there was no such association between PTSD and depression.

It is worth mentioning that, United Nations stated: "Syrian families have been burned in their homes, people bombed waiting for bread, children tortured, raped and murdered and cities reduced to rubble in Syria's two-year-old war that has sparked a humanitarian catastrophe [8].

This reality led Lynch et al. to ascertain that the Syrian Civil War is the most socially mediated war in history, that means almost every individual touched by the war carries the responsibility to do her / his best effort to speak out to the world and not pass it soundlessly as the previous crime done by the same Syrian regime in Hamah city in 1980s, that new attitude made many people hazard their lives in order to report the humanitarian violation as much as they can, hence risking themselves for more psychological traumas and critical incidents [36]. As a result, one can comfortably assume that victims ordinarily sustained multi traumatic experiences which could be accounting for the higher psychopathology consequences.

### Limitations and future studies

Several limitations to this study should be pointed out:

- This study is a cross-sectional type which prevent from tracing the time effect and influence trauma sequels.

- Sampling (snowball)
- No structured interview was done to clinically validate the questionnaires' findings.
- Other psychopathology could have been present and not investigated.
- Nature of traumatic events and their times were not collected in this study.
- Limited number of females agreed to participate in the study.

In spite of assurance of anonymity and confidentiality people were guarded in their acceptance to get involved in the study, it was noticed that some participants were hesitant to reply due to a fear of political consequences based on their responses. Some of the refugees expressed their concern and suspicion with a sarcastic or humorous undertone. "That might be a detective survey", a refugee stated. This attitude can be explained by the collective load of subconscious insecurity and mistrust, particularly with such participants who came from repressive political system backgrounds.

Lacking freedom of opinion-expression is an obstacle and could be considered as a moderator of the political desirability bias in social sensitive researches like this which needs to be explored tactfully in certain societies [37-44].

### Implications of this study and future research

There are several humanitarian, clinical, and political implications of the finding. This study highlights the importance of mental health services in these refugee camps since the risk of developing psychopathological distress or disorders is high among refugees and victims of political conflict. It assures the necessity of having a specialized team of psychiatrists, psychologist and counselors to cope up with the enormous number of victims in psychosocial crisis intervention training programs.

Further research is required to investigate the independent influence of many other variables with a larger sample, employing stronger randomization methods.

### Conclusion

The political violence and adverse situations in Syria resulted in a high level of psychological trauma. This is represented strongly by the high level of PTSD amongst Syrian refugees in Turkey which requires prompt crisis intervention campaign and urgent psychological support. Further research investigating the issue is required.

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