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Refugee adolescents' future hopes, stigmatisation and mental health problems

Mülteci ergenlerin gelecek umutları, damgalanmaları ve ruhsal sorunları

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Abstract

Aim: In this study, it is aimed that refugee adolescents' hopes for the future, their stigmatisation status and mental health problems.

Materials and Methods: The research was conducted as descriptive, relational and instrumental. Research sample of the study was refugee adolescents between the ages of 11-18. It was used the Adolescent Information Form, Brief Symptom Inventory, Internalised Stigma Scale for Children and Adolescents and Children's Hope Scale to collect the data. In total, it was excluded 78 refugee adolescents and conducted with 484 refugee adolescents.

Results: It was found that refugee adolescents' mental symptoms (anxiety, depression, hostility, somatisation and negative self) explained 54.6% of the stigmatisation they experienced. In addition, It was determined refugee adolescents' mental problems explained 42.7% of their hope for the future.

Conclusion: It can be said that adolescents' hopes for the future play a mediating role in the relationship between their psychological symptoms and stigma.

Keywords: Stigma; Refugee adolescent; Mental symptoms; Hope.

Öz

Amaç: Bu araştırmada, mülteci ergenlerin geleceğe dair umutları, damgalanma durumları ve ruhsal sağlık sorunlarını belirlemek amaçlanmıştır.

Gereç ve Yöntem: Araştırmanın modeli; tanımlayıcı, ilişkisel ve aracı modeldir. Araştırmanın örneklemini 11-18 yaşları arasında mülteci ergenler oluşturmaktadır. Verilerin toplanmasında Ergen Bilgi Formu, Kısa Semptom Envanteri, Çocuklar ve Ergenler için İçselleştirilmiş Damgalanma Ölçeği ve Çocukların Umut Ölçeğini kullanılmıştır. Toplamda 78 mülteci ergen kapsam dışı bırakılmış ve 484 mülteci ergen ile yürütülmüştür.

Bulgular: Mülteci ergenlerin ruhsal belirtilerinin (anksiyete, depresyon, hostilite, somatizasyon ve olumsuz benlik) yaşadıkları damgalanmalarının %54.6'sını açıkladığı tespit edilmiştir. Ayrıca, mülteci ergenlerin ruhsal sorunlarının geleceğe dair umut düşüncelerinin %42.7'sini açıkladığı belirlenmiştir.

Sonuç: Ergenlerin geleceğe dair umutlarının, yaşadıkları ruhsal semptomları ile damgalanma arasındaki ilişkide aracı rol oynadığı söylenebilir.

Anahtar Kelimeler: Damgalanma; Mülteci ergen; Ruhsal semptomlar; Umut.

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Introduction

Refugee status is defined as "a well-founded fear of being persecuted in the country of nationality for reasons of race, religion, nationality, membership of a particular social group or political opinion".[1] The negative social and psychological effects of migration are more evident for migrant women and children. Child migrants are among the most vulnerable, even after arriving at their destination.[1,2] Because of their dependency, children need support from adults not only for physical resilience but also for psychological and social well-being.[3]

According to UNICEF's September 2016 report, there are approximately 50 million "uprooted children in the world" and 28 million of these children have been forced to leave their homes to seek a safer and better life because of internal or interstate conflict.[4] According to the United Nations report published in 2022, 3.1 million children have fled the violent civil war in Syria and today 6.1 million children are in need of water, food, sanitation, hygiene, health, education and psychological support.[5] Turkey is the country with the largest refugee population in the world, especially since April 2011, hosting an intensive wave of migrants displaced by the war in Syria.[6] Although there are requests for international protection in Turkey from Afghanistan, Iraq, Iran and other countries, the number of individuals under temporary protection is much higher than these applications. According to the report published by the Ministry of Internal Affairs Directorate of Migration Management in 2022, the number of Syrian migrant children between the ages of 0 and 18 is 1,747.67.[7]

Much research in the literature on refugee adolescents mental health has focused on post-trauma stress, anxiety and depression symptoms.[8–10] In a study conducted by Ünver et al. (2021) with 156 refugee adolescents in Turkey between the ages of 7 and 18 years old, it was found that 26.9% of the children complained of attention deficit and hyperactivity disorder, 26.9% complained of post-traumatic stress disorder, 25% complained of major depressive disorder, 23.1% complained of anxiety disorders and 8.3% complained of sexual abuse.[11] In a study of children aged 4-10 years, parents reported that these children showed anxiety and withdrawal (49%), emotional problems (45%), behavioural problems (38%) and symptoms of hyperactivity (20%).[12] However, alienation, marginalisation and isolation of refugees, especially by the society in the countries where they migrate, lead to the concept of stigma. Internalised stigma or self-stigma means that the individual becomes aware of the negative stereotypes in the society and internalizes and accepts them with his/her personal value system and self-perception. As a result of negative consequences such as decreased self-esteem and shame, the individual withdraws from the society.[13] However, high hope levels of individuals protect their mental and physical health, well-being, life satisfaction, motivation and quality of life. On the other hand, low hope levels of individuals decrease their resilience in risky conditions.[14] There should be a shift to a strength-based approach that focuses on resilience. In order for refugee adolescents to overcome internalised stigma, mental health promotion programs should be promoted through communication between clinicians and the community.[2,15]

Refugee experience has a strong psychological impact on adolescents. This study will be the first study in the literature to investigate the relationship between mental symptoms, internalised stigma and hope levels in refugee adolescents. The aim of this study is to examine the mental health problems, stigmatisation and hope for the future of refugee adolescents living in Turkish region and to reveal the mediating role of hope in the relationship between mental health problems and stigmatisation.

Research Questions

Question-1. Is there a mediating effect of hope for the future in the relationship between mental health problems experienced by adolescents and their stigmatization status?

Materials and Methods

Design of the research

It was conducted the research as descriptive, relational and mediator model.

This study was designed as a quantitative study using structural equation modelling to determine the mental health symptoms, stigma and hope levels of refugee adolescents and the relationship between these concepts.[16]

The population of the research and the sample

The study was conducted in the outpatient clinics and clinics of the Department of Paediatrics of Harran University. It was conducted the study with refugee adolescents who were followed up for diagnosis and control purposes in the outpatient clinics of the Department of Pediatrics and who were hospitalised in paediatric clinics for treatment. It was preferred the quota sampling method, which is a non-probability sampling method.[17]

Here, it was conducted the research with refugee adolescents who met the inclusion criteria. The research was conducted between 1 November 2023 and 31 March 2024.

It was reached 562 refugee adolescents in the study. Nine adolescents with Type I diabetes mellitus, fifteen adolescents with heart diseases, seventeen adolescents with epilepsy, fourteen adolescents with cerebral palsy, twelve adolescents were excluded due to lack of parental consent and eleven adolescents dropped out of the study. In total, it was excluded 78 refugee adolescents and conducted with 484 refugee adolescents.

Inclusion criteria

- Being between the ages of 11 and 18,
- Having no communication problems,
- Not having any diagnosed mental and neurological health diseases (Down Syndrome, CP),
- Those without chronic illness
- Agreeing to participate in the study,
- They migrated after the outbreak of the war in Syria in 2011,
- They have lived in Turkey for at least six years.
- Refugee children who can read and write in Turkish
- Refugee children with legal permission from their parents

Exclusion criteria

- Adolescents under 11 years of age,
- Adolescents over 18 years of age,
- Diagnosed with diabetes,
- Diagnosed with Down's syndrome,
- Diagnosed with epilepsy,
- Diagnosed with Cerebral Palsy
- Diagnosed with any heart disease,
- Adolescents who dropped out halfway through the study were excluded.

Data collection tools

Data were collected by using Adolescent Information Form, Brief Symptom Inventory, Internalised Stigma Scale for Children and Adolescents and Children's Hope Scale.

Adolescent information form

The form was created by the researchers by reviewing literature.[11,13] The Refugee Child Monitoring Form consists of questions such as the child's age, gender, educational status, experiencing losses during war and migration, number of losses, separation from family, etc.

Brief symptom inventory – BSE

The original scale was developed by Derogatis (1992).[18] The scale has been adapted to the Turkish population by Şahin et al. (1994).[19] The inventory assesses general psychopathology. The Cronbach alpha of the scale was reported to be between 0.70-0.88. The Brief Symptom Inventory (BSI)SE consists of 53 items. It has five subscales. The scale is made up of five sub-dimensions, including anxiety, depression, negative self, somatisation and hostility.[19] In this research, the Cronbach's alpha coefficient of the scale was found to be 0.94. Permissions were obtained from the people who developed the scale and conducted the validity study.

Internalised stigma scale for children and adolescents (ISSCA)

It is a self-report scale developed to assess the phenomenon of internalised stigma in children and adolescents. Its validity and reliability study was conducted by Çağlayan (2019). The scale consists of 32 items. The items of ISSCA are answered in two different subscales as the thoughts of others (people sub-

dimension) and my own thoughts (me sub-dimension). Each item is evaluated on a Likert-type scale ranging from 1 to 5 (1: I do not believe at all that this thought is true, 5: I strongly believe that this thought is true). Higher values of this scale indicate higher levels of internalised stigma.[20] The Cronbach alpha of the scale was 0.90.The scale had a Cronbach alpha coefficient of 0.91 in this research. Permissions were obtained from the people who developed the scale and conducted the validity study.

Children's hope scale

The Children's Hope Scale (CHS) was developed by Snyder et al. (1997).[21] Turkish validity and reliability study of the scale was conducted by Atik and Kemer. In terms of internal consistency, the Cronbach alpha coefficient was .74 for the overall scale.The scale consists of 6 items and two sub-dimensions: "pathways" and "agency". The scale is scored as "Never=1, Rarely=2, Sometimes=3, Often=4, Most of the time=5 and Always=6" according to Likert-type rating. The scale can range from 6 to 36. [22] The Cronbach alpha coefficient of the scale was found to be 0.74 in this research. Permissions were obtained from the people who developed the scale and conducted the validity study.

Data collection

The research data was collected using face-to-face interviewing in the hospital waiting room. The interviews were conducted by the researcher with refugee adolescents and their families in the appropriate waiting rooms of the outpatient clinic by using face-to-face interview techniques. The data collected from the adolescents hospitalized in the clinic for treatment were obtained by face-to-face interview technique in the periods when adolescents were available in their rooms. Data collection took an average of 30-60 minutes. The researcher was present in the paediatric outpatient clinics five days a week and in the clinic during working hours seven days a week to collect data.

Data analysis

The data were analysed with IBM AMOS V23. Descriptive statistics (number, percentage, standard deviation, minimum and maximum) were used to show socio-demographic data. Compliance with the normal distribution was analysed with the assumption of multiple normality. Relational survey model was used in the design of the study. The reason for using a correlational survey model is to examine the interactions between two or more sets of variables in multiple directions (direct and indirect effects). For this purpose, structural equation modeling is preferred. Therefore, structural equation modeling was used in this research. The maximum likelihood method was used to test the model. In order to test whether the Hope Scale had a mediating role in the relationship between mental health problems and internalised stigma, an analysis based on the bootstrap method was conducted. The mediator model was run with 5000 samples and a confidence level of 95%. Model 4 was used in the analysis and the significance was considered to be $p<0.050$. In structural equation modeling, which shows whether the model established with the factors obtained as a result of the research is verified or not with more than one fit index, all indices are evaluated together instead of a single fit index. The fit indices of the mediator model were acceptable (CMIN/df=3.907; CFI=0.996; GFI=0.979; AGFI= 0.958; NFI=0.994; TLI=0.993; RMSEA= 0.059; SRMR=0.009). Figure 1 about modeling is given below.

Ethical considerations

Ethical approval (23.06.2023-237165) was obtained from Harran University Human and Human Science Ethics Committee. Written informed consent and verbal consent were obtained from the parents of each child. Informed consent and verbal consent were obtained from refugee children. Institutional approval was obtained from the university's department of paediatrics. The research was conducted according to the Declaration of Helsinki principles.

Results

In the study, it was found that 51% (247) of the refugee adolescents were girls, 52% (252) were separated from their families after the war and 56% (271) of them experienced the loss of

one of their family members. It was found that the average age of the adolescents was eleven years and they had an average of eight siblings. We found that each adolescent was separated from his/her family for an average of eight months and had average monthly earnings of $226 (Table 1).

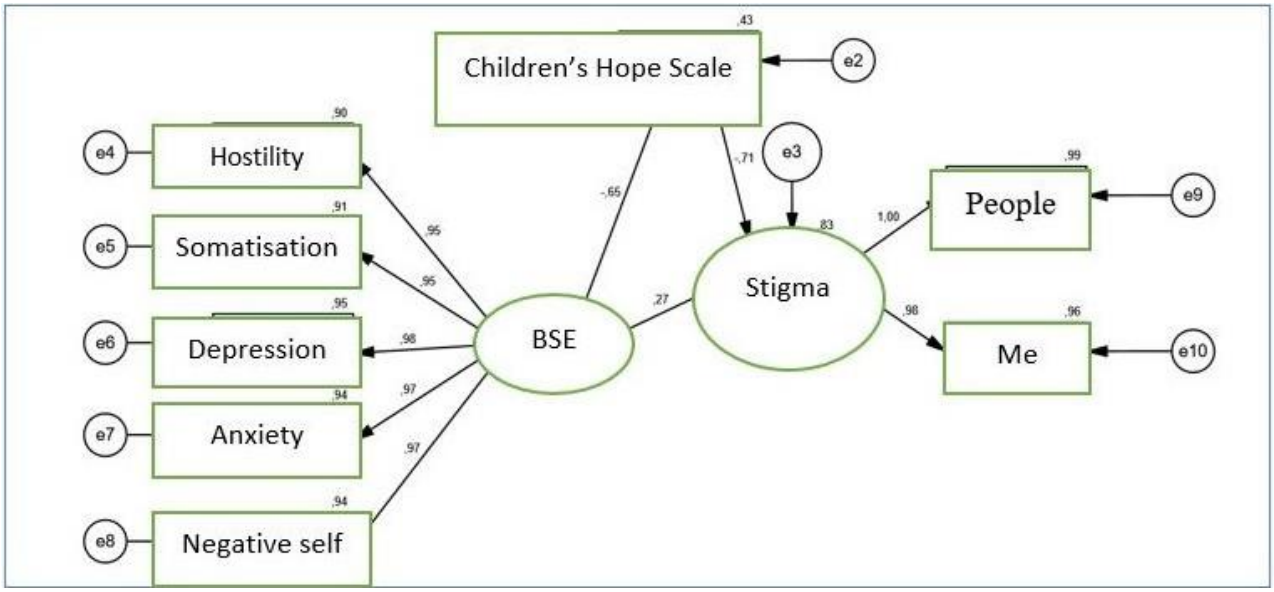

Figure 1. Standardized path coefficients

Table 1. Mean and distribution of demographic characteristics of refugee adolescents

Mean of demographic characteristics	**Mean ± SD**	
Age	11.24 ± 2.67	
Number of siblings	8.65 ± 2.36	
Time separated from the family(Month)	0.80 ± 0.78	
Number of losses	0.50 ± 1.06	
Average monthly income of the family(Dollars)	226.10 ± 0.091	
Distribution of demographic characteristics	**n**	**%**
Gender		
Female	247	51
Male	237	49
The status of being separated from the family		
No	232	48
Yes	252	52
The status of having losses		
No	213	44
Yes	271	56

A one-unit increase in refugee adolescents' mental health problems causes a 1.011-unit decrease in their hope levels(p<0.001) and a 0.840-unit increase in their internalised stigma*(*p<0.001*)*, A one-unit decrease in refugee adolescents hope levels leads to a 1.444-unit increase in their internalised stigma*(*p<0.001*)*. Health problems causes a one-unit increase in somatisation symptoms of refugee adolescents leads to 0.025-unit increase in mental health problems*(*p<0.001*)*. A one-unit increase in depression symptoms leads to 0.027-unit increase in mental health problems *(*p<0.001*)*. A one-unit increase in anxiety symptoms leads to 0.031-unit increase in mental health problems*(*p<0.001*)*. A one-unit increase in refugee adolescents' negative self-perception leads to a 0.027-unit increase in their mental health symptoms *(*p<0.001*)*. A one-unit increase in the people sub-dimension of refugee adolescents leads to a 0.995-unit increase in their internalised stigmatisation *(*p<0.001*)* (Table 2).

In Table 3, the relationship between refugee adolescents' mental health states and internalised stigma and the mediating role of hope between their mental health states and internalised stigma states were examined. According to the results of the analysis, it was found that refugee adolescents mental health

problems predicted their internalised stigma (β= 0.739; p<0.001) and explained 54.6% of their internalised stigma (R^2) (Table 3).

Table 2. Results of the PATH model for refugee adolescents. (n=484)

			β[1]	β[2]	S. error	Test statistics	*p*
Hope	<---	Mental problems	-0.654	-1.011	0.043	-23.682	**<0.001**
Stigma	<---	Hope	-0.714	-1.444	0.039	-36.886	**<0.001**
Stigma	<---	Mental problems	0.269	0.840	0.062	13.641	**<0.001**
Hostility	<---	Mental problems	0.947	1.000			
Somatization	<---	Mental problems	0.952	1.550	0.025	61.013	**<0.001**
Depression	<---	Mental problems	0.976	1.918	0.027	70.178	**<0.001**
Anxiety	<---	Mental problems	0.968	2.051	0.031	66.538	**<0.001**
Negative self	<---	Mental problems	0.971	1.836	0.027	67.944	**<0.001**
People	<---	Stigma	0.996	1.000			
Me	<---	Stigma	0.979	0.995	0.009	116.344	**<0.001**

β[1]: Standardized coefficients, β[2]: Unstandardized coefficients

Table 3. The mediating role of hope scale in the effect of mental problems on stigma

Predictor variables	**Dependent variables**			
	Hope		**Stigma**	
	β (95 CI%)*	**SE**	**β (95% CI)***	**SE**
Mental problems (total effect)			0,739 (0,696; 0,774)	0,020
R^2			0,546	
Mental problems	-0,654 (-0,700; -0,599)[1]	0,026		
R^2	0,427			
Mental problems (indirect effect)			0,269 (0,231; 0,307)[1]	0,019
Hope			-0,714 (-0,747; -0,679)[1]	0,017
R^2			0,832	
Indirect effect			0,467 (0,428; 0,502)	

[1]<0,001; SE Standard Error; β: Standardized coefficients; R^2: Determination coefficient; *Bootstrap effect (95% CI)

In structural equation modelling was constructed in which refugee adolescents hope status was considered as a mediating variable. According to the results of the mediated structural model analysis, refugee adolescents mental health problems predicted their hope status (β=-0,654; p<0.001) and explained 42.7% of their hope status (R^2). It was concluded that the increase in adolescents' mental health problems caused a decrease in their hope status (Table 3).

In the mediator model for refugee adolescents, the effect of hope on the dependent variable internalised stigma was found significant (β=-0.714; p<0.001). It was observed that the path coefficient between mental health problems and internalised stigma became important when the mediating variable hope was included in the model (β=0.269; p<0.001). Mental problems and hope status of refugee adolescents together explain 83.2% of the change (R^2) in internalised stigma. Bootstrap analysis revealed that the indirect effect of refugee adolescents mental health problems on internalised stigma through their hope status was statistically significant (β=0.467; 95% CI [0.428-0.502]) (Table 3).

Discussion

It has been reported that many families and their adolescents have been forced to leave their homes due to the wars and conflicts that have emerged in recent years and are still continuing to do so. Although long years have passed since the forced migration and war, adolescents have continued to experience the effects.

In this study, it was found that hope levels of refugee adolescents were a mediating factor in the relationship between their mental health problems and internalised stigma. It was also found that internalised stigma and mental health problems of adolescents are related to each other and positive expectation for the future is an important trigger in this relationship.

Refugee adolescents and adolescents have to cope with numerous challenges of conflict, displacement, exposure to uncertain life situations and resettlement at the most

important stages of their physical, emotional, social and cognitive development.[10,23] These situations put refugee children and adolescents at high risk for mental health problems.[24,25] As a result of analysis examining the relationship between refugee adolescents mental problems and stigma, it was found that refugee adolescents mental health problems predicted their internalised stigma. Similarly, internalised stigma levels were found to be high among individuals with mental problems in literature [26,27] and it was stated that stigma is associated with psychological phenomena. A meta-analysis and two systematic reviews conducted in this field, which included 127 studies, showed that approximately one quarter of people with mental illness experience internalised stigma.[27,28] Similarly, it has been stated in studies that an increase in the severity of mental health symptoms, including positive, negative and depressive symptoms, is associated with high levels of internalised stigma.[29–31] It can be seen that internalised stigma has been reported to be associated with low self-esteem, low quality of life and low recovery rate, which are the risks faced by refugee children and adolescents.[32,33] It is thought that the ongoing exclusion of refugee adolescents by the society they live in even though many years have passed since the war they have been through causes them to experience mental problems such as anxiety, depression, hostility, negative self-perception and somatisation. It can be seen that the feelings of stigmatisation that adolescents experience by people and themselves are also an effective trigger for mental health problems.

Another important finding of this study is that refugee adolescents' mental health problems predicted their hope status. Factors such as depression, anxiety, somatisation, negative self and hostility experienced after the war were found to be important triggers of adolescents hope status (Table-3). Similarly negative relationship was reported between hope and psychological symptoms.[15,34] Studies examining the relationship between hope and psychological functioning have shown that hope fosters meaning and purpose in life[35], while hopelessness is the main component of depression.[36] It has also been reported to be a determinant for hopelessness, dysfunctional coping, general maladjustment and suicidal ideation.[37] In another study, it was stated that high hope level is a protective factor that increases resilience in terms of psychological symptoms, and being hopeful as a psychological resource or hopelessness when this resource is exhausted is effective on the psychological functioning of individuals.[38,39]

Hope is defined as an important emotion for adolescents in coping, overcoming negativities, and continuing to live under uncertain and stressful life experiences.[40,41] A review of the literature has also found that a sense of hope among adolescents exposed to violence and armed conflict has an important protective and developmental effect on mental health.[42,43] Adolescents who report higher levels of hope have been found to have increased internalising behavioural problems and decreased life satisfaction when faced with negative life events[44] and that the feeling of hope can contribute to the well-being of children in all these negativities.[45,46] Therefore, it can be said that hope is a resilience factor for children and adolescents in the face of psychological problems. While adults may never be able to protect children and teenagers from all the negative events in their lives, these results highlight the importance of providing parents and health professionals with programmes that promote cognitive and motivational skills, like hopeful thinking, to help them cope better with stress.

In this study, the indirect effect of mental problems of refugee adolescents on internalised stigma through hope states was found to be statistically significant (Table 3). When the literature was examined, no studies were found addressing the mediating role of hope status in refugee adolescents with the same or different dimensions. However, research examining the impact of internalised stigma on people with mental illness shows that the experience of internalised stigma leads to a decline in self-concept, hope, self-esteem, social interactions, academic and vocational success, life chances and quality of life.[47] In a qualitative study conducted by Goodman, it was found that one of the factors that sustained Sudanese refugee children living in the United

States without their families after traumatic experiences and difficult processes related to the war was hope.[48] It was also found that the mean hope scale scores of people with high internalised stigma were lower than the mean scores of individuals with low internalised stigma. Also results similar research findings were found between internalised stigma and hope.[49] In a research study of patients with mental health problems, resistance to stigma was found to be associated with higher self-esteem, better quality of life and less depression, which is thought to be associated with hope.[49,50] It can be seen that the increase in the level of hope for the future in adolescents who have experienced war is an important factor in reducing the internalised stigma and mental health problems created in children by the society. In social studies, it is thought that the sense of hope will play a protective role against internalisation and externalisation problems in risky groups such as refugee adolescents. This shows the importance of the feeling of hope especially in adolescents who are victims of war and who have been exposed to numerous traumatic experiences.

Limitations

This study has several limitations. First, the study was cross-sectional and single centered. Second, the findings of the study were obtained from the scales. Third there is no control group in the study to help clarify the role of refugee adolescents' hopes for the future in general between stigmatization and mental symptoms.

Conclusion

As a conclusion, refugee adolescents were found to be at high risk for negative mental health outcomes. In line with the data of this study, four important results were obtained. It was determined that there is a strong relationship between adolescents' mental problems (anxiety, depression, negative self, somatisation and hostility) and stigma and that these affect each other. Also, refugee adolescents' mental problems were effective on stigma through their future hope levels. The most important result is that hope has a mediating role between adolescents' mental health problems and internalised stigma.

Interventions that reduce self-stigmatisation and promote empowerment by the health team working with risky groups can be an important point of focus in ensuring mental well-being.[10] From this point of view, it can be concluded that both intervention programs to change the stigma of the society and intervention plans that address stigma as a part of treatment are needed.

In particular, research on individual and contextual factors that can protect adolescents from negative outcomes and promote psychosocial well-being is of critical importance. Identifying protective and promotive factors in these studies can provide information for interventions that aim to promote positive aspects of mental health and prevent mental health problems.

On the other hand, although hope is included in the literature as a protector and provider of resilience in adolescents exposed to traumatic experiences related to war and migration, it can be seen that many dimensions of hope have not been studied with this group of children and adolescents to the best of our knowledge. In particular, it is essential to protect and develop psychological resilience in refugee adolescents as a growing and uncertain population. On the other hand, in the face of this ongoing uncertainty, especially for Syrian refugee adolescents, it is important and necessary to identify the characteristics, conditions and factors that protect and enhance resilience and to develop protective and preventive interventions.

Ethics Committee Approval

Ethics committee approval number (2023/06-23) of this research was obtained from Harran University. The research was conducted according to the Declaration of Helsinki principles.

Informed Consent

Informed Consent and Parental Consent Forms were obtained from the refugee adolescents participating in the study.

Author Contributions

All authors involved in the study contributed to the article.

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Conflict of Interest

There is no conflict of interest between the authors.

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Externally peer-reviewed.

References

1. Özdemir A, Budak F. Göçün çocuk ruh sağlığı üzerine etkileri. *Kadem Kadın Araştırmaları Derg*. 2017;3(2):212-223.
2. Hacıhasanoğlu A, Yıldırım A. Göçün sosyal ve ruhsal etkileri ve hemşirelik. In: *Göç ve Göçmen Sağlığı*. 1. Baskı. Türkiye Klinikleri; 2018:10-20.
3. Sarvan S, Efe E. Suriyeli Çocuk Mülteciler ve Sorunları. *Balıkesir Sağlık Bilim Derg*. 2020;10(1):55-62.
4. UNICEF. United Nations Children's Fund. 1. Published 2023. https://www.unicef.org/turkiye/basın-bültenleri/türkiye-ve-suriyeyi-etkileyen-ölümcül-depremlerin-üzerinden-bir-ay-geçti-ve-hala
5. UN. United Nations. 1. Published 2023. https://news.un.org/en/focus/syria
6. UNHCR. United Nations Refugee Agency. 1. Published 2023. https://donate.unhcr.org/int/en/turkiye-syria-earthquake-emergency#_ga=2.163563256.550622083.1679034707-1111216869.1669789907
7. GİGM. İçişleri Bakanlığı Göç İdaresi Başkanlığı. 1. Published 2023. https://www.goc.gov.tr/gecici-koruma5638
8. Dangmann C, Dybdahl R, Solberg Ø. Mental health in refugee children. *Curr Opin Psychol*. 2022;48:101460. doi:10.1016/j.copsyc.2022.101460
9. Solmaz F, Karataş H, Kandemir H, Solmaz A. Depression, loneliness and factors influencing in Syrian refugee children. *Int J Clin Pract*. 2021;75(5). doi:10.1111/ijcp.14039
10. Demirbaş H, Bekaroğlu E. Evden Uzakta Olmak: Sığınmacıların/Mültecilerin Psikolojik Sorunları ve Alınacak Önlemler. *Kriz Derg*. 2013;21((1-2-3)):11-24.
11. Ünver H, Çeri V, Poyraz Findik OT, Rodopman Arman A. 3-year data of the refugee child mental health unit (tur). *J Clin Psychiatry*. 2021;24(1):15-22. doi:10.5505/kpd.2020.57614
12. Selcuk R, Sirin LR. *The Educational and Mental Health Needs of Syrian Refugee Children: Young Children in Refugee Families*. DC: Migration Policy Institute.; 2015. https://www.migrationpolicyinstitute-europe.com/sites/default/files/publications/FCD-Sirin-Rogers-FINAL.pdf
13. Koç A, Tok H. Does the relationship between internalized stigmatization, perceived social support and dependence dimensions change by preference substance? *Anatol J Psychiatry*. 2020;21:1. doi:10.5455/apd.91431
14. Cihanyurdu İ, İlbasmış Ç, Toksoy Aksoy A, Ünver H, Rodopman Arman A. The Anxiety and Hope Levels of Adolescents for the Future in the COVID-19 Outbreak. *Turkish J Child Adolesc Ment Heal*. 2021;28(1):19-26. doi:10.4274/tjcamh.galenos.2020.68552
15. Dehnel R, Dalky H, Sudarsan S, Al-Delaimy WK. Resilience and Mental Health Among Syrian Refugee Children in Jordan. *J Immigr Minor Heal*. 2022;24(2):420-429. doi:10.1007/s10903-021-01180-0
16. Karasar N. *Bilimsel Araştırma Yöntemi: Kavramlar İlkeler Teknikler*. 32nd ed. Nobel Akademik Yayıncılık; 2017.
17. Kilic S. Sampling methods. *J Mood Disord*. 2013;3(1):44. doi:10.5455/jmood.20130325011730
18. Derogatis L. Clearly Confirmation of The Dimensional Structure of The SCL–90: A Study in Construct Validation. *J Clin Psychol*. 1997;33:981-989.
19. Şahin HN, Uğurtaş S. Kisa Semptom Envanteri (Brief Symptom Invetory-BSI): Turk Gencleri Icin Uyarlanmasi. *Türk Psikol Derg*. 1994;9(34):44-56.
20. Çağlayan İ. *Dikkat Eksikliği Ve Hiperaktivite Bozukluğu Tanısı Almış Çocuk Ve Ergenlerde İçselleştirilmiş Damgalanmanın Benlik Saygısı, Umut Ve Depresyon İle İlişkisi*. Hacettepe Üniversitesi; 2019.
21. Snyder CR, Hoza B, Pelham WE, et al. The Development and Validation of the Children's Hope Scale. *J Pediatr Psychol*. 1997;22(3):399-421. doi:10.1093/jpepsy/22.3.399
22. Atik G, Kemer G. Çocuklarda Umut Ölçeği'nin Psikometrik Özellikleri: Geçerlik ve Güvenirlik Çalışması. *İlköğretim Online*. 2009;8(2):379-390.
23. Reed R V, Fazel M, Jones L, Panter-Brick C, Stein A. Mental health of displaced and refugee children resettled in low-income and middle-income countries: risk and protective factors. *Lancet*. 2012;379(9812):250-265. doi:10.1016/S0140-6736(11)60050-0
24. Barenbaum J, Ruchkin V, Schwab-Stone M. The psychosocial aspects of children exposed to war: practice and policy initiatives. *J Child Psychol Psychiatry*. 2004;45(1):41-62. doi:10.1046/j.0021-9630.2003.00304.x
25. Mels C, Derluyn I, Broekaert E, Rosseel Y. The psychological impact of forced displacement and related risk factors on Eastern Congolese adolescents affected by war. *J Child Psychol Psychiatry*. 2010;51(10):1096-1104. doi:10.1111/j.1469-7610.2010.02241.x
26. Werner P, Aviv A, Barak Y. Self-stigma, self-esteem and age in persons with schizophrenia. *Int Psychogeriatrics*. 2008;20(1):174-187. doi:10.1017/S1041610207005340
27. Brohan E, Elgie R, Sartorius N, Thornicroft G. Self-stigma, empowerment and perceived discrimination among people with schizophrenia in 14 European countries: The GAMIAN-Europe study. *Schizophr Res*. 2010;122(1-3):232-238. doi:10.1016/j.schres.2010.02.1065
28. Boyd CA, Quigley MA, Brocklehurst P. Donor breast milk versus infant formula for preterm infants: systematic review and meta-analysis. *Arch Dis Child - Fetal Neonatal Ed*. 2007;92(3):F169-F175. doi:10.1136/adc.2005.089490
29. Livingston JD, Boyd JE. Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Soc Sci Med*. 2010;71(12):2150-2161. doi:10.1016/j.socscimed.2010.09.030
30. Krajewski C, Burazeri G, Brand H. Self-stigma, perceived discrimination and empowerment among people with a mental illness in six countries: Pan European stigma study. *Psychiatry Res*. 2013;210(3):1136-1146. doi:10.1016/j.psychres.2013.08.013
31. Corrigan PW, Larson JE, Rüsch N. Self-stigma and the "why try" effect: impact on life goals and evidence-based practices. *World Psychiatry*. 2009;8(2):75-81. doi:10.1002/j.2051-5545.2009.tb00218.x
32. Chan RCH, Mak WWS, Lam MYY. Self-stigma and empowerment as mediating mechanisms between ingroup perceptions and recovery among people with mental illness. *Stigma Heal*. 2018;3(3):283-293. doi:10.1037/sah0000100
33. Vogel DL, Wade NG, Hackler AH. Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *J Couns Psychol*. 2007;54(1):40-50. doi:10.1037/0022-0167.54.1.40
34. Bekiroğlu S. Türkiye'de Mülteci ve Sığınmacı Ağır Ruhsal Hastalığa Sahip Birey Olmak. *Tıbbi Sos Hizmet Derg*. 2019;0(13):56-69.
35. Varahrami A, Arnau RC, Rosen DH, Mascaro N. The Relationships between meaning, hope, and psychological development. *Int J Exist Psychol Psychother*. 2010;3(1):1.
36. Chang EC. A Critical Appraisal and Extension of Hope Theory In Middle-Aged Men and Women: is it Important to Distinguish Agency and Pathways Components? *J Soc Clin Psychol*.

2003;22(2):121-143. doi:10.1521/jscp.22.2.121.22876
37. Yalçındağ B, Kahya Y. Psikolojik Belirti ve Duygulanımda Özgün Yönelim, Umut ve Canlılığın Rolü: Bir Klinik Örneklem İncelemesi. *Türk Psikol Derg*. 2019;34(84):93-106.
38. Chang EC, DeSimone SL. The Influence of Hope on Appraisals, Coping, and Dysphoria: A Test of Hope Theory. *J Soc Clin Psychol*. 2001;20(2):117-129. doi:10.1521/jscp.20.2.117.22262
39. Eggerman M, Panter-Brick C. Suffering, hope, and entrapment: Resilience and cultural values in Afghanistan. *Soc Sci Med*. 2010;71(1):71-83. doi:10.1016/j.socscimed.2010.03.023
40. Snyder CR. The Past and Possible Futures of Hope. *J Soc Clin Psychol*. 2000;19(1):11-28. doi:10.1521/jscp.2000.19.1.11
41. Valle MF, Huebner ES, Suldo SM. An analysis of hope as a psychological strength. *J Sch Psychol*. 2006;44(5):393-406. doi:10.1016/j.jsp.2006.03.005
42. Perry BM, Taylor D, Shaw SK. "You've got to have a positive state of mind": An interpretative phenomenological analysis of hope and first episode psychosis. *J Ment Heal*. 2007;16(6):781-793. doi:10.1080/09638230701496360
43. Ridgway P. ReStorying psychiatric disability: Learning from first person recovery narratives. *Psychiatr Rehabil J*. 2001;24(4):335-343. doi:10.1037/h0095071
44. Edwards LM, Lopez SJ. Making hope happen for kids. *Unpubl Protoc*. Published online 2000.
45. Betancourt TS. Stressors, Supports and the Social Ecology of Displacement: Psychosocial Dimensions of an Emergency Education Program for Chechen Adolescents Displaced in Ingushetia, Russia. *Cult Med Psychiatry*. 2005;29(3):309-340. doi:10.1007/s11013-005-9170-9
46. Green S, Grant AM, Rynsaardt J. Evidence-Based Life Coaching for Senior High School Students. In: *Coaching Researched*. Wiley; 2020:257-268. doi:10.1002/9781119656913.ch13
47. Anand T, Kandasamy A, Suman L. Self-stigma, hope for future, and recovery: An exploratory study of men with early-onset substance use disorder. *Ind Psychiatry J*. 2022;31(2):299. doi:10.4103/ipj.ipj_52_21
48. Goodman JH. Coping With Trauma and Hardship Among Unaccompanied Refugee Youths From Sudan. *Qual Health Res*. 2004;14(9):1177-1196. doi:10.1177/1049732304265923
49. Hellman CM, Gwinn C. Camp HOPE as an Intervention for Children Exposed to Domestic Violence: A Program Evaluation of Hope, and Strength of Character. *Child Adolesc Soc Work J*. 2017;34(3):269-276. doi:10.1007/s10560-016-0460-6
50. Raij TT, Korkeila J, Joutsenniemi K, Saarni SI, Riekki TJJ. Association of stigma resistance with emotion regulation — Functional magnetic resonance imaging and neuropsychological findings. *Compr Psychiatry*. 2014;55(3):727-735. doi:10.1016/j.comppsych.2013.10.010