

Are refugees applying to child and adolescent psychiatry departments only to obtain a disability report? The experience of a department in a Turkish city on the Syrian border

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Abstract

Aim: Children and adolescents are the most affected by wars. They are also at higher risk for psychiatric disorders. However, as in all disadvantaged groups, the reasons for applying to psychiatry departments in refugees may differ from the local population. So we aimed to investigate reasons for applying to psychiatry department, the sociodemographic characteristics, presence of psychopathologies, prescriptions and treatment compliance of child and adolescent Syrian refugees.

Materials and Methods: This research comprises an outpatient clinical sample of 400 refugee patients. The data was obtained by retrospectively examining the records of Syrian refugee patients aged between 0 and 18 years old who applied to Mardin State Hospital Child and Adolescent Psychiatry Department between May 2018 and May 2019. The sociodemographic characteristics of the cases, their psychiatric diagnoses according to DSM-5, medicines, and their continuation to psychiatric controls were evaluated.

Results: 59% (235) applied to the department for treatment of psychiatric symptoms and 41% (165) applied to obtain a disability report. The mean age of refugees included in the study was 8.1 ± 4.7 , out of which 231 were boys (58%) and 169 were girls (42%). The two most common diagnoses were Intellectual Disabilities: $n=46$ (19%) and Trauma and Stressor Related Disorders: $n=39$ (17%). Only 27% of patients showed compliance with the offered treatment. The most used medications were antipsychotics (41.17%) and antidepressants (38.16%).

Conclusion: In our sample psychopathology rates were high and treatment compliance was low. In addition, the application rate for the disability report was quite high. As a result protective and therapeutic strategies should be implemented to address these issues and awareness should be increased for psychiatric disorders.

Keywords: Children; refugee; Syria; trauma; treatment compliance

INTRODUCTION

Turkey has been one of the major migration destinations from the first days since the start of the Syrian war. As the violence increased, the migration wave expanded from the west of the Euphrates River to the east. Many Syrian refugees began to live in the southern border cities of Turkey. Only 8 % of Syrian refugees living in border cities such as Kilis, Hatay, Sanliurfa, Gaziantep, and Mardin live at refugee camps and the number of registered refugees has been as high as the number of locals in some Turkish cities (1). Out of 3.5 million refugees currently living in Turkey, nearly half are under 18 years of age (2). For this reason, in organizing refugee mental health programs, studies of children and adolescents are vital.

Refugee adolescents are more likely to be exposed to displacement, violence, and traumatic events than their host country peers. So they have a greater risk for psychological disorders (3). Although they may have arrived in a safer country, apparently, they could not leave all their problems behind. Issues such as discrimination, financial hardships, housing and nutrition, language barriers, social isolation, and peer bullying contribute to the continuation of their psychological stress in the host country (4). It is known that the frequency of psychiatric disorders such as Post-Traumatic Stress Disorder (PTSD), Depressive Disorders, and Anxiety Disorders is increased in studies conducted with refugee children and adolescents (5). Besides, social withdrawal, enuresis, sleep problems, and psychosomatic symptoms are frequently observed in asylum seekers

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children and adolescents (6). Neurodevelopmental psychopathologies also have great importance in the field of child and adolescent mental health and the frequency of these psychopathologies, where both genetic and environmental factors play a role, should be investigated further in refugees (7). Refugee children and adolescents are more vulnerable and have more difficulty in accessing health care, thus they are less likely to receive a psychiatric diagnosis (8). Although some psychiatric disorders occur immediately after the war, many psychiatric disorders appear to occur in later years of migration. For example, Norredam et al. evaluated refugee children who received residence permits in Denmark. In this study, the incidence of psychiatric disorders among children living who have lived there for a considerable period of time was found to be higher than their non-refugee peers (9). In addition, the levels of psychiatric disorders were observed to be higher than the local population during the twenty years after resettlement (10).

Given all these data, there is an urgent need for preventive and therapeutic precautions for the mental health of refugee children and adolescents. In addition, determining the distribution of refugee's psychiatric disorders can guide the scope of these precautions. In this context, the refugee children and adolescents who applied to Mardin State Hospital in Mardin City on the Syrian border between May 2018 and May 2019 were evaluated retrospectively. This study aimed to investigate refugees in the 0 to 18-year-old age range with respect to their sociodemographic data, reasons for applying to psychiatry department, DSM-5 (Diagnostic and Statistical Manual of Mental Disorders-5) psychiatric diagnoses, psychiatric medications prescribed and treatment compliance.

MATERIALS and METHODS

The data was obtained by retrospectively examining the records of Syrian refugee patients aged between 0 and 18 years old who applied to Mardin State Hospital Child and Adolescent Psychiatry Department between May 2018 and May 2019. Mardin State Hospital is a general hospital and it has a child and adolescent outpatient clinic run by the child and adolescent psychiatrists. File screening was performed at least 3 months after the patient's admission to determine treatment compliance. Data collection forms were filled with the information in the hospital records. The data obtained relate to the age of the patients, the major diagnosis according to DSM-5 and the prescribed medications, the number of visits to the clinic, and the department to which the patient presented to first. Interviews with refugees were conducted with interpreters employed by the government who spoke Arabic, Kurdish and Turkish fluently, the patients were diagnosed by child and adolescent psychiatrist in an outpatient setting. Some of the patients applied to the outpatient clinic with a psychiatric complaint to seek treatment, whereas some of the patients applied in order to obtain a disability report, an official document about the level of disability. This report may include neurodevelopmental disorders that are diagnosed by a child and adolescent psychiatrist such

as intellectual disabilities and autism spectrum disorders and is generally used in order to obtain financial aid from the government or non-governmental organizations. This research was conducted on a sample of 400 refugee children and adolescents. The study was approved by Health Sciences University Gazi Yasargil Education and Research Hospital Ethics Committee on 29.03.2019 with decision number 247.

Statistical Analysis

The data obtained from the hospital records were processed with SPSS 22.0 package program and then statistical analysis was conducted. The suitability of the variables to normal distribution was examined using the Kolmogorov-Smirnov test. Mann-Whitney U and Student t-tests were used to compare the scale scores among groups and other categorical variables. Chi-square and Fisher's Exact tests were used to compare qualitative variables. Pearson and Spearman correlation analysis were used to investigate the correlation of scale scores with quantitative data. The statistical significance level was accepted as $p \leq 0.05$.

RESULTS

The mean age of the refugees included in the study was 8.1 ± 4.7 and the gender distribution was as follows: 231 boys (58%) and 169 girls (42%). The mean age for the refugee children presenting for a psychiatric treatment was 8.4 ± 4.5 years, gender distribution being 138 boys (59%), and 97 (41%) girls. On the other hand, the mean age of refugee children who presented to obtain a disability report was 7.6 ± 5.0 , with 93 boys (56%) and 72 girls (44%). A statistically significant difference was not found between these groups in terms of age and gender distributions. Overall, the number of male patients was significantly higher. Other data in the study were collected only from the patients who applied with a psychiatric complaint, in that follow-up and treatment does not apply to patients who presented only to obtain a disability report. If a patient had applied for both psychiatric treatment and disability reports during the study period, they were examined with the treatment group. Child and Adolescent Psychiatry Department was the initial application department for 45% of patients, while 55% had applied to another department initially.

40% (85) of the children and adolescents who had applied for treatment and received a psychiatric diagnosis did not present again. 33% (72) of the patients re-applied for 1 to 3 follow-up visits, whereas 27% (55) had more than 3 follow-up visits. 23 patients did not receive a psychiatric diagnosis; thus, they were not called for follow-up. In the correlation analysis between the number of follow-ups and the age of the patient, the number of follow-ups increased with age ($p < 0.001$; $r = 0.27$). 50% (118) of the patients who presented for psychiatric treatment were not given any psychotropic medication. The most frequently initiated medications were antipsychotics (17%), SSRIs (Selective Serotonin Reuptake Inhibitors) (16%) and psychostimulants (8%). Sociodemographic data and clinical features are shown in detail in Table 1.

Table 1. Sociodemographic and Clinical Features of Refugee Patients

	Refugee Children Presenting for Psychiatric Treatment	Refugee Children Presenting for Disability Report	Total	p values
Age*	8.4±4.5	7.6±5.0	8.1±4.7	p>0.05
Gender				
Male	138 (59%)	93 (56%)	231 (58%)	p>0.05
Female	97 (41%)	72 (44%)	169 (42%)	
Initial Clinical Presentation				
Department of Child and Adolescent Psychiatry	105 (45%)			
Other Departments	130 (55%)			
Number of follow-up visits				
None	85 (40%)			
1-3	72 (33%)			
More than 3	55 (27%)			
Initiated medications				
None	118 (50%)			
SSRIs	38 (16%)			
Antipsychotics	41 (17%)			
Methylphenidate	19 (8%)			
Other	19 (8%)			

*Given in mean ± standard deviation

Table 2. Frequencies of Psychiatric Diagnoses for Child and Adolescent Refugee Patients

	Refugee Children Presenting for Psychiatric Treatment	Refugee Children Presenting for Disability Report	Total
Any Psychiatric Disorder	23 (10%)	58 (34%)	81 (20%)
Intellectual Disabilities	46 (19%)	89 (54%)	135 (34%)
Autism Spectrum Disorder	16 (7%)	15 (9%)	31 (8%)
Attention-Deficit/Hyperactivity Disorder	30 (12%)		30 (7%)
Conduct Disorder	13 (5%)		13 (3%)
Specific Learning Disorder	7 (3%)	1 (1%)	8 (2%)
Motor Disorders	1 (1%)		1 (0.3%)
Schizophrenia Spectrum and Other Psychotic Disorders	1 (1%)		1 (0.3%)
Depressive Disorders	17 (7%)		17 (4%)
Anxiety Disorders	26 (11%)	1 (1%)	27 (7%)
Obsessive-Compulsive and Related Disorders	1 (1%)		1 (0.3%)
Trauma and Stressor Related Disorders	39 (17%)	1 (1%)	40 (10%)
Elimination Disorders	11 (5%)		11 (3%)
Sleep-Wake Disorders	3 (1%)		3 (1%)
Total	235 (100%)	165 (100%)	400 (100%)

Among all the patients, 20% (81) did not receive a psychiatric diagnosis. The most common diagnostic group was Intellectual Disabilities (%34,135). Other diagnoses were Trauma and Stressor Related Disorders: 40 (10%), Autism Spectrum Disorders: 31 (8%), Attention-Deficit/Hyperactivity Disorder: 30 (7%), Anxiety Disorders: 27 (7%), Depressive Disorders: 17 (4%), Conduct Disorder: 13 (3%), Elimination Disorders: 11 (3%), Specific Learning Disorders: 8 (2%), Sleep-Wake Disorders: 3 (1%), Obsessive-Compulsive and Related Disorders: 1 (0.3%),

Motor Disorders: 1 (0.3%) and Psychotic Disorders: 1 (0.3%) respectively.

The diagnostic distribution changed when the refugees were investigated into two groups, those who presented for psychiatric treatment and those who applied for a disability report. The diagnoses in the psychiatric treatment group were 46 (19%) patients with Intellectual Disabilities, 39 (17%) with Trauma and Stressor Related Disorders, 30 (12%) with Attention-Deficit/Hyperactivity Disorder, 26 (11%) with Anxiety Disorders, 17 (7%) with Depressive

Disorders, 16 (7%) with Autism Spectrum Disorders, 13 (5%) with Conduct Disorder, 11 (5%) with Elimination Disorders, 7 (3%) with Specific Learning Disorder and 1 patient each (1%) with Obsessive-Compulsive Disorder, Chronic Tic Disorder, and Schizophrenia. On the other hand, diagnostic variety in the disability report group was lower, with 89 patients (54%) being diagnosed with Intellectual Disabilities, 15 (9%) with Autism Spectrum Disorders and 1 patient (1%) each with Specific Learning Disorder, Major Depressive Disorder and Unspecified Anxiety Disorder. The frequencies of diagnoses have been shown in Table 2. In addition, boys had an openly higher frequency than girls in all psychiatric diagnoses, except for Trauma and Stressor Related Disorders (girls/boys: 1.05) and Anxiety Disorders (girls/boys: 0.85).

Intellectual Disabilities were the most common diagnoses. Regarding the severity level of Intellectual Disabilities, the most common group was Mild (n=65, 69%), followed by Moderate (n=11, 13%), Severe (n=9, 10%) and Profound (n=4, 5%), as shown on Table 3. Also, there was a positive correlation between the severity level of Intellectual Disability and age, as age increased, severity of intellectual disability increased ($p < 0.001$, $\rho = 0.46$).

Table 3. Severity of Intellectual Disabilities in Child and Adolescent Refugee Patients Presenting for Disability Report

Level of Intellectual Disability	
Mild	69 (65%)
Moderate	11 (13%)
Severe	9 (10%)
Profound	4 (5%)
Total	86 (100%)

DISCUSSION

In the literature, this study has the largest clinical sample for child and adolescent psychiatry of Syrian refugee children in Turkey so far. A total of 400 Syrian children and adolescent's patient files were examined. The high frequency of presentations to a state hospital by Syrian refugees within a period of 12 months may have had several causes. The first reason may be that the city of Mardin, where the study was conducted, is on Turkey's border with Syrian. Mardin is one of the first regions where refugees arrived from Syria to Turkey. However, a study conducted in Gaziantep, another Turkish city on the border with Syria reported only 51 refugee children and adolescents within a period of 18 months (11). Another factor may be the increase in demand for disability reports. In two recently published studies in Turkey, there were high rates of Syrian refugee patients who presented to the child and adolescent psychiatry to obtain a disability report (12,13), the study conducted by Uygun et al. had 32% of the patients presenting to obtain a disability report (14), whereas Bilgili et al. reported a rate of 62.5% (13). In our study, this rate was also high (n=165, 41%). The reason for the high rate of disability reports in the study by Bilgili et al. might be that it was conducted in Ankara, the capital city of Turkey. One of the most important reasons

for disability report applications is to facilitate the process of migration to developed countries in addition to reaching social benefits provided for patients with disabilities. Thus the higher rate of disability reports in the capital where consulates are located (14). Refugee children apply for disability reports at a higher rate than local children. In a study examining the reasons for the application of local children in the same region of the country, the most common reason for the application was nervousness and the highest diagnosis was attention deficit hyperactivity disorder (15). In another study was found that only 21.9% of local cases applying to the psychiatry department for obtaining the disability report (16). This rate corresponds to approximately half of our study rates. This difference can be interpreted as that refugees are not aware of psychiatric disorders, but mostly come to psychiatry departments to gain economic privileges.

In our sample, the frequency of boys was higher than that of girls (boys: n=231, 58%, girls: n=169, 42%). Similar findings were obtained in most previous studies (13,17). This difference may be due to the higher frequency of externalizing psychiatric symptoms in boys versus girls and the tendency of girls to go out in public less in Middle Eastern societies and staying home and avoiding a hospital visit even if they have psychological issues (17,18). While 60% of the children and adolescents who came for outpatient psychiatric treatment did present for at least one follow-up visit, 40% did not. The rate decreased to 27% for the third follow-up visit. Most psychiatric disorders tend to have a chronic course (19). In compliance with treatment, the patient is expected to use the given medicines in a complete, timely and recommended manner and to behave in accordance with the recommended behaviors, he/she should not discontinue before the recommended time or to assume that he or she has recovered. The problem of adherence to treatment in chronic diseases impedes successful treatment. The deterioration of disease in patients who do not follow recommendations is inevitable (20). Patients with psychiatric disorders may have lower compliance to treatment due to various reasons such as low education, low socio-cultural level, and stigmatization (21). In addition, it was found that the presence of psychiatric disorders showed a strong negative correlation with treatment compliance (22). In a study by Tel et al. only 35% of patients had regular follow-up visits (23). In our study with refugees, this rate was found lower (27%). The number of studies comparing refugees to the host country population in terms of treatment compliance is very limited. A study showed that pregnant women with psychiatric disorders were found to have higher drop-out rates in women from ethnic minorities (24). Although psychiatric symptoms in minority groups are often more frequent than the general population (25,26), difficulties in accessing health services can cause failure to adapt to treatment programs (27).

In our study, the most common diagnoses were Intellectual Disabilities. This diagnosis is followed by PTSD. In previous literature, Intellectual Disability was the most

common diagnosis for Syrian refugee children within Turkey, in accordance with our study (12,13,28). The most important factor in this high frequency might be that the organizations regulating the migration of refugees to third countries (mostly European countries for refugees residing in Turkey) and those providing financial support give priority to those with disabilities who have medical reports detailing the severity of their disability (14). The fact that externalized psychiatric problems are the most common reason for admission may be an additional reason for Intellectual Disability and the associated symptoms being the most common for refugee children seeking outpatient medical aid (29). Furthermore, another study evaluating the clinical presentation of refugees in the Netherlands found a high rate of Intellectual Disability with a rate of 23% (30).

The frequency of PTSD is very high among refugees (31, 32). A systematic review by Fazel et al. found that the prevalence of PTSD in refugee populations ranged from 7 to 17% (36). In our study, PTSD was the second most common diagnosis with a prevalence of 10% overall and even higher, 17% in the group that presented for psychiatric treatment, these results being consistent with previous studies. Some Turkish studies have shown an even higher incidence (33). The prevalence of PTSD was the highest diagnosis in the refugee group in a study by Pinto et al. (30). However, the frequency of PTSD is lower in studies conducted with refugee groups that have been in the host country for a shorter duration (11,13). The cause of increasing PTSD symptoms with longer duration of stay in the host country may be due to lack of diagnosis shortly after arrival in the host country, but it is a topic that needs to be clarified by methodologically complex studies.

Psychiatric disorders associated with internalizing symptoms such as PTSD and anxiety disorders were more common in girls in our study. This was an expected finding considering that neurodevelopmental and externalizing disorders are more common in boys. Furthermore, the fact that previous literature has shown girls to be more sensitive to traumatic events is in accordance with the findings of our study. There is evidence that girls are more vulnerable to traumatic events (34), are at higher risk for PTSD symptoms due to neurobiological differences, and have more difficulty in coping with PTSD symptoms (35).

In our study, among the refugee children presenting to the child and adolescent psychiatry outpatient clinic, the most frequent severity of Intellectual Disabilities was found to be Mild (65%). This frequency seems to be lower than those reported in previous literature. According to Kaplan and Sadock's Synopsis of Psychiatry, approximately 85% of Intellectual Disability is of Mild severity, whereas 10% is moderate, 3-4% is severe, and 1-2% is very severe (36). We found that the rate of Mild severity was lower in our sample (Moderate: n=11, 13%, Severe: n=9, 10%, Profound: n=4, 5%). Refugees and asylum-seekers are more vulnerable to medical illnesses and also carry a serious risk to mental health (7). Both researches in Turkey and elsewhere have indicated that refugee populations tend to show more severe psychiatric symptoms and disorders than local populations (37).

Psychotropic medication was initiated in 50% of refugee patients who applied to the outpatient clinic. Antipsychotics were used most frequently (17%), closely followed by SSRIs (16%). In previous studies, SSRIs and antipsychotic drugs were the most used among psychotropic medications in refugee patients, like our study. In a study of various ethnic minorities in the Netherlands, minorities were reported to be more likely to be on SSRIs or antipsychotics (38). A review on mental health problems in refugee children recommends SSRIs in treatment of moderate to severe depression accompanying PTSD (39). In another overview article on refugees, antidepressants and antipsychotics are mentioned as pharmacotherapeutic options for refugee populations (40).

LIMITATION

The first limitation of our study was that data relating only to the major diagnoses could be obtained and data relating to psychiatric comorbidities is lacking. In addition, this is a retrospective study where the diagnoses were established by the child and adolescent psychiatrists after an outpatient visit without more objective diagnostic tools such as semi-structured interviews or psychiatric scales and questionnaires. Without such tools, we could not evaluate the symptom intensity for psychiatric disorders either. Finally, our clinical sample of refugee children represents those of a lower socioeconomic status and further studies are needed evaluating the impact of socioeconomic status and regional differences in wider samples.

CONCLUSION

This study has been conducted with a relatively large clinical sample group of refugee children and reveals a general picture of Syrian refugees' mental health status in Turkey. We reveal that Syrian refugee children who applied to the child and adolescent psychiatry outpatient clinic had high rates of psychopathologies and low rates of treatment compliance. Therefore, mental health policies and therapeutic intervention strategies should be developed to address these issues relating to Syrian refugee children and adolescents residing in Turkey. In addition, refugees should be encouraged to apply to psychiatric departments except the disability report by increasing their awareness about psychiatric diseases.

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