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Mehmet Karadag, Cem Gokcen, Funda Dandil & Baran Calisgan

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SHORT REPORT



## Our experience with Syrian refugee patients at the child and adolescent psychiatry clinic in Gaziantep, Turkey

Mehmet Karadag, Cem Gokcen, Funda Dandil and Baran Caliskan 

Department of Child and Adolescent Psychiatry, Gaziantep University Faculty of Medicine, Gaziantep, Turkey

### ABSTRACT

Reporting from Turkey's frontier with the civil war in Syria, we examined the demographic characteristics, psychiatric diagnoses and treatments for the Syrian refugee patients who have presented to Gaziantep University, Child and Adolescent Psychiatry Clinic through 2016 and the first half of 2017 retrospectively, having aimed to understand the special characteristics and needs of this novel patient group. Within a year and a half, we evaluated 51 children and adolescents and 25 (51%) had come from refugee camps, where primary healthcare services are available. Twenty-eight patients (54.9%) had special educational needs. Among our patients, there were only 15 (29.4%) girls. After our experience with refugee patients, we conclude that the role of primary healthcare services in reaching psychiatric treatment should be investigated for child refugees that special educational needs of Syrian refugees in Turkey needs urgent attention and that more research is needed to establish whether gender may be a factor in negligence of internalising symptoms by refugee families.

### ARTICLE HISTORY

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### KEYWORDS

Child; mental health services; psychiatry; refugees; Syria; Turkey

### Objective

The civil war in Syria has caused the death and migration of thousands of people since 2012. Over 2,000,000 refugees have arrived in Turkey from the war environment and pressures in Syria. According to the United Nations Refugee Agency, 44.7% of these refugees are below the age of 18 (UNHCHR, 2017). Our province, Gaziantep, as a major urban hub near the Syrian border, is hosting the second largest refugee population among Turkish provinces.

Research has shown that child refugees who have been subjected to persecution are at an increased risk of psychological distress and that the frequency of psychiatric disorders in refugees differ from that of the host country (Bogic, Njoku, & Priebe, 2015; Fazel, Wheeler, & Danesh, 2005). Receiving a psychiatric diagnosis is important for children who have had traumatic experiences since delays in treatment constitute a more severe clinical picture; early intervention with medical treatment, planned special education programmes and social support are essential in reducing the problems that may possibly arise in advanced age (Bhugra et al., 2014; Kirmayer et al., 2011).

With the idea that better understanding of the characteristics of refugee patients who visit child and adolescent psychiatry clinics can lead to improved adaptation to cope with this novel patient group; we examined the demographic characteristics, distribution of psychiatric diagnoses and treatments of the Syrian refugee patients presenting to our clinic within a period of 1 and a half years retrospectively. Reporting from Turkey's frontier with the civil war in Syria, we wanted to summarise our experience with Syrian refugee patients and share our views on how we could better accommodate Syrian refugee patients as child and adolescent psychiatrists.

### Methods

In this study, 51 Syrian refugee children and adolescents between the ages of 3 and 17 who presented to Gaziantep University Faculty of Medicine Department of Child and Adolescent Psychiatry for the first time between 1 January 2016 and 30 June 2017 were evaluated retrospectively. Patients from refugee camps in Gaziantep province were directed to all child and adolescent psychiatry clinics in the province by primary healthcare physicians stationed in the camps, whereas refugees living outside camps could apply themselves or were referred by other physicians for psychiatric evaluation.

All children had been evaluated for an average of 45 minutes with a detailed psychiatric interview. Interviews were made by child and adolescent psychiatrists in the presence of accredited interpreters to translate between Turkish and Arabic when necessary. Demographic data had been taken through interview of the caregivers and recorded. Psychiatric disorders were diagnosed in our clinic and were defined according to DSM-V diagnostic criteria, based on evaluation of symptoms as reported by the caregivers and psychiatric evaluation of children, for children attending school information was also obtained from teachers. The psychiatric diagnoses and the treatment modalities that the patients were started on had been included in the patient files. Descriptive statistics were calculated using SPSS Statistics Version 22.

### Results

From 1 January 2016 to 30 June 2017, a total of 51 Syrian refugee children and adolescents made their first visits to our clinic. Thirty-six were boys (70.6) and 15 were girls (29.4%). The age

range was 3–17 (mean  $9.2 \pm 4.36$ ). 49% ( $n = 25$ ) of the patients were living in refugee camps, while 51% ( $n = 26$ ) were living outside camps. Most of the patients lived as extended families, with 2–12 children, and the mean number of siblings was  $4.3 \pm 2.3$ . Five (9.8%) patients had lost a parent due to the conflict in Syria. The demographic data are shown on Table 1.

Out of 51 patients who presented with various complaints, 47 (92.2%) had a psychiatric diagnosis according to DSM-V diagnostic criteria. Among the patients, attention deficit hyperactivity disorder (ADHD) rate was 33.3% ( $n = 17$ ), whereas that of conduct disorder was 21.6% ( $n = 11$ ) followed by autism spectrum disorder (ASD) (19.6%,  $n = 10$ ), mental retardation (37.3%,  $n = 19$ ), anxiety disorders (11.8%,  $n = 6$ ), post-traumatic stress disorder (PTSD) (19.6%,  $n = 10$ ), major depressive disorder (3.9%,  $n = 2$ ) and psychotic disorder (3.9%,  $n = 2$ ), respectively. Twenty-three patients had comorbid diagnoses (45.1%). The most frequent diagnoses were ADHD (38.9%) followed by mental retardation (33.3%) conduct disorder (22.2%) and PTSD (22.2%) for boys, whereas for girls they were mental retardation (46.7%) followed by ASD (26.7%), ADHD (20.0%) and conduct disorder (20.0%). The distribution of psychiatric diagnoses is shown in Table 2.

Thirty-two of our patients were given medical treatment by our clinic (62.7%). Twenty-eight patients (54.9%) had special educational needs, especially due to mental retardation or ASD.

**Table 1.** Demographic characteristics of Syrian refugee patients who visited Gaziantep University Faculty of Medicine, Child and Adolescent Psychiatry Clinic from 1 January 2016 until 30 June 2017.

	<i>n</i>
Gender	
Girls	15 (29.4%)
Boys	36 (70.6%)
Residence	
Inside refugee camp	26 (51.0%)
Outside refugee camp	25 (49.0%)
Father	
Employed	26 (51.0%)
Unemployed	25 (49.0%)
Deceased	26 (51.0%)
Mother	
Employed	6 (11.8%)
Unemployed	37 (72.5%)
Deceased	3 (5.9%)
	Mean $\pm$ SD
Age	
Girls	$9.6 \pm 4.8$
Boys	$9.1 \pm 4.2$
Number of siblings	$4.3 \pm 2.3$
Father's age	$36.3 \pm 15.1$
Mother's age	$33.2 \pm 12.1$

**Table 2.** Distribution of psychiatric disorders in Syrian refugee patients who visited Gaziantep University Faculty of Medicine, Child and Adolescent Psychiatry Clinic from 1 January 2016 Until 30 June 2017.

	Total ( $n = 51$ )	Boys ( $n = 36$ )	Girls ( $n = 15$ )
Attention deficit hyperactivity disorder	17 (33.3%)	14 (38.9%)	3 (20.0%)
Conduct disorder	11 (21.6%)	8 (22.2%)	3 (20.0%)
Autism spectrum disorder	10 (19.6%)	6 (16.7%)	4 (26.7%)
Mental retardation	19 (37.3%)	12 (33.3%)	7 (46.7%)
Anxiety disorders	6 (11.8%)	4 (11.1%)	2 (13.3%)
Post-traumatic stress disorder	10 (19.6%)	8 (22.2%)	2 (13.3%)
Major depressive disorder	2 (3.9%)	1 (2.8%)	1 (6.7%)
Psychotic disorder	2 (3.9%)	0	2 (13.3%)
No psychiatric disorder	4 (7.8%)	4 (11.1%)	0

## Conclusions

Through 2016 and the first half of 2017, we evaluated a total of 7253 patients in our clinic, out of which 51 (0.7%) were refugees. The ratio of refugee children to the total paediatric population was 20.2% in 2016 for Gaziantep province (Turkish Ministry for Internal Affairs, 2017). This discrepancy may point to limited access or failure to seek help for refugee children with mental health issues.

After a perilous journey, only some refugee families could find accommodation in refugee camps. Due to the limited capacity of the refugee camps against the overwhelming number of refugees, some families had to find accommodation elsewhere, often being forced to join to rent houses. Only 11.0% of Syrian refugees in Gaziantep live within refugee camps (Sandal, Hancerkiran, & Tiras, 2016); however, 51.0% of our patients had come from these camps. We feel this was due to the uninterrupted and easily accessible primary health care services in refugee camps, where psychiatric symptoms could be recognised by primary care physicians and the patients could be directed to child and adolescent psychiatry clinics, yet further research is needed to establish the significant role of ease of access to primary healthcare services in effectively reaching psychiatric treatment.

Twenty-eight refugee patients out of 51 refugee children who applied (54.9%) had special educational needs. The fact that such educational programmes are not yet adequately adapted for Syrian refugee patients in Turkey continues to be a major issue. The mean age of children diagnosed with ASD in our study was 6.5 with a standard deviation of 3.17, yet a diagnosis before three years of age and early intervention with education programmes could have changed the prognosis significantly (Zwaigenbaum et al., 2015). Since educational intervention opportunities are severely lacking for Syrian refugee children with ASD, we feel establishment of such educational services should take priority over means of earlier diagnosis in dealing with this crisis.

The number of refugee girls presenting to our clinic (29.4%) was lower than that of boys. While the most common diagnosis was ADHD (33.3%), as we would have expected, the most frequent diagnosis in girls was mental retardation (46.7%) followed by ASD (26.7%). These differences could be caused by some refugee families possibly ignoring or normalising internalisation problems in girls, which would have been expected to present to a psychiatrist more often (Jones, 1998). Refugee caregivers can often be uncongenial to the post-traumatic psyche of their children, they may fail to seek psychiatric treatment either due to the refugee child's reluctance to express psychological derangement or because of the caregivers' inflexible approach adopted due to their own history of difficulties (Bean, Eurelings-Bontekoe, & Spinhoven, 2007). After our experience with Syrian refugee patients, we believe these factors may be in play especially for girls, however further research with larger sample groups are needed to elucidate the role the child's gender in negligence of psychiatric signs.

We observe that the most important limitation of our study was the small sample group. We also observe that the most powerful aspect of our research is our examination of cases with special attention to refugees. After our experience with Syrian refugee patients in the child and adolescent psychiatry clinic, we conclude that the role of availability of primary healthcare services should be investigated in reaching psychiatric treatment more efficiently for child refugees, that special educational needs of Syrian refugee patients needs urgent attention and that more research is needed to establish whether gender may affect negligence of certain psychiatric signs by refugee families.

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## Compliance with ethical standards

Ethical approval was granted by Gaziantep University Ethics Committee on Clinical Research.

## Disclosure statement

The authors have no conflicts of interest to disclose.

## ORCID

Baran Caliskan  <http://orcid.org/0000-0002-3169-9825>

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