THE INVESTIGATION OF ATTACHMENT STYLES, RESILIENCE AND POSTTRAUMATIC STRESS DISORDER IN SYRIAN REFUGEES IN TURKEY

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SEPTEMBER 2021

THE INVESTIGATION OF ATTACHMENT STYLES, RESILIENCE AND POSTTRAUMATIC STRESS DISORDER IN SYRIAN REFUGEES IN TURKEY

A THESIS SUBMITTED TO THE
GRADUATE SCHOOL
OF
BAHÇEŞEHİR UNIVERSITY

BY

FATEMA ASAAD

IN PARTIAL FULLFILMENT OF THE REQUIREMENTS
FOR
THE DEGREE OF MASTER OF ARTS
IN THE DEPARTMENT OF GUIDANCE AND PSYCHOLOGICAL COUNSELING

SEPTEMBER 2021

BAHÇEŞEHİR ÜNİVERSİTESİ
LİSANSÜSTÜ EĞİTİM ENSTİTÜSÜ

22/ 09 /2021

YÜKSEK LİSANS TEZ ONAY FORMU

Program Adı:	Guidance and Psychological Counseling
Öğrencinin Adı Soyadı:	Fatema Asaad
Tezin Adı:	THE INVESTIGATION OF ATTACHMENT STYLES, RESILIENCE AND POSTTRAUMATIC STRESS DISORDER IN SYRIAN REFUGEES IN TURKEY
Tez Savunma Tarihi:	14.09.2021

Bu tezin Yüksek Lisans tezi olarak gerekli şartları yerine getirmiş olduğu Lisansüstü Eğitim Enstitüsü tarafından onaylanmıştır.

Prof. Dr. Fatma ÖZKUL
Enstitü Müdürü

Bu Tez tarafımızca okunmuş, nitelik ve içerik açısından bir Yüksek Lisans tezi olarak yeterli görülmüş ve kabul edilmiştir.

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ABSTRACT

THE INVESTIGATION OF ATTACHMENT STYLES, RESILIENCE AND POSTTRAUMATIC STRESS DISORDER IN SYRIAN REFUGEES IN TURKEY

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Master's Thesis, Master's Program in Psychological Counseling and Guidance

Supervisor: Dr. Berna Güloğlu

September 2021, 119 Pages

In this thesis, the relationships between attachment styles, resilience and posttraumatic stress disorder in Syrian refugees in Turkey were examined. The study sample consisted of 595 (321 females, 274 male) Syrian refugees above the age of 18 who came to Turkey after the start of war in Syria at 2011. Yarmouk Scale of Adult Attachment Styles (Y-SAAS), Connor-Davidson Resilience Scale 25 (CD-RISC-25), and Davidson Trauma Scale (DTS) was utilized to collect data. One-way ANOVA test, independent sample t-test, Pearson correlation and multiple linear regression analysis were performed to examine the research questions. Statistically significant relationship between resilience, avoidant attachment, anxious attachment and secure attachment and PTSD was found. PTSD was examined according to some personal variables of refugees such as gender, marital status, income level, occupational status, time of living in Turkey and age. Accordingly, it was found that level of PTSD did not make a significant difference in terms of gender and duration of living in Turkey. However, married refugees compared to singles were significantly lower in PTSD; And working refugees scored significantly lower in PTSD than nonworking ones. Besides, PTSD differed significantly according to the age of refugees; Where those with younger ages exhibited higher levels of PTSD than elder one. The results regression analysis revealed that resilience, avoidant attachment, anxious attachment and secure attachment significantly predicted PTSD; Where 23% of the variance in the PTSD variable was explained by the changes of resilience, avoidant

attachment, anxious attachment, and secure attachment.

Keywords: Attachment Styles, Resilience, Posttraumatic Stress Disorder (PTSD), Refugee

ÖZ

TÜRKİYE'DEKİ SURİYELİ MÜLTECİLERDE BAGLANMA STİLLERİ, PSİKOLOJİK SAĞLAMLIK VE TRAVMA SONRASI STRES BOZUKLUĞUNUN İNCELENMESİ

Asaad, Fatema
Yüksek Lisans Tezi, Psikolojik Danışmanlık ve Rehberlik Yüksek Lisans Programı
Danışman: Dr. Berna Güloğlu

Eylül 2021, 119 Sayfa

Bu tezde Türkiye'deki Suriyeli sığınmacılarda bağlanma stilleri, dayanıklılık ve travma sonrası stres bozukluğu arasındaki ilişki incelenmiştir. Araştırmanın örneklemini 2011 yılında Suriye'de başlayan savaşın ardından Türkiye'ye gelen 18 yaş üstü 595 (321 Kadın, 274 Erkek) Suriyeli birey oluşturmaktadır. Veri toplamak amacıyla Yarmuk Yetişkin Bağlanma Stilleri Ölçeği (Y-SAAS), Connor-Davidson dayanıklılık Ölçeği (CD-RISC-25) ve Davidson Travma Ölçeği (DTS) uygulanılmıştır. Araştırma sorularını incelemek için tek yönlü ANOVA testi, bağımsız örneklem t testi, Pearson korelasyonu ve çoklu doğrusal regresyon analizi yapılmıştır. Psikolojik sağlamlık, kaçınmacı bağlanma, kaygılı bağlanma ve güvenli bağlanma ile TSSB arasında istatistiksel olarak anlamlı ilişki bulunmuştur. TSSB, mültecilerin cinsiyet, medeni durum, gelir düzeyi, mesleki durum, Türkiye'de yaşama süresi ve yaş gibi bazı demografik değişkenlerine göre incelenmiştir. Buna göre TSSB düzeyinin erkekler ve kadınlar arasında anlamlı bir fark yaratmadığı ve Türkiye'de yaşam süresine göre farklılık göstermediği bulunmuştur. Ancak, evli mültecilerin TSSB düzeyi bekarlara kıyasla daha düşüktür. Ayrıca, çalışan mülteciler çalışmayanlara göre TSSB'de önemli ölçüde daha düşük puan almıştır. Ayrıca TSSB düzeyi mültecilerin yaşına göre anlamlı bir farklılık göstermektedir. Daha genç yaşta olanlar, yaşlılardan daha yüksek TSSB düzeyine sahiptir. Çoklu regresyon analizi sonuçları psikolojik sağlamlık, kaçınmacı bağlanma, kaygılı bağlanma ve güvenli

bağlanmanın TSSB'yi anlamlı düzeyde yordadığına işaret etmektedir. TSSB değişkenindeki varyansın %23'ü psikolojik sağlamlık, kaçınmacı bağlanma, kaygılı bağlanma ve güvenli bağlanmadaki değişikliklerle açıklanmaktadır.

Anahtar Kelimeler: Bağlanma Stilleri, Psikolojik sağlamlık, Travma Sonrası Stres Bozukluğu (TSSB), Mülteci

To the soul of my beloved brother “Mohammed”.

To my future children and friends.

To all of war survivors around the world

ACKNOWLEDGMENTS

Firstly, I want to thank my advisor Doç. Dr. Berna Güloğlu. It has been an honor for me to be your student. I appreciate all of your contributions of time, ideas, and guidance to make this research experience productive and motivating. I am grateful for your patience, and thankful for the good example you provided for me as a successful professor.

As well as, I'd like to express my gratitude to my dearest professor and supporter, Doç. Dr. Zeynep Ceren Acartürk, for being a wonderful role model and exceptional teacher. Besides, I would like to thank my beloved teacher Prof. Dr. Bilge Uzun for her honorable support and guidance.

Beyond that, I would like to thank my entire family (my parents Iman and Asaad, my beloved brother Mohammed, my supportive sister Rasha and her husband Hicham, my dear husband Ahmad and my second family in low); Big thanks and gratitude from all of my heart, I will forever be grateful for you.

Without my father, my thesis would not be achievable. Since the day I was born, you have placed me in the center of your heart. I can't express my gratitude enough for the time, effort, support, and unconditional love you've shown me over the last 28 years. Thank you for always being there to raise my spirits whenever I needed encouragement or motivation. You were always there for me, even though I was miles away. This thesis would never have been possible without your unwavering love, support, and encouragement. You're my greatest inspiration, my biggest supporter, and my dearest beloved. Dad, you are my Hero and I’m so proud to be your daughter.

I would next like to thank my beloved companion and life partner Ahmad Şeyhoğlu who supported me in every possible mean throughout my master studies and was the most important factor in the timely delivery of this thesis. You have always encouraged me, showered me with your patience, generosity and love. I can’t thank you enough for everything you have done. I love you from all of my heart.

Besides, I would like to thank Asil Vakfi, their administration and members for believing

in me and my dream and for their generous support and assistance. Without your help, this master journey wasn’t possible; Thank you.

In addition, I'd would really like to express my love and appreciation to Danya Vahud, Dalia Karataştan, and Alaa Arar, my dearest companions who have always been by my side, providing me with support, love, and compassion. Similarly, my friend Melek Merve Erklnç for her assistance in completing my thesis; and my esteemed teacher Mustafa Deniz for his contributions to my thesis research.

Lastly, I would like to thank every caregiver, family member, teacher, friend, patient, honest critic and anyone who I have crossed paths with at my journey of lifelong learning. You have made my life so worthwhile and I can't express how much of an influence you've had on me in the course of learning about human beings.

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LIST OF ABBREVIATIONS

ANOVA	Analysis Of Variance
APA	American Psychological Association
DSM	Diagnostic And Statistical Manual Of Mental Disorders
DSM	Diagnostic And Statistical Manual Of Mental Disorders
IOM	International Organization For Migration
IV	Fourth
PTG	Post-Traumatic Growth
PTSD	Post-Traumatic Stress Disorder
SOHR	Syrian Observatory For Human Rights
TL	Turkish Lira
UNHCR	United Nations High Commissioner For Refugees
V	Fifth
VIF	Variance Inflation Factor

LIST OF SYMBOLS

% - Percentage

B - Unstandardized Beta *SE* - Standard Error

df - Degrees of Freedom

F - *F* Ratio

M - Mean

Max. - Sample Maximum

Min. - Sample Minimum

MS - Mean Square

n - Sample Size

*R*2 - R-Squared Statistic β - Standardized Beta

SD - Standard Deviation

SEM - Standard Error of the Mean

SS - Sum of Squares

Chapter 1

Introduction

1.1 Statement of the Problem

Traumatic events have different effects on human's lives in person and in general. Trauma is constituted from unexpected incidents that scare the individual, produce a sense of terror and powerlessness, and result in the death or injury of the person or a family member (Harvey, 1996). The traumatic event causes a great shock to the person, makes the person feel helpless and powerless, and has such a great effect that it disrupts the coping mechanisms of the person (Öztürk, 2017). Individuals with a history of trauma have more struggle with emotion-focused coping and impulsive behavior, have a feelings of low level of self-esteem, are more susceptible to high risk actions, and suffer more on a professional and personal aspect of their lives (Amatya & Barzman, 2012; Kalmakis & Chandler, 2014; McDonald et al., 2014; Wamser-Nanney & Vandenberg, 2013). Moreover, traumas are linked to a broad variety of dysfunctional activities, including violence, inattention or hyperactivity, non-suicidal self-injury, drug abuse, and juvenile behaviors (Auerbach et al., 2014; Dierkhising et al., 2013; Dube, Dong, Chapman, Giles, Anda, & Felitti, 2003; Gregorowski & Seedat, 2013; Krupnick et al., 2004; Robertson & Burton, 2010; Smith & Saldana, 2013).

According to John Steinbeck "All war is a symptom of man's failure as a thinking animal". Whereas for Janet Morris wars don't provide long-term peace; they only bring long-term death. In fact, in a research carried by Varlk (2013) on the definition of "War", the features of war were expressed as the following: 1) It is the application of force. 2) Hostility in attitude and character of conduct. 3) It has a legal aspect to it. 4) The state is to blame. Therefore, according to the previously mentioned essential qualities, "war" was defined as a hostile motive and/or action taken out by nations or groups of countries via the use of all or part of the public power elements, acknowledged by the participants as having a war nature, including any use of violence (Aksoy, 2012). Based on the nature of

war, many undesirable phenomena are created as a result of different kinds of wars such as "immigration, refugee, asylum seeker, and displacement".

In the same context, “migration” is described as a temporary or long-term shift of location done by individuals for cultural, economic, social, or political reasons, under the conditions of compulsion or voluntarism. In terms of political and administrative limitations, the phenomena of migration can take on several meanings (Aksoy, 2012). At the same time “Forced Migration” is a term used by social analysts to describe people who are forced to leave their country's boundaries against their will due to natural catastrophes, starvation, conflict, or war. However, as a legal notion, the use of the term "forced migration" is avoided.

In order to avoid misunderstanding while dealing with other displaced individuals, the United Nations High Commissioner for Refugees (UNHCR, 2016) uses the word "refugee" rather than "forced migration." Because refugees are people who have been subjected to violence, wars, or attacks and have requested 'international protection' in their place of destination or in other nations in the event of major societal disruptions. Because it is extremely risky for refugees to return to their nation, they are given the status of "refugee" and placed under UNHCR protection.

According to the UNHCR (2016), since March 2011, 5.6 million Syrian citizens have been forced to flee their country and 6.6 million have become internally displaced as a result of the Syrian conflict. Many nations have taken in Syrian refugees, with Turkey hosting the largest number Lately, according to the UNHCR statistical reports (2021), the number of Syrian refugees hosted on the Turkish land has reached over 3,672,646 refugee which is considered 65% of the total number of refugees hosted in the neighboring countries of Syria. While Lebanon hosted 15% of Syrian refugees, Jordan have hosted 11.9%; And the rest of refugees separated into Iraq, Egypt and other North African countries.

According to Mekky (2016), war has always been one of the main causes of migration and displacement. Many Syrian refugees have experienced displacement more than once (Daraji, 2016). When forcibly displaced persons arrive in the country of asylum, they are often faced with poverty, insecure housing, unemployment, migration from one neighborhood to another with environmental changes, isolation, stressful legal issues,

poor access to services, and general vulnerability in the country of origin; All of these are stressing factors that negatively affect mental health (Porter and Haslam, 2005; Morgan et al., 2017; Miler and Rasmussen, 2017).

However, even if the refugees are brought into protective custody, they will face major health difficulties in the nation to which they are sent. They are among the most vulnerable groups, as people are in a state of despair as a result of war's conflicts and horrific acts, fleeing their own countries, undergoing the most dramatic of migrations, and becoming asylum seekers and refugees (Turkish Medical Association Report, 2016). As a result of having to flee their homes, it was considered that most refugees are traumatized and susceptible to traumatic symptoms (Ai, Peterson, & Ubelhor, 2002).

In the same context, Syrian refugees are a high-risk population in terms of mental disorders, according to studies undertaken in several countries involving Syrian refugees (Acartürk et al., 2017; Chung et al., 2018; Tinghög et al., 2017). Depression was found to be the most common mental condition among Syrian refugees in Sweden, with a rate of 40.2%, followed by low subjective well-being with 37.7%, anxiety with 31.8%, and PTSD with 29.9% (Tinghög et al., 2017). According to the few research on Syrian refugees in the literature, the rate of PTSD ranges from 27.2 percent to 83.4 percent (Acartürk et al., 2017). Another research of Syrian refugees in Sweden and Turkey indicated that Syrian refugees in Turkey had greater trauma characteristics and PTSD levels than Syrian refugees in Sweden (Chung et al, 2018).

Post-Traumatic Stress Disorder (PTSD) is considered as a disorder in which a person experiences fear, panic, or helplessness as a consequence of an occurrence in which they believe their life, bodily integrity, or safety is in peril (Harvey, 1996).

Looking at the risk factors leading to high susceptibility to developing PTSD, a meta-analysis study by Brewin, Andrews, and Valentine (2000) has indicated that the individual's gender, ethnicity, personality traits, low education level, low financial income, traumatic experiences in his past life, whether there is a psychiatric illness in his family, the severity of the trauma, the timing of trauma, resolution, traumatic memory emission, perceived life-threatening danger, lack or low social support, post-traumatic distress were found to be important risk factors for the development of PTSD. This is also

supported by another study that indicated that the severity levels of PTSD vary a lot depending on the variables level of trauma exposure, the time of onset, the amount of traumatization and the damage and negative effect of trauma on life (Noyes, 1998).

However, trauma is not caused by all situations that produce discomfort and suffering in a person's life. For example, when a relative who has battled the cancer for years dies, the likelihood of trauma is minimal. Nevertheless, losing a relative suddenly and without warning has greater painful consequences (Turkish Psychiatry Association, 2017). Therefore, painful life circumstances may not necessarily have severe psychological reactions; on the reverse, traumatic experiences can lead to beneficial consequences such as post-traumatic growth and resilience within the individual (Linley & Joseph, 2004).

Therefore, in the present time, instead of focusing on the reasons that cause PTSD, new research has concentrated on the protective factors of PTSD in order to develop more effective therapies that diminish the effects of trauma. In this context, resilience and attachment styles have gained prominence as a means of achieving good change in one's life following traumatic circumstances (Hall et al, 2008).

Traumatic event experiences are predicted to have an impact on a person's functioning and quality of life. As a result, anyone might be injured. However, when stressors reach the point of causing trauma or endangering a person's life, resilience shows that the individual will recover (Gizir, 2006). To develop resilience, an individual must be subjected to adversity or risk, and as a result of this exposure, adjust to the present circumstance, overcome challenges in various areas of life, and achieve success despite the traumatic circumstances (Bonanno, 2008). Resilience encompasses the ability to survive after hardship and adversity, or to lead a purposeful life after experiencing hardship and adversity (Thabet, 2017). In particular, resilience was known as the capacity of a person to adjust swiftly to stimuli (Masten, Best, & Garmezy, 1990). In fact, it was found that men were more traumatized than women. It was also reported that those with a lower income level and those with a lower education level showed more post-traumatic stress symptoms than other groups (Cengiz, 2017). Women evaluate their own physical and psychological health as worse than men (Çetrez & DeMarinis, 2017).

Nonetheless, it is important to note that not everyone who has experienced a tragic accident will acquire PTSD or resilient. Some conditions must be met for post-traumatic growth or resilience to take place. Ability to deal with issues, self-confidence, family and social support, and financial income all play a role in the improvement of post-traumatic growth and resilience (Abriado-Lanza, Guiner, & Colon, 1998). In this context, a very recent study about the effective factors of PTSD in Syrian refugees (Vahud, 2021), it was revealed that Syrian refugees in Turkey indicated high levels of resilience; And their levels of resilience and life satisfaction differed according to the coping style used. In addition, a statistically significant relationship was found between the coping style used and resilience and life satisfaction. This in return affect's refugees' mental health and PTSD level. Moreover, in the same study regarding refugees' resilience, it was found that there was no difference according to gender, marital status, duration of residence in Turkey, with whom he lived in Turkey, status of obtaining Turkish citizenship, status of receiving financial aid, income level and willingness to return to Syria. Apart from that, a significant difference was found in resilience levels according to the presence of psychiatric illness, employment status, loss due to war, and education level.

Another key idea in trauma and PTSD related research is "Attachment"; Since it is thought to be a protective factor for people from negative impacts of traumatic events. Human relations are governed by the concept of attachment, which is a psychological, evolutionary, and ethological foundation (Ainsworth,1989). The most basic idea is that young children must form a link with at least one significant caregiver for good social and emotional development. In reality, attachment was characterized as a strong emotional tie between a baby and his caregiver that results in a baby's feelings of contentment, joy, and security when the caregiver is near him/her, and tension and discomfort when the caregiver is momentarily absent from him/her (Lafreniere, 2000). This attachment connection continues to influence an individual's life throughout his/her adulthood as well. Whereas in the context of adulthood traumatic experiences, adult attachment style is considered one of the key factors contributing to one's level of resilience and posttraumatic stress disorder (PTSD) according to Bowlby (1980).

In the same context, several researchers have found a link between secure attachment style and resilience (Kararmak & Güloğlu, 2014: 7; Marriner, Cacioli, &

Moore, 2014). Likewise, individuals with secure attachment and resilience are considered to be better equipped to cope with mental health issues such as PTSD than those with other attachment types (Hazan & Shaver, 1990; Bassiouni & Al-hajjaji, 2019). Similarly, secure attachment pattern was found to be a favorable predictor of resilience in a study by Naderi, Akbari, and Abbasi-Asl (2016), but avoidant and anxious attachment styles were found to be negative predictors of resilience. Secure attachment type is considered to serve a protective effect in boosting resilience and reducing PTSD in this setting.

What's more, in very recent study about the protective factors of PTSD in Syrian refugees (Karataştan, 2021), it was found that the secure attachment style of Syrian refugees showed a positive and significant relationship with post-traumatic growth and psychological resilience. Likewise, anxious attachment style was found to be higher in those who had war-related trauma (such as arrest, loss of a loved one, and injury). Besides, anxious attachment style was found to be negatively correlated with resilience. However, contrary to expectations, it was found that avoidant attachment style showed a positive relationship with resilience.

In addition, there are many factors affecting refugees' level of resilience and PTSD such as gender, marital status, occupational status, education, age etc. For instance, there was a strong link between age and resilience. It was yielded that younger people have more resilience (Beutel, et al., 2009). Resilience was also found to be stronger among married people in the literature (Beutel, et al., 2009; Ernas, 2017). However, according to Cengiz (2019), single people have greater resilience than married people. Besides, when the educational status of individuals was taken into account, a link between education and resilience was discovered; where individuals with greater education exhibited stronger resilience (Cengiz, 2019; Biçen, 2019). At the same time, the working individuals had greater psychological resilience ratings than the non-working ones (Boell, Silva, & Hegadoren, 2016; Beutel, et al., 2009).

Overall, every war comes with a tangible and a non-tangible cost. Most of wars results in immigration, waves of refugees to several countries, psychological traumas and disorders such as PTSD that can be lessened by considering the protective factors such as resilience and attachment styles.

1.2 Purpose of the Study

The purpose of the current study was to investigate the relationship between attachment styles, resilience and posttraumatic stress disorder among Syrian refugees living in Turkey. Another aim of the study was to investigate the difference of level of PTSD in Syrian refugees living in Turkey in terms of gender, marital status, occupational status, duration of living in Turkey, and age.

1.3 Research Questions

In accordance with these purposes, the subsequent research questions were pursued to be answered in the study.

1. Is there any significant difference in the level of PTSD in Syrian refugees living in Turkey in terms of

- Gender
- Marital status
- Occupational status
- Duration of living in Turkey
- Age

2. Is there a relationship between resilience, attachment style, and PTSD?

3. Does the resilience and attachment styles have predictive role on PTSD?

1.4 Significance of the Study

For the last ten years, Syrians have been forced to leave their homes and countries and have been forced to flee to another country to protect themselves and become refugees in several countries around the world. There are more than 5 million 6 thousand registered Syrian refugees all over the world. According to the latest data released by the UNHCR (2021), more than 3 million 6 thousand Syrian refugees resided in Turkey. With this number of Syrian refugees, Turkey is considered as the country that hosts the highest number of refugees in the world (UNHCR, 2021).

What makes this thesis important is that it was conducted in a country that is assumed to best represents Syrian refugees. Besides, the research and collecting the data

of this study, which took place in the sample of Syrian refugees, in the form of a questionnaire in their own language has helped to obtain more reliable results.

Adding to that, the most important aspect that adds original value to the study was that looking at the literature, there were studies that measure the level of PTSD in different refugees. However, these studies that examined resilience and attachment styles as protective factor for PTSD are limited and since the complexity of the issue, there is a need to do more study. In this sense, this study is considered to eliminate the lack of research with these variables in the field of psychology; as well as, providing a better understanding of the resources that lead to positive outcomes on the mental health of traumatized individuals and refugees in particular.

1.5 Definitions

Trauma: Any stressful psychological event that causes severe anxiety, helplessness, dissociation, disorientation, or other disruptive feelings that have a long-term detrimental impact on a person's attitudes, behavior, or other elements of functioning (APA, 2021).

War: Is a state of mutual power / force or conflict between two or more wills (Varlık, 2013).

Refugee: An individual who is outside the region of his or her citizenship because of a legitimate fear of violence due to his or her religion, race, nationality, involvement in a specific social group, or political beliefs, and who does not wish to benefit from the protection of his or her home country because of the fear in issue (Çiçekli, 2013).

Post-Traumatic Stress Disorder (PTSD): A psychological health condition that might emerge after experiencing or witnessing a life-threatening incident such as war, natural catastrophe, automobile accident, or sexual assault (DSM-V, 2013).

Resilience: The capacity to adapt to a hardship, or the ability to live a worthwhile life in the face of difficulty (Thabet, 2017).

Attachment: Attachment is a form of intimate relationships between a person and another (Abo-Ghazal et al, 2009).

Chapter 2

Literature Review

In this chapter, the literature review consists of two essential sections: theoretical background of the variables and empirical findings about the associations among the variables. In other words, the key concepts of the study including war, refugees, migration, trauma, posttraumatic stress disorder, resilience and attachment patterns were reviewed in terms of their theoretical background; then empirical researches regarding the relationship between each other were revised.

2.1 Trauma

Until the 19th century, the word "trauma" was attributed to physical wounds. In the 20th century, the word "trauma" began to have a psychological connotation (Jones and Wessely, 2007). In the years when the concept of trauma first emerged, the basis of the psychological problem experienced by the person after the traumatic event was not seen as external factors, but as the person himself, that is, it was assumed that the person had a predisposition, a physical disorder or had a trauma in childhood (Jones and Wessely, 2007).

However, traumatic event in the Diagnostic and Statistical Manual of Mental Disorders (DSM V) was defined as a confrontation of an actual or serious injury or sexual assault in a way that is directly experienced or witnessed, or experienced by a family member or close friend, or professionally experienced (American Psychological Association (APA), 2013). Relatively, it traumatic event is also defined in the International Classification of Diseases ICD-11 as an exposure to an extremely horrific or threatening event or series of events (https://icd.who.int, 2021).

Several scholars and clinicians have advocated for a broadening of the concept of trauma to include a broader spectrum of events, as well as a study of the cumulative impact of these early traumatic events on a person's mental health and functioning (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; McDonald, Borntrager, & Rostad, 2014; Wamser-Nanney & Vandenberg, 2013). According to these scholars, physical and

sexual abuse, neglect, psychological maltreatment, loss or disruption of primary attachment, dependency on an impaired caregiver, witness to violence, community violence, and serious injury are all experiences that can result in trauma-related symptoms and other lasting effects, and therefore should be considered as a trauma (McDonald et al., 2014).

According to Öztürk (2017), natural disasters such as earthquakes, floods, wars, sexual or physical assault, torture, sexual abuse, childhood abuse, traffic accidents, occupational accidents, diagnosis of a life-threatening disease are events that are compelling and have negative effects on the person's ability to cope, such as being hit by a stroke, witnessing a dangerous event, are called 'traumatic events'.

In the same way, modern research was claimed that a variety of other exposures to harsh realities all share and are associated with similar emotional, social, and behavioral challenges, bringing researchers to believe that events such as witnessing domestic violence, frequent relocation or homelessness, parental substance use, loss of a caregiver or other significant relationship, and exposure to community violence are all considered as traumatic events and at the same time linked to comparable emotional, social, and behavioral difficulties (Cook et al., 2005; D'Andrea et al., 2012; Dierkhising,et al., 2013; Krupnick et al., 2004).

In the meantime, traumatic events have been classified in many different ways. For example, in DSM 5, traumatic events are divided into three main groups: [a] direct human traumas (e.g., war, rape, assault, violence), [b] accidental human traumas (e.g., car accident, fire), and [c] traumas caused by natural disasters (e.g. flood, earthquake) which are all stated in (APA, 2013). Whereas, Terr (1991) divides trauma into two types, type 1 : sudden, unexpected, non-repeated traumas. Experiences such as assault, death of a relative, accident, rape can be given as examples of these traumas. Type 2 includes repeated, long-term traumas. Traumas such as domestic violence and sexual abuse can be given as examples.

However, according to Şahin (1995), human-induced trauma types are; Victims of political violence (detentions, extrajudicial executions, assassinations); Victims of violence for non-political reasons (judicial prisoners, interrogation, detainees); Victims of war trauma (prisoners, refugees, soldiers, civilians living in a war environment) and

victims of domestic violence, sexual assault, harassment and rape.

2.2 War, Syrian Crisis, Syrian Refugees and Migration

In this section, the literature review of some key concepts related to the subject of the study such as war, Syrian refugees and crisis and migration are examined carefully.

2.2.1 War. War brutally harms all people, regardless of their ethnicity, gender and age. This event should be considered as a violation of human rights (Buchowska, 2016). Even though war and politics are so much related to each other, they still hold some differences. For instance, while politics can be resolved through dialogue and negotiations; war on the other hand insists to make people realize their own wishes by using force and violence (Daver, 1991). The features of the war were defined as the following; to use force, to include an act of hostility, to create a legal dimension and to be the state that implements it (Varlık, 2013).

However, there have been changes in the concept of war since the beginning of the 20th century. The nature of war has been changed; It has been devoid of war principles and morals, and war has become independent of politics (Kurtuluş, 2015). Although the concept of "new wars" was in question, but the purpose of war did not change in terms of old and new wars. It is possible to say that belief system and ethnic origin are essential reasons for war, while old wars are between states, new wars are more common among groups and continents (Eker, 2015; Karaosmanoğlu, 2011; Sokullu, 2019). In other words, civil war is a type of war that takes place between groups within the borders of a state, consists of religious / ethnic / political minority groups and aims to change the authority order (Sokullu, 2019).

The concept of war in the literature review has been used together with words such as immigration, asylum, refugee, forced migration. These concepts are presented in the following for more clarification.

2.2.2 Migration and refugees. Migration is the population movements in which people move internationally or within the borders of the state, regardless of the reason, duration and structure of migration (Çiçekli, 2013). Even though migration is essentially

defined as a 'relocation movement', it has emerged as a social event that is closely related to the social, cultural, economic and political structure of the society and affects it deeply (Ekici and Tuncel, 2015). Mainly, migration movement was divided into different types according to location, process and cause. “Internal migration” is the movement that takes place within the borders of the country, and “external migration” is the movement to another country. According to the duration of the migration movement, it was divided into two types as "continuous migration" and "temporary migration" (Bülbül and Köse, 2010). According to Kara and Korkut (2016), the most distinctive feature of the phenomenon of migration today is that it is not a choice but is experienced as a necessity and obligation. Today, the expression migration is associated with the concepts of displacement, asylum, and refugee.

In this context, “asylum seekers” are defined as people who have to leave their country and whose applications for refugee status are not accepted in the country they go to (Çiçekli, 2013). Whereas, the definition of a “Refugee” is a person who is outside the country of his/her nationality because of a well-founded fear of being persecuted because of his/her race, religion, nationality, membership of a certain social group or political opinion, and cannot benefit from the protection of that country, or does not want to benefit from it due to such fear; or to any person who, as a result of such events, is outside the country of his former residence, is unable to return there, or is unwilling to return because of such fear (Article 1 of the UNHCR Convention Relating to the Status of Refugees; 1951).

Similarly, asylum seeker was also defined as a person who does not meet the legal definition of a refugee but applies for asylum (or refugee) status after being already in a port of entry. Asylum seekers can have any (or no) immigration status when they apply. Asylum status can be granted by an immigration office asylum officer or an Immigration Judge within the Immigration Review Enforcement Office of the Ministry of Justice of the country of immigration (Section 208 of the Immigration and Nationality Act). People who have to leave their country and whose applications for refugee status are not accepted in the country they go to are defined as asylum seekers. (Çiçekli, 2013).

Another status for a person who leaves his country is a ‘Stateless person” which is person who is not bound to any state by citizenship and who is considered a foreigner

is called a stateless person (goc.gov , 2019). There is also a "Conditional refugee" who is a person who requests international protection from Turkey in order to seek asylum in third countries, claiming to meet the conditions defined as a refugee due to events occurring outside of Europe (goc.gov , 2019).

Another option for a person who leaves his country is called "Temporary protection" which is a form of protection developed to find urgent solutions in mass influx events. It is a practical and complementary solution that is applied to people who arrive at the borders of the country in masses within the framework of the non-refoulement obligations of the states, without wasting time with individual status determination procedures (goc.gov , 2019). According to the Temporary Protection Regulation published within the scope of Law No. 6458; The status of approximately 2 million registered people who came to Turkey from Syria is "Temporary Protection" and they cannot apply for conditional refugee status, which is an individual procedure.

As of April 28, 2021, the number of registered Syrians under temporary protection is 3,670,342. Children between the ages of 0-18 constitute 47.4% of these people. The total number of children and women between the ages of 0-18 is 2,599,756 people, 70.8% of the total number (multeciler.org.tr, 2021).

Migration has become a huge problem that requires a universal solution as it has increased and diversified a lot today. In addition, the migration wave that emerges in a region affects the whole world (Kaypak & Bimay, 2016). Finally, as Ekici and Tuncel (2015) claimed, migration is a phenomenon that can affect the world and every aspect of people.

2.2.3 Syrian crisis. The civil war in Syria started in March 2011 with the arrest and torture of pro-democracy protesters (Rodgers, Gritten, Offer, & Asare, 2016). Violence seems to have turned into a civil war when the opposition began to fight against the government. According to the United Nations, until June 2013, 90,000 people were killed in the conflict and more than 100,000 people went missing (United Nations Office of the High Commissioner for Human Rights, 2013). As of August 2015, the number of casualties exceeded 250 thousand. Approximately 600,000 people died in March 2021, with more than 22,000 children and 14,000 women (Syrian Observatory for Human Rights

(SOHR), 2021). The conflict, which was already unstable, became even more chaotic and catastrophic with the rise of ISIS. In addition to war casualties, many war crimes were also reported. It was seen that some of the crimes are murder, torture, rape, kidnapping, chemical warfare, mass murders. It was reported that bombs were dropped on high-population urban areas to kill large numbers of civilians indiscriminately (Kareem, 2015).

There were more than 5 million 6 thousand Syrian refugees who had to leave their country and were registered worldwide. More than 3 million 6 thousand of Syrian immigrants were located in Turkey. With the number of Syrian refugees, it has, Turkey is considered as the country that hosts the highest number of refugees in the world (UNHCR, 2021). In addition, more than 6 million 7 thousand people have been displaced within Syria (UNHCR, 2021). In other words, more than 11 million people had to leave their homes and go elsewhere (Rodgers et al., 2016).

Moreover, according to the report of SOHR, by March 15, 2021, 117,388 civilians among them, with the passing of the 10th anniversary of the Syrian crisis; A total of nearly 400,000 deaths were documented, including 81,279 men, 22,254 (under 18) children, and 13,855 women (syriahr.com, 2021). Among, 968,651 people, 15,498 of whom were women, was arrested by the Syrian regime since March 2011, when the Syrian revolution began. More than 83% of them died in detention centers between May 2013 and October 2015. The number of detainees remaining in the regime prisons was 152,342, among which 41,293 women were detainees. While the number of forcibly disappeared reached 128,074, there were 20,315 women among them , and the total number of those who were arrested together with the disappeared reached 280,416.

These numbers, beyond being symbols, represent people; They have families, children, mothers, fathers, siblings, spouses and friends. In this context, it was seen that these people have been exposed to or witnessed serious traumatic experiences. It can be assumed that this situation may have caused a serious negative psychological effect. In addition, although survivors are displaced or seek refuge in other foreign countries, this situation is thought to worsen them. According to the results of Aljundi (2018)'s 7-year research examining the psychological state of Syrian refugees living in Syria, Syrians living inside and outside Syria, especially women and children, present serious negative psychological symptoms.

In the same context, in a study conducted by International Organization for Migration (IOM);(2018) with Syrian refugees in Lebanon, it was stated that most of the families interviewed are hopeful that things will return to normal in a few months, the conflict will end and they will return to Syria in a few months. He said that most of the families have a strong desire to stay in Syria. He reported that many families decided to migrate to protect themselves and especially their children, and many families had to flee without taking anything when they migrated. He also stated that most of the families migrated from their usual place in the country to another place before they migrated abroad. In most cases, there has been direct experience with an event that led to the decision to leave (for example, witnessing murdered children, witnessing body parts on the street, family or self-arrest and imprisonment, etc.) or experiences such as a violent event or lack of adequate resources. All these factors were found to be the driving causes in their decision to leave.

Overall, even though the Syrian crisis has started in 2011, still after 10 years passing with tragic results and huge costs, the tragedy of Syrian refugees continues with pain with no solution or interventions for peace in the region.

2.2.4 Psychological status of refugees. Throughout history, wars have been associated with losses, including environmental or economic losses. However, the worst of these losses are the loss of life, physical injury, disability and psychological damage that people can experience. The war experience has negatively affected the Syrian refugees physically, economically and psychologically. These traumatic events can also occur in the region of war, when refugees leave their country or during the settlement process in the country where they took refuge. In the literature review, there are many studies conducted with Syrian refugees. For example, according to the results of a research conducted with Syrian refugees; the continuing hardships and violence associated with the war have had widespread effects on the mental health and psychosocial well-being of Syrian adults and children. The negative experiences they had with the war make the stress they experience with their migration more complicated. It covers the daily stresses of the displaced, such as poverty, lack of resources and services to meet basic needs, risks of violence and exploitation, discrimination and social isolation (Hassan et al. 2015).

According to The National Child Traumatic Stress Network (NCTSN), refugee families face financial stress, difficulties in finding housing and employment, loss of social support, transportation difficulties and lack of access to resources while trying to start a new life. Similarly, for many Syrian families, the main problems, whether for families with loss of life or for families experiencing emotional or financial losses, appear as "loss and grief" (Hassan et al. 2015). Furthermore, in order to determine the mental health needs of the Syrian refugees living in the camps, Beshati et al. (2015) conducted a pilot study for 2 months in the Zataari camp in Jordan. According to the results of the research, 56% of the participants reported that they complained of psychological symptoms such as anger, fear, irritability, difficulty falling asleep or staying asleep, hopelessness about the future, fear and panic attacks. It was observed that 37% of the participants suffered from all the above-mentioned problems.

It is obvious that refugees have lived under threat from extreme traumatic events such as death or serious injury. It is also known that many of the refugees suffer from post-traumatic stress disorder. For the mental health and recovery of refugees with PTSD, security in the country of refuge is a very important factor (Davis, 2006). For instance, as a result of a study conducted with 310 Syrian refugees in the Reyhanlı district of Hatay, it was found that 80% of the participants had PTSD symptoms (Cengiz, Ergün, & Çakıcı, 2019). Also, it was found that refugees with PTSD do not have a legal explanation for their protection in the country of asylum, and at the same time, the PTSD symptoms of resettled refugees persist for a long time (Davis, 2006). Regardless of whether these people are men or women, their stress levels were found to be high. However, looking at the Syrian refugees' mental health conditions before the war, people with mental disorders became even more vulnerable after experiencing traumatic events during the war or immigration. In fact, a significant proportion of Syrians experience severe mood disorders such as depression, long-term mourning and PTSD (Aljundi, 2018).

Another study was conducted in Gaziantep to investigate the level of PTSD among refugees in different cities (Acartürk et al., 2017). In this study, various factors such as gender, age, duration of residence in Turkey, marital status, number of children, number of people living together, occupation, education, smoking and alcohol consumption, substance use, previous psychiatric problems, medical disorders, familial disorders, and

drug use were investigated. analyzed socio-demographic variables. Researchers found that 33.5% of asylum seekers developed PTSD and revealed that women are four times more likely to have PTSD than men. In addition, it was found that people who have been exposed to two or more traumatic events and have a personal or family history of psychiatric disorders have a higher risk of developing PTSD.

Moreover, psychological negative effects of migration might be transferred from generation to generation (Danieli, 1998; Özgür, 2019). It was found that the level of exposure to trauma and the level of being affected by the event in Bulgarians experiencing forced migration was related to the self-esteem of the second generation (Özgür, 2019). Holocaust survivors, and especially survivors of detention, was found to have significant indirect effects on their children (Danieli, Norris, & Engdahl, 2016). It was found that children's life satisfaction and mothers' exposure to war trauma in their past experiences were related (Özüorçun & Karancı, 2013). It was yielded that veteran fathers with symptoms of post-traumatic stress disorder negatively affect family function, have difficulty in problem solving, and negatively affect the second generation (Davidson and Mellor, 2001).

Many refugees and displaced people have been subjected to war-based traumas; To clarify, women and girls in particular have been particularly exposed to sexual and gender-based violence (such as domestic violence, sexual violence, early marriage, harassment and isolation, exploitation and sex for survival) both in Syria and in countries of asylum (Hassan et al. 2015). According to Grisis Grup (2019), migrant Syrian youth in Turkey face enormous challenges where too many people are coping with anger, trauma, and loss by not getting an education and the need for work.

Refugee women experience psychological, social, cultural and physical problems. Women's reproductive health was also adversely affected by this situation (Yağmur and Aytekin, 2018). According to the results of Kurtuldu and Şahin (2018) studies examining the effects of migration on women's life and health, it was understood that women who received education due to migration could not continue their education, they worked to make a living, they had problems in family and marital relations, and their social connections decreased. At the same time, migration negatively affects women's health. These disadvantages are; It includes problems such as irregular menstruation,

sudden miscarriages, vaginal infections, infectious diseases, and pregnancies occurring at short intervals. According to the results of a study conducted with Syrian refugee women in Jordan, it was found that a significant portion of women showed high levels of postpartum (postpartum) depression symptoms and this result was associated with the poverty and lack of social support experienced by women (Muhammad, et al., 2018). Women may encounter stressors such as adapting to a new culture, difficulty in learning a language, and isolation (Baş, et al., 2017). It was reported that Syrian refugees, especially women and those with mental disorders, experience high levels of somatic distress (McGrath, 2020).

As it is understood from the literature review, war is recorded in human's memories and it is effective in forming thoughts, behaviors and shaping their futures. While some people have been involved in war and have been in direct contact with the negative effects of war, others have been indirectly exposed to its negative effects without being exposed to war.

In particular, interpersonal or deliberate traumas such as sexual assault, physical abuse, abandonment, experiencing domestic violence, homicide, and group violence have been linked to worse effects than non-interpersonal traumas such as natural disasters or severe illness. (Cyr et al., 2012; Krupnick et al., 2004; Scott-Storey, 2011; Wamser-Nanney & Vandenberg, 2013).

Consequently, traumatic events have different effects on human's lives in person and in general. For instance, the trauma experienced may have physical effects, as well as various psychological disorders as a result of trauma (Shakespear, et al., 2003; Lotfi and Başcılar, 2017). Besides, the same traumatic events can cause different results in different individuals, traumatic events can have negative effects as well as positive effects (Shakespear, et al., 2003). In fact, the traumatic event causes a great shock to the person, makes the person feel helpless and powerless, and has such a great effect that it disrupts the coping mechanisms of the person (Öztürk, 2017).

To clarify, looking at the literature of trauma's impact, trauma has been linked to a variety of negative psychological impacts, such as emotion dysregulation, depression, dissociation, embarrassment, guilt, and low levels of self-confidence. (Aspelmeier, Elliot, & Smith, 2007; Chapman, Whitfield, Felitti, Dube, Edwards, & Anda, 2004; Cook et al.,

2005; D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; McDonald, Borntrager, & Rostad, 2014; Valentino, Bridgett, Hayden, & Nuttall, 2012).

In addition, interpersonal difficulties are common among people who have undergone trauma, perhaps due to deficiencies in impulse control and the ability to participate in positive relationships or communicate to others (Amatya & Barzman, 2012; Cicchetti & Banny 2014; Cook et al., 2005; D'Andrea et al., 2012). Moreover, traumas are linked to a broad variety of dysfunctional activities, including violence, inattention or hyperactivity, non-suicidal self-injury, drug abuse, and juvenile behavior, which can be influenced by this collection of traumatic events (Auerbach et al., 2014; Dierkhising et al., 2013; Dube, Dong, Chapman, Giles, Anda, & Felitti, 2003; Gregorowski & Seedat, 2013; Krupnick et al., 2004; Robertson & Burton, 2010; Smith & Saldana, 2013).

Similarly, several researches that used a wider scope of definition of traumatic experiences discovered that individuals with a history of trauma have more struggle with emotion-focused coping and impulsive behavior, have a feelings of low self, are more susceptible to high risk actions, and suffer more on a professional and personal aspect of their lives (Amatya & Barzman, 2012; Kalmakis & Chandler, 2014; McDonald et al., 2014; Wamser-Nanney & Vandenberg, 2013).

Beyond that, researches that have inspected the psychological and behavioral correlations of trauma discovered that the more sorts of trauma was experienced, the higher association with suggestively enlarged amounts of depression, anger, and PTSD symptoms (Greeson et al., 2011; McDonald et al., 2014; Turner, Finkelhor, & Ormrod, 2006; Turner et al., 2010; Wamser-Nanney & Vandenberg, 2013). While advanced charges of substance abuse, mental health detects, health related risky behaviors, and health sickness reports were also prevelant amongst adults who were exposed to traumatic events (Chapman et al., 2004; Dong et al., 2003; Dube et al., 2003; Johnson, Pratt, Brems, & Neal, 2007; Krupnick et al., 2004).

On the whole, considering the factors related to trauma, Occurrence, severity, and the period of time the individual is exposed the trauma have independently been associated with more severe negative consequences (Nader, 2011; Wamser-Nanney & Vandenberg, 2013).

2.3 Post-traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder (PTSD) is a psychological health problem that develops after experiencing or witnessing a life-threatening event such as war, natural disaster, car accident or sexual assault. In DSM-V, post-traumatic stress disorder was defined as post-traumatic tension disorder and its diagnostic criteria are applied for children over the age of six, teenagers and adults. Whereas, ICD-10 defined PTSD as a state of extreme distress experienced by a person in the face of an event or situation that poses an extraordinary danger or has a catastrophic nature. Moreover, PTSD was considered as a disorder in which a person feels dread, panic, or powerlessness as a result of an incident in which they believe their life, physical integrity, or safety is in jeopardy (Harvey, 1996). Where the symptoms of PTSD include:

A. Painful recollections, flashbacks, or recurrent dreams or nightmares.

B. Avoidance of activities or places that trigger the traumatic event,

C. Diminished responsiveness (emotional anesthesia or numbing).

D. Disinterest in significant activities.

E. Feelings of detachment and estrangement from others;

F.Exaggerated startle reaction, disrupted sleep, difficulties focusing or remembering, and guilt at surviving the shock when others did not (DSM–IV, 2013).

Relatively, according to ICD 10, in order for a person to be diagnosed with PTSD, the symptoms must last for at least one month within six months after the traumatic event (Koryürek, 2011). Additionally, in order for a person to be diagnosed with PTSD, not only the symptoms must last at least one month, but also, they must cause clinically significant distress or impairment in daily life of the person. However, if the duration of symptoms is between 1 month and 3 months, the disorder is considered “acute”; And if it lasts longer than 3 months, it is defined as “chronic”. Nonetheless, if the symptoms occur 6 months after the traumatic event, it is called "clinically delayed onset" (Bilgic, 2011).

Looking back to the history of PTSD, it is noticed that it was initially associated with war, and the greatest improvement in understanding the effects of traumatic experiences that negatively affect the individual's life on psychological adjustment has emerged as a result of observing the reactions of combat soldiers (Doğan, 2001). The deep

hopelessness and sadness experienced by soldiers who were first sent to foreign lands in the 17th century and who were less likely to return were called “nostalgia” (Rosen, 1975). Finding people to entertain the soldiers at that time and increasing their hopes of returning were used as a treatment method, and it was aimed to increase the hope of recovery in others by sending the patients back to their homes (Jones, 1975).

However, during the American Civil War, mental and physical problems, defined as "soldier's heart", began to appear in soldiers. In 1871, Jacob Da Costa named this condition, which is accompanied by nightmares and irritability, as the "hypersensitive heart". Based on the symptoms being chest pain, palpitations and dizziness, and anxiety, Da Costa stated that the disease is a heart disorder characterized by hyperarousal (Ramsay, 1990). Later, a similar situation was observed in the soldiers who fought in the First World War. Symptoms such as severe tremors, dullness in the eyes, blindness and paralysis that could not be attributed to a physical cause were observed in these soldiers and this situation was called Shrapnel Shock (Coleman, 2006).

As a result of many war victims, soldiers or civilians, seeking help for their psychological problems, the "gross stress reaction" section has been added to the diagnostic criteria in DSM-I (Kaptanoğlu, 2001). It was defined as “Intolerable Stress Reactions” in DSM-I (1952) and as “Temporary Mental Disorder” in DSM-II (1968) (Gersons & Carlier, 1992). Following that, post-traumatic stress reactions were first included in the diagnostic classification systems after the Vietnam War and was defined as post-traumatic stress disorder and classified in DSM-III (DSM-III). Acute, chronic, and late-onset types were also defined in the DSM-IV (Bromet, Sonnega, Kessler, 1998). In DSM-V, if the diagnostic criteria are not fully met before at least six months after the delayed event, it was defined as the type with delayed expression (Köroğlu, 2014).

As one of the most important life events, was cause intense stress in people. In a study conducted 15 years after the Vietnam War, the PTSD level was determined as 15%, which indicates that the psychological effect of war and violence on people might be lifelong and continues to death (Kulka, 1990). Furthermore, most of the prevalence studies on the mental health of refugees have been conducted on the diagnosis of PTSD (Nickerson, Bryant, Silove, & Steel, 2011). For example, in a study on refugees after the Bosnian war, the rate of PTSD was found to be 26.3% (Mollica et al., 1999), and in a

study conducted with Bosnian women who had experienced the war, the rate of PTSD was 71% (Dahl, Mutabcic, Schei, 1998). Similarly, in a study conducted with refugees in Kosovo, PTSD was found to be 60.5% (Ai et al., 2002). While in another study on Iraqi Kurdish refugees living as refugees in Sweden, the rate of PTSD was determined as 37% (Sondergaard, Ekblad, Theorell, 2001). Generally speaking, PTSD was found in 1% of the general population, where 3.5% of civilians were exposed to physical violence, and 20% of injured and uninjured veterans in Vietnam (Halzer et al., 1987).

What's more, in studies conducted among individuals who were victims of genocide, 46% of individuals were diagnosed with PTSD (Card, 1987). While in another study conducted on American soldiers, the prevalence of PTSD was found to be 12% after the return of the soldiers who participated in the 2nd Gulf War to the USA (Hoge et al., 2004); And when measured one year later, it was found to be 16% (Hoge, Terhakopian, Castro, Messer, and Engel 2007).

Looking at the risk factors leading to high susceptibility to developing PTSD, a meta-analysis study by Brewin, Andrews, and Valentine (2000) has indicated that the gender, ethnicity, personality traits, low level of education, low level of income, traumatic experiences in his past life, whether there is a psychiatric illness in his family, the severity of the trauma, the timing of trauma. resolution, traumatic memory emission, perceived life-threatening danger, and lack or low social support were found to be important risk factors for the development of PTSD.

While another study on risk factors of PTSD conducted after an industrial explosion, physical injury, seeing a dead person, and witnessing one of their relatives being injured or killed were found to be important risk factors in the occurrence of PTSD. Additionally, it was found that individuals diagnosed with a psychiatric disorder before the explosion may be a risk factor in the development of PTSD due to the distress they experience (Taymur et al., 2014). Finally, in a study investigating the prevalence of PTSD in the armed conflict zone in Turkey, armed conflicts were found to be risk factors for PTSD (Yasan, Saka, Ertem, Ozkan, & Ataman, 2008).

In order to be able to understand the nature and the origins of PTSD, many theories have evolved by psychologists and scientists. For example, the psychoanalytic theory explained PTSD shortly as the following; The traumatic experience triggers pre-existing

but unresolved internal conflict. To clarify, Bilgiç (2011) argues that according to the Freudian theories, when all defense mechanisms are insufficient, the ego cannot cope with the damage caused by trauma. That's why, the individual regresses by using primitive defense mechanisms as a result of the forcing of the protective mechanism that encounters the trauma for the first time. However, when traumatic experiences that cause distress are repeated over and over in dreams, they try to harmonize with the ego by activating the trauma rather than experiencing the event passively (Bilgiç, 2011).

Another way of explaining PTSD is represented by Horowitz (1991) who suggested that individuals who experienced trauma deny the trauma and experience compulsions such as flashbacks. He explains that denial as a psychological defensive mechanism leads to repression of memories related to the traumatic experience; However, this repression of negative memories and feelings might finally be explicit by experiencing different sorts of compulsions including flashbacks and intrusive memories and thoughts. Whereas, it was suggested that the trauma experienced in childhood will regress as a result of reexperiencing it in adulthood (Özer, 2016); Meaning that recurrent experiencing of a traumatic event throughout adulthood, might ultimately lead to better understanding and acceptance to the situation as well as greater coping mechanisms with the childhood adverse experience.

Furthermore, the most comprehensive cognitive model to explain PTSD was developed by Ehlers and Clark (2000); where they stated that how the events that occur during and after the traumatic event are evaluated, the nature of the traumatic memories in the memory of the event and the relationship of these traumatic memories with other memories in the autobiographical memory are effective in the emergence of PTSD. Individuals who experience distress after their trauma experience see trauma as a phenomenon that has been experienced in a certain period of time and will have a negative impact on the integrity of the individual in the future. If individuals do not consider that their traumatic experiences are in the past, the traumatic event will always remain a threat. Ehlers and Clark (2000) stated that memory problems may occur due to traumatic experiences. The first explanation is related to the functioning of the autobiographical memory mechanism. In autobiographical memory, memories are voluntarily and automatically recalled due to various stimuli. Researchers argued that autobiographical

memory has a function to prevent the constant recall of past memories while doing our daily tasks.

2.4 Resilience

Wars may not always have negative effects, but there are also wars that resulted in positive effects in the history (Hall, 2003). He also evaluated the phenomenon of migration positively. He stated that the phenomenon of migration is a way out to get rid of the harmful effects of the war and the conflicts after the war, at the same time he sees the war as a way of coping with the crisis. Migration can also provide immigrants with a richer set of socioeconomic and psychological resources by compensating for the need for trust.

Although much of the literature focuses on the adverse consequences of traumatic experiences, developmental psychopathology advocates for a more balanced approach, recommending that individuals who experience and respond to trauma consolidate resources, which can result in the inadequacy of certain skills while enhancing the development of others. The study of resilience has evolved from this perspective, and more emphasis has been placed on a patient's defensive factors and positive adaptation in the face of difficulties (Luthar, Cicchetti, & Becker, 2000).

Resilience might be one of the most positive results of traumatic events in general and war and immigrating in specific. Resilience is a broad concept that refers to the ability to adapt positively to difficulties in general, and to have the ability to continue without collapsing in the face of difficulties. Resilience is generally recognized as the ability to survive after hardship and adversity, or to lead a purposeful life after experiencing hardship and adversity (Thabet, 2017). Resilience is also defined as the ability of individuals to adapt to life in a positive way despite being exposed to intense stress and difficulties (Hofgaard, Nes, & Roysamb, 2021; Jackson & Edenborough, 2007). Another definition of resilience is the ability to adapt to difficult and stressful events in life (Masten & Obradovic, 2006). In other words, resilience is accepted as a protective mechanism that works against negative stressors (Bonanno, 2008; Masten, 2001; Masten & Obradović, 2006).

However, even though the history of resilience is mostly linked to traumatic events such as wars, yet resilience as a term emerged from a longitudinal study of children born in poverty and difficult conditions (Garmezy, 1991). In accordance to that, resilience sometimes is looked at not as a personal trait, rather than a complex and dynamic process that includes the individual, event and environment (Almedom, 2008; Johnson & Wiechelt, 2004). Thus, the phenomenon of resilience has been defined as a dynamic process in which an interaction occurs between risk and protection factors at both individual and social levels (Sikorska, 2014).

In particular, looking at the nature of resilient people, Smith (2009) explains that resilience gives the ability for an individual or group to cope with and solve problems so that they are more likely to survive difficult times. Similarly, according to Herrman et al., (2011) the key components of resilience relate to a person's ability to adapt positively to a changing or unpredictable environment and to maintain or regain positive mental health when facing or coping with challenges. In addition, resilience as a factor protects individuals from depression and includes behaviors that can be taught to people who are vulnerable to difficulties such as physical illness, mental problems, psychosocial isolation and loneliness.

The personal factors that contribute resilience include several personality traits such as (openness, extroversion, and agreeableness), internal locus of control, self-efficacy, self-esteem, cognitive appraisal (positive interpretation of events and harmonious integration of distress into self-narrative), and optimism (Herrman et al., 2011). The findings of another research showed that intellectual functioning, cognitive flexibility, social connectedness, positive self-concepts, emotional regulation, positive emotions, spirituality, active coping, resilience, optimism, hope, resourcefulness and adaptability are associated with resilience (Josepph & Linley, 2006).

However, on the modern reviews of literature on resilience components, resilience was conceptualized as a multidimensional construct that combines personal skills and qualities, together with social environments and a supportive family network, rather than a complex of purely personal characteristics such as self-esteem or optimism. In addition, resilience was seen as a dynamic process that changes according to the cultural, developmental and historical contexts of individuals and differs according to different

ages and genders (Connor & Davidson, 2003). Developmental psychologists claimed that resilience was common among children growing up in disadvantaged conditions (Masten, 2001).

Another factor that is related to a person's level of resilience is the biological factor; Research findings on biological and genetic factors in resilience showed that challenging early environments can affect the developing brain structure, function, and neurobiological systems (Cicchetti, 2015). Similarly, environmental-systemic factors such as the microenvironmental level, social support, including relationships with family and peers, is associated with resilience. For example, attachment styles seem to play a role in a person's level of resilience in hardships; individuals with a secure attachment style tend to show higher levels of resilience and lower levels of negative emotions (Craparo et al., 2018). In addition, secure attachment to the mother, family stability, a secure relationship with an abusive parent, good parenting skills, and absence of maternal depression or substance abuse are associated with fewer behavioral problems and better psychological well-being and higher resilience levels.

Another factor that can influence the extent of resilience is the cultural factor, where Fernando (2012) has found ethnic differences in resilience among traumatized war-zone populations. In the same way, in the literature, it was indicated that resilience was generally associated with better mental health in displaced communities, while the components of resilience are developing one's abilities, coping with emotions, developing autonomy and maturation of personal relationships (Hassan, 2008).

Furthermore, issues such as family and community support, religion, personal skills and comparison with others have been identified as various strengths and resources for refugees to cope with migration stresses. They can act as promoters of resilience to the development of the psychological problems of forced displacement. Coping strategies constitute an important part of resilience in response to trauma and forced migration experience (Schweitzer et al., 2007).

In accordance with all of that, resilience can affect human's lives in many ways. In fact, there are many positive outcomes and traits linked to people having high resilience levels. For example, according to Al-Ahmadi (2007), the positive effects of resilience were good mood, optimism about life, ability to communicate effectively, and continuing

to work and give. Another research showed that resilience was positively correlated with post-traumatic growth. In addition, it was revealed that individuals classified as high in resilience were exposed to traumatic events at a high level and showed the absence of PTSD (Thabet, 2015).

Likewise, that there is a negative relationship between resilience and trauma. (Bindal, 2018). It was reported that resilience has moderator and mediator effects on the relationship between stress, depression, and anxiety (Song et al., 2021). Besides, resilience is an important factor in predicting the quality of life in people with chronic pain (Ravandi, 2013). It has also been observed that resilience predicts post-traumatic growth (Cengiz, Ergün, & Çakıcı, 2019). It was found that low resilience was significantly associated with high stress and high resilience was significantly associated with low stress (Judkins, 2001). It is reported that although the stress levels of those with high resilience are high, the disease rates are low and they are more successful, while those with low psychological resilience and high stress levels have higher disease rates (Kobasa, 1979). In other words, resilience protects the individual from the psychological and physical effects of stress rather than reducing stress (Kobasa et al., 1982; Kobasa & Puccetti, 1983).

In addition to talking about the ability to overcome traumas such as war-related deaths, natural disasters and cultural upheavals, resilience functions as a defense against mental health problems (Bonnano, 2004). In fact, resilience can predict an individual's adaptability (Herman, 2012; Smith, 2009; Thompson et al., 2011). For instance, Haddadi and Basharat (2010) indicated that there was a negative correlation between psychological stress, depression, anxiety, and resilience, and low or negative mental health indicators are influenced by different levels of resilience through self-esteem, self-efficacy, perseverance, religiosity, and control.

Taking everything into consideration, resilience is one of the most important factors in human’s lives, especially in hardships and difficult situations; And it consists of both internal and external factors. That’s why it is vital to look at it in a multidimensional way when examining it. Finally, resilience can bring great bio-psychosocial benefits for human’s in general and refugees in particular. Therefore, it is more than important to have further studies and research considering it.

2.5 Attachment

Over decades, there were many psychologists who were interested in the humans' attachment phenomena including Bartholomew, Horowitz, Hazan and Shafer; However, Bowlby was a pioneer psychologist in searching and describing carefully the phenomena of child-parent attachment. That's why, he was called "The father of attachment theory" (Bartholomew & Shaver; 1998). Followed by Ainsworth's work, the two psychologists did a unique job detecting the origins of attachment and offering a detailed explanation for it through the "Attachment theory". In fact, Bowlby's (1988) and Ainsworth's (1982) attachment theory has inspired many study lines in recent years. Originally, the concept of "Attachment" was intended to explain infant and adult psychopathology in terms of "attachment figures," or non-optimal connections between infants and their parents.

What's more, Attachment is a form of intimate relationships between a child and a caregiver who is often the mother. Many psychologists have tried to uncover the nature of this relationship, the role of both the child and the caregiver in forming it, the forms of this relationship and the extent to which these forms continue over time, and their future effects on the individual's personality and social compatibility. It has subsequent intimate relationships and social interactions in general (Abo-Ghazal et al, 2009).

For instance, Bowlby (1980) explained that human being establishes a close affectionate bond with a specific individual in order to maintain intimacy and avoid emotional pain. He claimed that this close affectionate bond "attachment" has a long-term effect on people's lives. Whereas, Ainsworth (1989) described attachment as a psychological mechanism that an infant learns after he or she is delivered in order to sustain a bond with the caregiver. The infant's crying triggers the caregiver's behavior and encourages them to approach the kid and satisfy his needs. Moreover, Ainsworth and Bowlby (1991) defined attachment as a strong emotional bond that a child forms with the primary caregiver, and later becomes the basis for future affectionate relationships; Where these attachment patterns are not aimed primarily at a single person.; Over time, the child continues to distinguish the caregiver from the other caregivers and also distinguishes the explicit attachment behavior, forming other affectionate bonds with others around him.

Based on the foregoing, the researchers believe that attachment is a strong mutual

emotion between the child and the caregiver, which reflects the desire of each of them to maintain the proximity between them and is the basis on which they built their relationships based on. For instance, in a joined study of Papalia, Old and Feldman (1999) where they intended to examine human attachment in order to arrive to a common understanding of the concept, they concluded that "Attachment" is the result of mutual efforts of the child and the caregiver. To clarify, they emphasized in their definition of attachment the contribution of both the child and the caregiver to the quality of the attachment bond; where no attachment bond is formed nor understood by focusing only on the child or the caregiver while excluding the other.

Beyond that, Kareem et al. (2009) explains that adults' attachment patterns as an extension of those individuals formed in their childhood. Children live under different conditions, and they are exposed to various social upbringing methods, which have a great impact on shaping their attitudes towards themselves and towards others, and in determining their personal relationships.

In general, theoretical explanations have varied regarding the reasons for the emergence of the attachment association, some scholars believe that it is related to the satisfaction of biological needs (Kemp & Page, 1986), while others believe that the child has an innate tendency to form this relationship (Bowlby,1982)

One of the theories that contributed to the understanding of the attachment concept is "Ethology". *Ethology* has made several contributions to attachment theory. Bowlby, in particular, has benefited greatly from Harlow and Lorenz's animal behavior research in developing the attachment hypothesis. Harlow (1958) investigated the behavior of juvenile and mother rhesus monkeys in relation to the feeding process in a research with rhesus monkeys. Without a doubt, this research contributed significantly to the attachment theory and the secure attachment idea (Suomi, 1995). Although the baby monkey was fed by a different monkey in Harlow's experiment, the fact that the newborn monkey returns to another monkey for warmth indicates that the mother-child bond exists and is beyond feeding.

Imprinting is another major addition of ethology to attachment theory. Lorenz (1952) discovered that newborn young birds automatically follow their mothers, and that

when they are in distress, they return to their moms. He noticed that this behavior was unaffected by the mother's ability to feed the infant. Bowlby (1958) believed that this behavior could be applied to all humans. He believed that the mother-baby bond observed in animals could be replicated in people, and that attachment might arise irrespective of feeding behavior.

Moreover, Infants that lack the mobility to give and sustain closeness convey a multitude of signals to others with their actions such as weeping or smiling to begin intimacy throughout early infancy, according to Campos and Barrett (1984). Intimacy between a child and an adult, on the other hand, is dependent not only on the infant's ability to convey proximity cues, but also on the adult's ability to respond to these signals. Babies acquire an attachment to adults who respond consistently and repetitively to proximity-providing cues through these predispositions that represent greater compliance, according to ethological-attachment theorists. . In this way, newborns learn to trust that they will be protected and cared for when they need it. Individual variations in attachment manifest themselves in many ways when individuals respond differently to signals given to themselves for closeness in terms of appropriateness and timeliness.

Taking everything into consideration, Bowlby's theory *"Ethology"* is an accepted view at the present time. It confirms the idea of the proponents of the psychoanalytic school, in that the type of attachment with the caregiver has deep and important implications for the child's sense of security and his ability to form a relationship full of trust. To clarify, Bowlby (1982) asserts that the human child is born equipped, like the pups of other types of animals, with a set of innate behaviors that make caregivers close to him, and thus increase his chances of survival such as sucking behavior, smiling, catching the mother and staring at her face and eyes. There is a suspensive behavioral system that includes a set of behavior patterns and emotional reactions aimed at maintaining closeness to the primary caregiver. It believes that this system has three basic functions: achieving proximity to the caregiver and providing a safe haven for the child, as the child rushes to the mother in situations danger and threat in search of support and a sense of comfort, and the mother adopts a safe base from which the child can carry out exploratory activities in his surrounding environment.

The person giving basic services to the infant is more or less familiar with the

child's needs (Bowlby, 1969). When a child is born, as according to Ainsworth (1989), he is often provided with a variety of behaviors to retain connectedness to the caregiver. When we look at this case from an evolutionary standpoint, the relevance of attachment to the human species' survival stands out. The baby requires the presence of its mother in order to survive, and the bond is the most basic means for achieving this (Harlow, 1958).

As for some supporters of the behavioral school, they explained the attachment by the use of the concept of (Drive Reduction) which was suggested by Hull. The mother satisfies the child's hunger (primary motivation), after which the mother's presence becomes a secondary motivation (learned behavior), because the mother's presence is associated with the child's feeling. As a result, the child learns to prefer all kinds of stimuli that go along with feeding, including gentle hugging of the mother, warm smiles and gentle words.

On the contrary, the person giving basic services to the infant is more or less familiar with the child's needs (Bowlby, 1969). When a child is born, as according to Ainsworth (1989), he is often provided with a variety of behaviors to retain connectedness to the caregiver. When we look at this case from an evolutionary standpoint, the relevance of attachment to the human species' survival stands out. The baby requires the presence of its mother in order to survive, and the bond is the most basic means for achieving this (Harlow, 1958).

Furthermore, feeding the child and satisfying his biological needs are the main context for forming the attachment bond. Thus, the psychoanalytic theory linked the attachment to breastfeeding behavior, which not only satisfies a child's bodily need, but also satisfies his sexual desire, according to the first stage of psychosexual development in the "Freudian" theory, which is the oral stage (Lafreniere, 2000).

In contract, Skinner, the owner of the Action Learning Theory, has rejected the idea of Hull that it is responsible for drive reduction. The attachment behavior, from his point of view, increases and is confirmed through the various reinforcements that follow this behavior, such as food, compliments, or toys. If a large group of child's behaviors are reinforced, this will lead to the formation of a strong attachment bond. Punishment, reprimand, or withdrawal of some privileges; the result will be a reduction in attachment behavior (Abu Ghazal, 2007.)

On the other hand, another theory that provided a deeper understanding of the human bonds is the *"attachment theory".* According to the attachment theorists the first bonds that an infant and mother form is extremely significant for a person's life, even in their early years. In fact, nowadays it is widely recognized that the mother-child relationship is one of the most important psychological realms for human development; Where a stable mother-child relationship provides a healthy foundation for the rest of life. That's why, Bowlby (1969) who is considered the father of attachment theory, coined the phrase "from cradle to grave" to describe the lifespan impact of attachment relationships. In this way, mothers bear a significant amount of responsibility for their children's bodily, psychological, and social well-being. As a result, based on prior observational research, it can be concluded that mothers' perceptions of their own skills and beliefs in life are accurate.

Attachment behavior, according to Bowlby (1980), is characterized as an individual's tendency to form a relationship with a source or to pursue connectedness with an individual, particularly in stressful contexts. Within the context of attachment, death, and mourning responses, Bowlby (1990) has reinterpreted the bond between mother and caregiver. While attachment describes the continuation of this relationship form, the absence of the attachment figure and the child's reaction to this deficiency are deeply influencing factors on child's development.

Whereas, according to attachment theory, attachment behavior is best understood through understanding the working models inside ourselves. To clarify, the existence of cognitive/emotional schemas or representations of the self in connection to intimate relationship partners is called "*internal working models*"; These models in return are responsible for the long-term impacts of early encounters with caregivers (Bartholomew, 1990; Shaver, Collins, & Clark, 1996).

In fact, one of the main key concepts that Bowlby (1973) has coined in order to describe how attachment appears and get formed is the phrase *"internal working models"*. He said that there are templates that are awaiting in the background. Peoples choices behavior is shaped by these templates, which act as a guide in the incidents they experience. Attachment, which supplies us with a life-long basis for intimate relationships, is one of the most significant basic components of human psychological distress from this

viewpoint. The relationship between the infant and the attachment partner is referred to as *"The Attachment Behavioral System"* because of both of these behaviors.

Working models are also known as cognitive maps, representations, schemes, or scripts that an individual possesses about himself as a physical and psychological entity, and about his surrounding environment, and that they may be at levels of complexity ranging from elementary to complex structures. (Marrone, 1996). Similarly, Berk (1999) defined *(internal working models)* as a set of expectations derived from early experiences with the caregiver, including the extent of the caregiver's presence, and the likelihood of providing support during times of distress and tension, so that these expectations become directives for future intimate relationships or a mental representation of the attachment relationship, which forms the basis for expectations in whole life aspects.

Beyond that, Bowlby (1988) goes on to say that there are two sides to these models: One that relates to *the self,* and that includes an estimate of the worthiness of the self. And another that relates *to others* and includes an estimate of the extent of their response and trust in them as social partners. The child will develop a working model in which the caregiver appears to be a rejectionist person and that the child is not worthy of love. That means that this child will grow up and socialize with others as an adult based on his believe that he is not worthy of love and trust; This will affect and be reflected on almost every social relationship he builds in his life which will in return reflect on his quality of social, emotional and physical life.

On the other hand, Bowlby (1973) believed that although the internal working models remain open to new experiences when the child interacts with new people, they nonetheless tend towards stability and constancy, because the child will choose his partners and form his new relationships in a way that is consistent with the working model he already has. He also believed that working models will resist change once they are formed because they operate outside the child's awareness and consciousness, and because the new information will be represented in the already existing model. When the child encounters new experiences and situations, the child will submit these experiences and situations to the working model he has, ignoring the clear evidence that refutes this model (Lafreniere, 2000).

As a consequence, in all intimate relationships, these internal representations

theoretically affect a person's expectations, emotions, defenses, and relational conduct. Although the theory does not presume or necessitate that internal working models remain constant throughout a person's life, both research and practice from longitudinal studies have led researchers to believe that the long-term impacts of childhood attachment relationships can be seen in the dimensions of future child rearing and establishment of close friendships and forming and maintaining intimate relationships (e.g., Bartholomew, 1990, 1993; Main, Kaplan, & Cassidy, 1985; Shaver, Hazan, & Bradshaw, 1988; Weiss, 1982). That is why Bowlby's theory of attachment appeared as a theoretical framework for studying human relations not only in childhood, but also in adulthood (Hazan and Shaver, 1987; Collins and Read, 1990).

In the same context, in his examination of personality disorders and their link to attachment theory and patterns, Lyddon (2001) verified the validity of this viewpoint. He stated that there are two sources of attachment pattern continuity over time: one source is : Attitudes and feelings of attachment that last and continue into adulthood are not only a result of internal working models formed in childhood, but rather that these models last and continue when confronted with situations and experiences consistent with the working models that were formed earlier.

Based on the assumption of the continuity of attachment patterns, Shaver and Hazan (1987) argue that the individual’s feelings, behaviors, and thoughts in romantic relationships as an adulthood are subject to caregiver attachment processes in childhood. To test this idea, they constructed a scale of attachment patterns in adulthood that reflects the basic patterns of attachment that has been observed by evolutionary researchers in infants. According to Hazan and Shaver (1987) there are three attachment styles:

1. Secure Attachment: It easier for individuals of this type to approach, trust and rely on others, and feel comfortable that others trust them as well. They also depend on others, and they do not worry that others will abandon them or reject them, nor do they worry about others approaching them.
2. Avoidant Attachment: This pattern is characterized by its owner’s acknowledgment that he does not feel comfortable staying close to others,

and it is difficult for him to trust and rely on them, and he feels anxious when someone approaches him too much.

3. Anxious-Ambivalent Attachment: People with this pattern indicate that others refuse to approach them and are anxious that their peers do not care about them, even though they have the desire to be very close to their peers.

In two studies of them on two independent samples, Hazan and Shaver (1987, 1990) found that the percentage of these patterns in the first study was: 56% Secure Attachment, 25% Avoidant attachment, and 19% Anxious-Ambivalent Attachment. Similarly, in their second study they found that these percentages were 56% Secure Attachment, 23% Avoidant attachment, and 21% Anxious-Ambivalent Attachment; In the same context, they also found that these percentages are similar to those found in the study of infant attachment patterns in the United States of America, which indicates the continuity of attachment patterns from childhood to adulthood and throughout the entire life of a human.

On the other hand, Bartholomew and Horowitz (1991) developed an advanced model of adult attachment that includes two dimensions. This model is consistent with the inner working models that Bowlby assumed (the self-system and the system of others). The first dimension, in this model, includes the distinction between self and others. While the second dimension includes positive / negative. Based on the intersection between these two dimensions, the result is four patterns of adult attachment, which are:

1. Secure Attachment: Individuals who have this style of attachment are characterized by having positive internal working models towards the self and towards others. People with secure attachment trust in themselves as well as trusting others.
2. Preoccupied Attachment: It is common to find that individuals with this attachment style are characterized by having negative internal working models towards oneself and positive towards others, and this is exemplified by their sense of their lack of worthiness in the love of others,

and their positive evaluation of others, and they also have a strong desire to form intimate relationships in order to obtain the acceptance of others.

3. Dismissive Attachment: Individuals with this style of attachment are characterized by having positive internal working models towards self and negative towards others, and their avoidance of relationships with others is a means of *self-protection mechanism* from rejection and disappointment.
4. Fearful Attachment: Individuals with this style of attachment are characterized by having negative internal working models towards the self as well as towards others, as well as these individuals with this fearful attachment style are characterized by their feeling of inadequacy, in addition to their belief that others are not trustworthy.

It should be noted that, according to Hazan and Shaver, the Anxious-Ambivalent Attachment pattern is synonymous with the Preoccupied Attachment pattern in Bartholomew and Horowitz (Ari, 2005).

Taking everything into consideration, it is undeniable to dismiss the importance of adult attachment style and its effects on individuals lives socially, academically, romantically and professionally.

2.5 National Studies

There are different studies considering Syrian refugees living in Turkey and their legal, social and mental situation. For example, regarding the legal status of Syrian refugees, according to (goc.gov , 2019), a "Conditional refugee" is someone who seeks special protection from Turkey in order to attain refugee in a third country, claiming to satisfy the criteria for being a refugee as a result of circumstances that occurred in his home country. However, according to the Temporary Protection Law established under Law No. 6458, the status of roughly 2 million enrolled Syrian refugees in Turkey is "Temporary Protection," and they are not eligible to apply for conditional refugee status, which is a one-on-one process (goc.gov , 2019). Relatively, the number of Syrians registering for temporary protection was 3,670,342 as of April 28, 2021. Children aged 0

to 18 account for 47.4 percent of the population. The total number of children and women aged 0 to 18 is 2,599,756, accounting for 70.8 percent of the total population (multeciler.org.tr, 2021).

On the other hand, other studies considering Syrian refugees living in Turkey have focused on the mental and physiological health aspect. For instance, according to a research done to investigate the relationship between posttraumatic stress disorder, posttraumatic growth and resilience in 310 Syrian refugees in Turkey's Reyhanli province; 80 % of the subjects exhibited signs of post-traumatic stress disorder; Refugees with PTSD had higher war-related traumatic events; Resilience and posttraumatic growth were found to be positively correlated and regression analysis showed that resilience promotes posttraumatic growth (Cengiz, Ergün, & Çakıcı, 2019).

Another research in Gaziantep looked at the prevalence of PTSD among migrants living in different towns (Acartürk et al., 2017). Gender, age, length of stay in Turkey, marital status, number of children, number of individuals living together, employment, education, smoking and alcohol usage, substance use, prior mental issues, medical disorders, family disorders, and drug use were all studied in this study. socio-demographic factors were examined. Researchers discovered that 33.5 percent of asylum seekers suffer from PTSD, and that women are four times more likely than males to suffer from it. Furthermore, it was shown that persons who had been exposed to two or more toxins had a higher risk of developing cancer.

While in another study that was done in Bursa, Ankara, İstanbul and Kocaeli to evaluate the relationships between traumas, attachment styles and psychological resiliencies of participants who had traumatic life events (n= 138); A negative relationship was found between resilience and insecure, avoidant and anxious attachment styles (İnan, 2015).

In addition to that, a recent study done by Syrian-Turkish researcher (Karataştan, 2021) that was aimed to examine attachment styles in Syrian refugees (n=360)who have experienced migration trauma and to evaluate its effect on post-traumatic growth and psychological resilience; The findings of the study of secure attachment style demonstrate that a statistically significant positive correlation was found with post-traumatic growth and resilience. While the anxious attachment style was found to be significantly negatively

correlated with resilience, the avoidant attachment style was positively correlated with resilience. Also, a significant positive correlation was found with post-traumatic growth and resilience.

In another study done by Syrian-Turkish researcher (Vahud, 2021), the effects of coping style used by Syrian refugees in Turkey on psychological resilience and life satisfaction 10 years after the Syrian civil war and the Syrian migration movement (n= 383) were examined. The results revealed that active coping style, psychological resilience, and life satisfaction in Syrian refugees showed a statistically significant positive relationship; Where statistically positive relationship was observed between life satisfaction and psychological resilience in Syrian asylum seekers. Besides, active and passive coping styles had a 32% predictive power of psychological resilience.

2.6 International Studies

According to the results of a study conducted with 426 refugees, 61.7% of the refugees showed signs of PTSD. PTSD is common in 58.6% of refugee women. Being a woman, low education level and the magnitude of trauma are seen as important predictors of PTSD (Ssenyonga, Owens, & Olema, 2012).

Another study indicated that there is a statistically significant positive correlation between total war-related traumatic events and PTSD, and a negative correlation with post-traumatic growth and resilience (Murad & Abdel Aziz, 2017).

Moreover, immigrants were not more prone than the regular population to have major health problems and mental health issues (Kinzie et al., 2008; Mills et al., 2008; Sabin et al., 2006); but also to have difficulty accessing health care due to linguistic and cultural barriers ((Mizra et al., 2013; Morris et al., 2009; Saechao et al., 2011).

In order to evaluate resilience, depression and trauma history, 339 Syrian refugee children between the ages of 10-17 were studied. According to the results of the study; all children have been exposed to at least one traumatic event, and 48.6% of these involve very serious traumatic events such as hostage taking, kidnapping or arrest. High rates of suicidal ideation and depression symptoms were found. It was found that resilience showed a significant negative relationship with depression. Accordingly, it has

been understood that social support increases the level of resilience and decreases the depressive level (Connor, Davidson, & Lee, 2003).

Another international study regarding Syrian refugees' mental and physiological health was done by Aljundi (2018). According to the findings of the study, the psychological status of Syrian refugees living in Turkey, women and children, both exhibit psychiatric symptoms and suffer from mental health issues related to the violence they experienced back in war areas. Besides, the continuous challenges and trauma connected with the fight have had broad repercussions on their psychiatric and physical well-being.

Another important finding is that social support is an easy and active method that can be applied to develop resilience and prevent other mental disorders (Dehnel, et al., 2021). For example, in the sample of refugee Syrian adolescents; social support, collective memory, work, common hobbies, activities and religion; were defined as supporting factors for the formation of resilience (Nagi, et al., 2021).

While in another study that was aimed to obtain better insight into the associations between attachment styles and psychological well-being, by testing the possible mediating role of resilience; In a community sample of 632 individuals, secure and avoidant attachment styles were found to be associated with high levels of resilience, and anxious attachment styles were associated with low levels of resilience (Karreman & Vingerhoets, 2012). Moreover, it was reported that resilience plays a mediating role between insecure attachment style and perceived stress, according to a study done to examine relationship attachment style, perceived stress, and resilience in medical students that are mainly exposed to recurrent traumatic events (n= 188) (Thompson, et al., 2018). Similarly, in another study aimed to investigate the mediating role of resilience in relationship between attachment styles and quality of life of high school students in Babolsar, Iran (n= 367), resilience was found to be a complete mediator between secure attachment style and quality of life (Naderi, Akbari, & Abbasi-Asl, 2016). Whereas, in a different research that has examined the relationship between attachment styles and resilience and their impact on perceived stress in a cross-sectional sample (n= 196); It was stated that avoidant attachment style and resilience are negatively related (Marriner, Cacioli, & Moore, 2014).

Karaırmak and Güloğlu (2014) found a statistically positive relationship between

secure attachment style and psychological resilience in a study they conducted with adults who had experienced earthquakes. It also showed that secure attachment style predicted optimism and resilience. All of that emphasizes that primary relationships, together with supportive family and friend networks, facilitate coping mechanisms and strengthen psychological resilience.

Another important aspect related to human's psychological wellbeing is the chronic interpersonal trauma in early childhood; For example, individuals who have been abused, such as sexually or physically, show significantly more avoidant and anxious attachment styles than individuals who have experienced late interpersonal and non-interpersonal traumatic events. At the same time, adult attachment style was seen as a partial predictor of the relationship between trauma type and PTSD symptom severity (Pivodic, 2011).

In a meta-analysis that aimed to investigate the relationship between adult attachment styles and PTSD symptoms; A random-effects model was used to analyze 46 studies (N = 9268) across a wide range of traumas. Results revealed a significant relationship was found between attachment styles and post-traumatic stress disorder; A negative relationship was found between secure attachment style and PTSD; while a positive relationship was found between insecure attachment style and PTSD (Woodhouse, Ayers, & Field, 2015).

However, in a research that used attachment and relational perspectives to understand adaptation and resilience among immigrant and refugee youth; It was found that immigrants' attachment styles, quality relationships and secure attachment with important people in their lives are valuable resources that increase their sense of protection and trust when dealing with the chronic stress and loss they experience while migrating (Juang, 2017).

Exposure to human-induced traumatic events, including torture, is associated with persistent avoidant attachment tendencies in refugees. While the avoidant attachment style was associated with human-induced trauma experiences, no relationship was found with nature-induced traumas, and the anxious attachment style was not associated with any type of trauma (Morina, et al., 2016).

As a result of his work with Mexican and Central American adult immigrants,

Carreon (2016) separated from the first caregiver as a child; showed a statistically significant finding that attachment style and acculturation stress predict marital distress in this group of immigrants. It has been revealed that ethnic discrimination and cultural stress of immigrants, insecure attachment orientation and insecure attachment are predictors of psychological distress. In addition, it has been found that attachment orientation mediates the relationship between cultural stress and psychological distress (Zakowski, Horvath, & Amer, 2020).

It has also been shown that secure attachment style improves stress resilience compared to insecure attachment style in cancer patients. Other findings also show that inadequate perceived social support is a negative factor in resilience (Basal, et al., 2020).

Taking everything into consideration, the goal of listing all of these previous studies was to show how trauma, PTSD, resilience and attachment styles are very much linked to one another and have a huge effect on human's lives and psychological wellbeing.

Chapter 3

Methodology

This chapter goes through the study's methodology in detail. The first section covers the study's research design, then the second section covers sampling procedures and characteristics of participants, the third section covers data collection instruments, and the fourth section covers data collection procedures and data analysis.

3.1 Research Design

The current study was designed as a non-experimental quantitative correlational research. Correlational analysis was used to assess the correlations between two or more variables as well as the degree to which two or more variables vary. This method would not enable the researcher to manipulate or intervene because the model represents an ongoing interaction between variables. This method of study is conducted in order to examine and classify possible associations between phenomena occurring in the nature, without trying to change them in any way (Fraenkel & Wallen, 2005). A correlational research model was applied to examine the relationship among attachment styles, resilience and PTSD among Syrian refugees living in Turkey.

3.2 Participants

The population of the study consisted of Syrian adult refugees above the age of 18 who came to live in Turkey after the start of war in Syria at 2011. On the other hand, individuals who were below the age of 18, living outside of Turkey, came to Turkey before the start of war in Syria at 2011 were not considered a war refugee and excluded from the study. Convenient sampling method was used as a sampling method. Which is a non-probability sampling technique in which a sample is taken from a group of individuals who are simple to contact or approach.

In the current research, there were 595 (321 females, 274 male) participants. The age of the participants ranged between 18- 78 years old where the mean of the age was 35.13, and the standard deviation was 12.132. Looking at the age of the participants in

particular, 22% of them (n = 131) were between the age of 18-24 years old, 49.1% of them (n = 292) were between the age of 25-40 years old, 25.4% of them (n = 151) were between the age of 41-60 years old, 3.5% of them (n = 21) were above the age of 60.

Regarding the education level of participants, 24% of them (n = 143) were graduated from high school, 74.8% of them (n = 445) were graduated from university and 1.2% of them (n = 7) had master's or doctoral degree. Regarding the marital status of participants, 68.4% of them (n = 407) were married, 25.9% of them (n = 154) were single, 1.8% of them (n = 11) were divorced and 3.9% of them (n = 23) were widow. Regarding the duration of time living in Turkey, 34.3% of participants (n = 204) have been living between 0-5 years, 65.7% of them (n = 391) have been living between 6-10 years.

Regarding occupational status of participants, 43.2% of them (n = 257) stated that they have a job, while 56.8% of them (n = 338) stated that they don't have a job. Regarding the financial income of the participants, 38.7% of them (n = 230) stated that they don't have a monthly income, while 11.9% of them (n = 71) stated that they have a monthly income less than 1500 TL, Whereas 14.6% of them (n = 87) stated that they have a monthly income between 1500- 2000 TL, 11.9% of them (n = 71) stated that they have a monthly income between 2500- 3000 TL, 22.9% of them (n = 136) stated that they have a monthly income equal or above 3500 TL. Regarding getting financial aid, 78.8% of participants (n = 469) stated that they don't get any financial aid, while 21.2% of them (n = 126) stated that they get financial aid.

Regarding having ever had a psychiatric illness, 11.4% of participants (n = 68) stated that they have had a psychiatric illness before, while 88.6% of them (n = 527) stated that they have never had a psychiatric illness before. Regarding getting a Turkish nationality, 35.1% of participants (n = 209) stated that they have got a Turkish nationality, while 64.8% of them (n = 386) stated that they have not got a Turkish nationality. Regarding returning to Syria after the end of war, 29.9% of participants (n = 178) stated that they would like to return back to Syria after war finishes, 20.5% of them (n = 122) stated that they would not like to return back to Syria after war finishes, while 49.6% of them (n = 295) stated that they have not decided whether to go back to Syria after war finishes or not. Regarding having relatives back in Syria, 98.7% of participants (n = 587) corresponded with Yes, while 1.3% of them (n = 8) corresponded with No. Table 1

summarizes the demographic characteristics of the study sample.

Relatively, the participants of the study came from different regions and cities of Turkey; Where 41% of the participants came from Istanbul, 32% from Hatay, 8.6% from Gaziantep and the rest of sample came from other cities such as Şanlıurfa, Mersin, Bursa, Konya, Yalova, Kilis, Adana and other different cities.

Table 1

Demographic Characteristics of the Study Sample

Variables		*N*	**%**
Age group	18 – 24	131	22
	25 – 40	292	49.1
	41 – 60	151	25.4
	Over 60	21	3.5
Gender	Male	274	46.1
	Female	321	53.9
Marital status	Married	407	68.4
	Not Married	188	31.6
Staying period in Turkey	0 – 5 Years	204	34.3
	6 – 10 Years	391	65.7
Having relatives in Syria			
	Yes	587	98.7
	No	8	1.3
Education level	High school	143	24.0
	Graduated	445	74.8
	Higher education	7	1.2
Do you have job	Yes	257	43.2
	No	338	56.8

Table 1 (cont.d)

Variables		N	%
Do you have monthly income	No, I don't	230	38.7
	Less than 1500 TL	71	11.9
	1500 – 2000 TL	87	14.6
	2500 – 3000 TL	71	11.9
	3500 TL or more	136	22.9
Do you get any financial aid	Yes	126	21.2
	No	469	78.8
Have you ever had a psychiatric	Yes	68	11.4
illness	No	527	88.6
Have you gotten the Turkish	Yes	209	35.1
nationality	No	386	64.9
Would you like to return after the	Yes	178	29.9
end of war	Haven't decided yet	295	49.6
	No	122	20.5

3.3 Data Collection Instruments

This section contains information about data collection instruments along with the validity and reliability studies of the surveys used in the research. Since the population and sample of the study was consisted of Syrian refugees who speaks mainly Arabic language, all of the scales and questionnaires adminstered in the study were applied in Arabic language.

3.3.1 Demographic information form. Participants were requested to complete a demographic information form that included information about the characteristics of the participants. This form was prepared both in English and Arabic by the researcher and

contained 16 questions. Participants' age, gender, marital status, who they live with, which provinces in Turkey they live in, duration of residence in Turkey, education level, job status, monthly salary, financial support, whether they had a psychiatric condition, whether they still have relatives living in Syria, whether they had Turkish nationality, and whether or not they want to return to their homeland after the war is over are among the things asked on the form. (See Appendix B.1 for English & B.2 for Arabic Form)

3.3.2 Yarmouk scale of adult attachment styles (Y-SAAS). This scale was developed by Ghazal and Jaradat (2009) in order to measure attachment styles that adults build with each other. So, they firstly looked at measures of adult attachment styles that were included in some of the published studies such as (Hazan and Shaver, 1987; Becker and Billing, 1997; Bakker, Van Oudenhoven and Van der Zee, 2004; Huntsinger and Luecken, 2004). Then they developed an Arabic scale of attachment that they called "Yarmouk Scale of Adult Attachment Patterns". For content validity of the attachment scale, the researchers presented the scale to six members from the faculty of the Department of Counseling and Educational Psychology at Yarmouk University and they agreed on its content validity.

This scale is a 6-point Likert-type scale that consists of (20) items, which are intended to examine three attachment styles (secure attachment, avoidant attachment, and anxious attachment) based on answering the main question "Determine to what extent this description\item applies to you" through numbers between 0 and 5; where (0) Represents that this item 'does not apply to me at all'; while (5) represents that this item 'fully applies to me'. For example: Item number 2 "It is difficult for me to completely trust others", the participant is asked to determine to what extent this item applies to him\her by choosing a number between 0 to 5.

Later on, the answers are set into groups that represents three styles of attachments: secure attachment style, anxious-ambivalent attachment style and avoidant attachment style. The secure attachment style consists of 6 items, its total scores range from 0 to 30. Anxious attachment style and avoidant attachment style both consist of 7 items and their total scores range from 0 to 35. The alpha coefficient and internal consistency of the scales, anxious attachment style .74 The attachment style was .60 and the secure attachment style

was .57. Taking all of that into consideration, the Yarmouk Scale of Adult Attachment Styles was proved to be both valid and stable. (See Appendix C.1 for English & C.2 for Arabic Yarmouk Scale of Adult Attachment Styles (Y-SAAS))

In addition to that, the reliability analysis for Yarmouk Scale of Adult Attachment Styles was conducted in this current study, and the Cronbach's Alpha value was found 0.584 for Secure attachment which is a Medium reliability level, 0.78 for Anxious attachment which is a High reliability level, 0.643 for Avoidant attachment which is a Medium reliability level.

3.3.3 Connor-Davidson resilience scale (CD-RISC-25). This scale was developed by Connor and Davidson (2003) and the main purpose of the resilience scale was to measure the individual's ability to cope with stress. The scale consists of 25 items and it is a 5-point Likert type scale. The answers are (0) not correct at all, (1) rarely correct, (2) correct towards the base, (3) often correct, (4) almost always correct. The total score range is between 0-100. Higher scores indicate that the individual is more resistant to stress. In another words, when a participant scores high on the resilience scale, this indicates that his ability to cope with stress is high.

The scale was translated into Arabic by Ghazwan, Fterz, Hamad, Talat, and Jacob (Thabet, 2009).The scale's Cronbach alpha coefficient was reported as .89 in the original study. Then, Thabet (2009) carried out the scale's Arabic validity and reliability analysis. As a result, the scale's internal stability and Cronbach alpha coefficient were both found to be .88. (See Appendix D.1 for English & D.2 for Arabic Connor-Davidson Resilience Scale 25 (CD-RISC-25))

In addition to that, the reliability analysis for Connor-Davidson Resilience Scale was conducted in this current study, and the Cronbach's Alpha value was found 0.877 which is a High reliability level.

3.3.4 Davidson trauma scale (DTS). The DTS is a self-report measure that consists of a Likert-scale with 17 items that evaluates people's PTSD symptoms according to the 17 symptoms suggested by DSM-IV. An example of the PTSD symptoms assessed by this scale are (Startle, Physiological Arousal, Anxiety, and Numbness). The scale is also used

in the diagnosis of PTSD by deciding whether or not the symptoms match the DSM-IV requirement for PTSD. The Scale was translated and adapted into Arabic by a Thabet (2005) (See Appendix E.1 for English & E.2 for Arabic Davidson Trauma Scale (DTS) for DSM-IV)

The items of the scale are divided into three subscales, which are: Recallection of the traumatic experience, Avoidance, Arousal. Where the main question of the scale is about symptoms experienced in the past week. And the points are calculated on a five-point scale from 0 to 4, and the total scores are from a 153 point.

According to the DTS, cases suffering from post-traumatic stress disorder are diagnosed in the following way:

- Having a symptom of the traumatic memory recallection.
- Having three of avoidance symptoms
- Having a symptom of arousal

Researchers used the Cronbach Alpha to determine the scale's internal consistency. The study dealt with 215 drivers compared with employees in Gaza, and the Alpha Cronbach coefficient was .78 (Abu Layla, Thabit et al 2005).

Moreover, the reliability analysis for Davidson Trauma Scale was conducted in this current study, and the Cronbach's Alpha value was found 0.879 which is a High reliability level.

3.4 Data Collection Procedures

This section includes the procedures followed to obtain and clollect the data of the study. Besides, it contains the ethical considerations and permissions taken before the begning of the data collection.

3.4.1 Ethical considerations and permissions of the research. The permission to perform this study with Syrian refugees within Turkey was obtained prior to the examination from the Ethical Committee of Bahcesehir University where the procedures of the study were explained in details and totally approved by the Scientific Research and Publication Ethics Board of Bahcesehir University (See Appendix F).

In addition to that, the objective of the research and the subject of confidentiality were described to each participant within the voluntary Informed Consent Form that was proposed at the begining of the online survey on Google form. Also, the participants had total freedom to accept or reject to participate in the study and if they accepted to, they had to express it within the online form at the start of their participance in the research. Only those who chose to engage voluntarily in the study and expressed their acceptance at the beginning of the survey form, were permitted to complete the survey and their data was analyzed eventually. In the Informed Consent Form, the researcher introduced herself and presented general information about the subject of the study, the aim of the study, the main principle of confidentiality, the code of volunteering, that it does not contain any personal evidence and any distressing questions. (see appendix A. for English 1 &A.2 for Arabic Informed Consent Form). In addition, to ensure the accuracy of the answers, participants were asked to answer the questions in an honest and sincere manner. Likewise, the participants were informed that they could direct their questions to the researcher when needed, and the researcher's contact information was presented. Moreover, the data were collected online anonymously and randomly to protect the privacy of the participants and there were no records of the participants ID or anything that can identify them.

3.4.2 Data collection procedures. After receiving all the ethical permissions in February 2021, the data collection process was begun. Soon after, the research was applied using an online survey. All four data collection tools were arranged using the website https://www.google.com/intl/tr_tr/forms/about/ at Google Forms as an online survey equipment and were distributed to the participants electronically via social media platforms such as Whatsapp Groups and Facebook. Snowball sampling method was used to reach potential study participants. It took about twenty minutes to answer the scales per person and almost one month was needed for the data collection process to be completed.

Equally important to mention, is that there were two main reasons why data collection of the research was preferred to be done online via a google form by the researcher; first of them was that collecting the data online was more convenient for reaching the targeted participants which are Syrian refugees who were spread all over

different geographic cities of Turkey. Hence, this way of data collection helped consuming minimum time, effort and cost. Another reason of choosing to collect data electronically is that due to Covid-19 circumstances, online research was saught to be safer and better for the both researcher and participants.

3.4.3 Data analysis. The Statistical Package for the Social Sciences (IBM SPSS) was used to perform statistical analyses. The data collected from Syrian refugees living in various regions of Turkey via Google forms was entered and analyzed within the context of the research questions.

To review the data obtained for this study, a number of steps were listed below; The data scanning process was carried out first in the sample to ensure that the data was free of outliers and missing values, and that it was complete enough for statistical analysis. Six subjects were removed from the data before the statistical analysis because they were outliers.

After the screening and cleaning procedure was completed, several statistical tools were used to analyze data properly. For example, Cronbach's Alpha was used to measure the level of the reliability of the utilized questionnaire, where the reliability has been tested for all of the questionnaire, for each scale and for the sub-scales as well. Later on, descriptive statistics such as frequencies and percentages of the demographical questions were determined for each variable. Accordingly, the mean, standard deviations, minimum, and maximum values were all regulated to decide the variable's descriptive characteristics.

Then, to test if the scales and subscales are normally distributed the values of the Skewness and Kurtosis were used, since this is the first principle in all parametric tests. If data is symmetrically distributed, the sample size on the left and right sides are equal; And their confidence intervals contain the 0 value this means the data is normally distributed (Mardia, 1974). Besides, in many circumstances, according to George and Mallery (2012), Skewness and Kurtosis values between +2.0 and 2.0 are proper in the context of normality assumption. As it is seen in Table 4.1, the skewness values for total Attachment score of participants is 0.869 and kurtosis 0.376, for Resilience's skewness is 1.923 and kurtosis is 0.007, while PTSD skewness is 0.063 and kurtosis is1.893. Therefore, it can be concluded that all values which the analyses were conducted are normally distributed.

In addition to that, the statistical test of Durbin-Watson was applied to check if there is a correlation between the error terms, while Durbin-Watson value varies from 0 to 4, and when its result is close to 2, this means there is no inner correlation between the error values (Nerlove & Wallis, 1966). Results indicated that the data met the assumption of independent errors since (Durbin-Watson value = 1.849) which is close to 2 which in terms mean that there is no correlation between the error terms.

In addition to that, to check if there is a multi-collinearity issue between the independent variables, Tolerance and VIF tests were applied to the study variables. In order to be able to say there is no Multi-collinearity between the independent variables, the Tolerance value should be greater than 0.2, and the VIF value should be less than 5 (Mansfield & Helms,1982). Results of these tests indicated that there is no multi-collinearity between the independent variables since all of the Tolerance values in the Coefficients table are greater than 0.2, and the VIF values of all independent variables are less than 5 (Secure Attachment, Tolerance = .83, VIF = 1.204; Anxious Attachment, Tolerance = .93, VIF = 1.065; Avoidant Attachment, Tolerance = .97, VIF = 1.030; Resilience, Tolerance = .81, VIF = 1.220).

Furthermore, to check if there are any unusual distances between the values of the independent variables in the regression model, Mahalanobis Distance analysis was applied. After extracting the Mahalanobis distances, they were compared with the values of the cumulative distribution function of Chie-square distribution. The results showed that the CDF values that against Mahalanobis distances are greater than 0.001, which means the distances between the independent variables do not contain outliers in the distances. This assures that is it convenient to proceed with the regression analysis.

Another statistical test that was used in analyzing data was Pearson Correlation. This test is explained as a linear link between two variables is measured by the intensity and direction of the relationship. The values are always between -1 (strong negative relationship) and +1 (strong positive association) (Havlicek et al, 1967). It was utilized to examine if there is a relationship between resilience, attachment style, and PTSD.

In addition to all of those prior statistical tests and in order to be able to test the research hypothesis, multiple tests were utilized. In this way, Independent Samples t-test was used in order to be able to examine the difference in the means of two groups,

such as the gender, if they have relatives in Syria, and if they have job. However, to be able to examine the difference in the means of more than two groups, such as the age groups, One-way Analysis of Variance (ANOVA) test was used. For the both of the tests, when having the Sig value (or P value) in the test results greater than 0.05, the Null-hypothesis that says there is no difference in the means of the groups can be accepted. On the other hand, if the sig value is less than or equal to 0.05, the Null-hypothesis can be rejected and the Alternative-hypothesis that says there is a significant difference between the means of the groups can be accepted.

At the same time, in order to be able to set the model of how the independent variables (Secure attachment, Anxious attachment, Avoidant attachment, and the resilience), how these variables affect the dependent variable (PTSD), Multiple linear regression was used. Later on, to test if the used regression model is statistically significant, testing the regression model was done. Finally, all results of the statistical tests applied were reported in chapter 4 and 5.

3.5 Limitations

In brief, possible limitations of the study were identified as limitations regarding the study instruments and the data collection process. Accordingly, using an online survey might be considered as a limitation of the study. Because participants did not have the ability to ask questions regarding the study when needed, thus leading them to answer incorrectly, or random-choose answers. However,t is important to mention that the answers of participants who responded randomly were excluded from the cleaning and screening phase of the data analysis of the study. Another limitation of online data collection process is that you can only reach the person who have an internet and ability of using computer.

Another probable internal threat of the study was the usage of self-report instruments. Since self-report measurements merely replicate persons' perception of the subject examined within the measurement, the answers might be considered personal and limited to one's perception so it cannot reflect perception of a group of people (Lavrakas, 2008). Another limitation related to the self-report measurements is the social desirability. Since social desirability was identified as the tendency of a participant or a group of

participants to respond to the instrument in a way that they might think that pleases the researcher therefore become more socially accepted than reporting their "real" answers (Lavrakas, 2008). People, according to Lavrakas (2008), tend to portray an ideal picture of oneself in order to avoid unfavorable judgment. This is considered a possible threat or limitation since it can lead to a false or fake answer which will affect the data's reliability.

Relatively, the usage of Davidson trauma scale was considered a limitation of the study; Since it evaluates people's PTSD symptoms according to the 17 symptoms suggested by DSM-IV not DSM-V, where other scales such as PCR 5 and Impact of Event scale could be a better tool to assess trauma according to the recent classification of DSM-V. In addition to that, 74% of the study sample consisted of university graduate participants, which kind of limited the ability to generalize the results of the study to other who are none educated ones.

Chapter 4

Results

In this chapter of the study, data analyses conducted in accordance with the research questions are given. Firstly, findings regarding descriptive statistics and correlation analysis are presented. Then, the results of the regression analysis between variables are presented.

4.1 Preliminary Analysis of the Study

In order to investigate descriptive characteristics of the measures utilized in this study, means, standard deviations, minimum and maximum values were calculated or Adult Attachment Styles Scale with its subscales of secure attachment, avoidant attachment, and anxious attachment, Connor-Davidson Resilience Scale, and Davidson Trauma Scale. The results were presented in the Table 2.

Table 2

Descriptive Statistics for the Variables in the Study

Measures	*N*	*Min*	*Max*	*M*	*SD*	Skewness	Kurtosis
Attachment	595	1.05	4.25	2.6814	.49420	0.869	0.376
Secure Attachment	595	.33	5.00	3.2854	.85220	1.813	1.447
Anxious Attachment	595	.00	4.71	1.3263	.94421	0.428	1.550
Avoidant Attachment	595	1.00	5.00	3.5188	.80911	1.571	1.035
Resilience	595	.96	4.00	2.7487	.49438	1.923	0.007
PTSD	595	.00	3.59	1.4455	.69816	0.063	1.893

As can be seen Table 2, the mean score of the individuals with Secure Attachment was 3.28 ± .85, Anxious Attachment was 1.32 ± .94, Avoidant Attachment was 3.51 ± .80 as the subscales of Adult Attachment Scale, and the mean score of the individuals with Resilience was 2.74 ± .49, PTSD was 1.44 ± .69.

4.2 Results Regarding Any Significant Difference In Post-Traumatic Stress Disorder Symptoms According To Gender Among Syrian Refugees

In order to answer the first research question "Is there a significant difference in PTSD levels according to gender among Syrian refugees?"; an Independent-Samples t-test was used. Results were utilized to indicate whether Syrian refugees' PTSD scores differ according to be a male or female. Results were shown in Table 3.

As it was observed in Table 3; there was no statistically significant difference in level of PTSD in terms of gender [F(593, 582.6) = .189, p = .195]. In other words, men (M=1.40, SD=.68) and women (M=1.47, SD=.70) had almost similar levels of PTSD.

Table 3

Independent Sample t-test for PTSD according to Gender

Variable	*GENDER*	*N*	*M*	*SD*	*df*	*t-test*	*p*
PTSD	Female	321	1.4798	.705	593	-1.297	.195
	Male	274	1.4053	.688			

4.3 Results Regarding Any Significant Difference In Post-Traumatic Stress Disorder Symptoms According To Marital Status Among Syrian Refugees

An Independent-Samples t-test was employed to answer the second study question, "Is there a significant difference in PTSD levels according to marital status among Syrian refugees?" The findings were used to see if the symptoms of PTSD in Syrian refugees differed depending on being married or single. Equal variance was not assumed. Results were presented in Table 4.

As it was presented in Table 4, according to the results of the Independent Samples t-tests conducted; there was a statistically significant difference in PTSD levels in terms of marital status [F(593, 358.6) = .295, p = .029]. In another words Married refugees (M=1.40, SD=.69) had significantly lower level of PTSD scores than single (M=1.53,

SD=.70).

Table 4

Independent Sample t-test for PTSD according to Marital status

Variable	*Marriage*	*N*	*M*	*SD*	*df*	*t-test*	*p*
PTSD	Married	407	1.40	.69	593	-2.186	.029*
	Not Married	188	1.53	.70			

** p<.05*

4.4 Results Regarding Any Significant Difference In Post-Traumatic Stress Disorder Symptoms According To Occupational Status Among Syrian Refugees

The findings the third study question, "Is there a significant difference in PTSD levels according to occupational status among Syrian refugees?" assessed if Syrian refugees' level of PTSD differed depending on whether or not they had a job; after applying an independent t-test. Findings were shown in Table 5.

As it was shown in Table 5, the findings showed that there was a statistically significant difference in level of PTSD in terms of occupational status [F(593, 567.2) = 1.929, p = .023]. Those who had a job (M=1.37, SD=.67) received lower scores on PTSD scale than those who didn't have a job (M=1.50, SD=.71).

Table 5

Independent Sample *t-test for PTSD according to occupational status*

Variable	*Occupation*	*N*	*M*	*SD*	*df*	*t-test*	*p*
PTSD	Have a job	257	1.37	.67	593	-2.283	.023*
	No job	338	1.50	.71			

** p<.05*

4.5 Results Regarding Any Significant Difference In Post-Traumatic Stress Disorder Symptoms According To The Duration Of Living In Turkey Among Syrian Refugees

When applying an Independent-Samples t-test to find out if there was a significant difference in PTSD levels according to the duration of living in Turkey among Syrian refugees?; Results were utilized to indicate whether Syrian refugees' PTSD scores differ according to staying 0-5 years or 5-10 years in Turkey. Results are shown in Table 6.

It can be seen in Table 6 that there was no statistically significant difference in favor of any condition at the [F(593, 424.9) = .050, p = .480]. In another words, those who reported staying 0-5 years (M=1.47, SD=.68) and 5-10 years (M=1.43, SD=.70) in Turkey scored nearly the same on the PTSD scale.

Table 6

Independent Sample t-test for PTSD according to Time of living in Turkey

Variable	*Duration*	*N*	*M*	*SD*	*df*	*t-test*	*p*
PTSD	0 - 5 Years	204	1.47	.68	593	-2.283	.480
	5 - 10 Years	391	1.43	.70			

4.6 Results Regarding Any Significant Difference In Post-Traumatic Stress Disorder Symptoms According To Age Among Syrian Refugees

The one-way ANOVA test was performed to answer the fifth study question, "Is there a significant difference in PTSD levels according to age among Syrian refugees?"; Equal variance was not assumed. The findings are presented in Table 7.

According to the results of the One-way ANOVA Test; there was a statistically significant difference in PTSD levels in terms of age among the four groups [F(3, 591) = 5.936, p = .001]. Refugees ranged from 18-24 years old had the highest levels of PTSD (M=1.56, SD=.73) Preceded by those who ranged from 25-40 years old (M=1.32,

SD=.65), Then those who ranged from 40-60 years old (M=1.01, SD=.69); Finally the lowest group in PTSD scores were those who are over 61 years old (M=1.43, SD=.70).

Table 7

One-way ANOVA Test for PTSD according to Age

Age group	*N*	*M*	*SD*	*p*	*Mean Square*	*F*
18 - 24	131	1.5626	.73442	.001	2.823	5.936
25 - 40	292	1.4875	.69984	.001	.476	
41 - 60	151	1.3222	.65636	.001		
Over 60	21	1.0168	.43591	.001		

4.7 Results Regarding Regression Analysis: *"Is there a predictive role of attachment and resilience on the PTSD levels among Syrian refugees?"*

In the hope of answering the research question "Do attachment and resilience of Syrian refugees significantly predict their levels of PTSD?"; and to set the model of how the following independent variables (Secure attachment, Anxious attachment, Avoidant attachment, and the resilience scale), affect the dependent variable (PTSD), multiple linear regression analysis was conducted. Results are shown in Table 9. However, a Pearson Correlation Analysis was applied firstly in order to discover if there is a relationship between resilience, attachment style, and PTSD.

According to the findings in Table 8, significant correlations between the variables were detected and there was a positive and significant relationship between Attachment and PTSD ($r(595)=.281$; $p<0.00$) and positive and significant relationship between Anxious Attachment and PTSD ($r(595)=.365$; $p<0.00$). Avoidant Attachment was also positively correlated with PTSD ($r(595)=.266$; $p<0.00$). However, Participants' PTSD level was negatively corelated with both Secure Attachment ($r(595)=-.223$; $p<0.00$) and Resilience ($r(595)=-.254$; $p<0.00$).

Table 8

Pearson correlation Analysis of resilience, attachment style, and PTSD

Variables	*P*	*r*	1	2	3	4	5	6
PTSD	0.000	595	1					
Attachment	0.000	595	.281**	1				
Secure Attachment	0.000	595	-.223**	3.77**	1			
Anxious Attachment	0.000	595	.365**	.663**	-.159**	1		
Avoidant Attachment	0.000	595	.266**	.631**	-0.60	.134**	1	
Resilience	0.000	595	-.254**	.109**	.397**	-.185**	.049	1

*** Correlation is significant at the 0.01 level (2-tailed).*

On the other hand, the results of the multiple linear regression indicated that the proposed model was significant [F(4, 590) = 44.309, p = .000) with R2 = 0.231], which indicates that 23.1% of the variance in the PTSD variable was explained by the regression model. In another words, Resilience, Avoidant Attachment, Anxious Attachment, Secure Attachment significantly predicted PTSD.

Secure Attachment significantly predicted PTSD (B = -0.077, t(590) = -2.361, p = .019). This indicates that on average, a one-unit increase of Secure Attachment will decrease the value of PTSD by 0.077 units. Anxious Attachment significantly predicted PTSD (B = 0.212, t(590) = 7.691, p < .001). This indicates that on average, a one-unit increase of Anxious Attachment will increase the value of PTSD by 0.212 units. Avoidant Attachment significantly predicted PTSD (B = 0.199, t(590) = 6.281, p < .001). This indicates that on average, a one-unit increase of Avoidant Attachment will increase the value of PTSD by 0.199 units. Resilience significantly predicted PTSD (B = -0.248, t(590)= -4.396, p < .001). This indicates that on average, a one-unit increase of Resilience will increase the value of PTSD by 0.248 units. Results of Multiple Linear Regression are shown in Table 9.

Table 9

Multiple regression analysis examining the predictor of PTSD by Resilience and Attachment styles

Independent Variables	*B*	*SH*	*β*	*t*	*p*	*r*	r^2	Sr^2	*Tolerance*	*VIF*
(Constant)	1.398	.191		7.308	.000**					
Secure Attachment	-.077	.032	-.094	-2.361	.019	.223[a]	.050	.048	.830	1.204
Anxious Attachment	.212	.028	.287	7.691	.000**	.365[a]	.133	.132	.939	1.065
Avoidant Attachment	.199	.032	.230	6.281	.000**	.266[a]	.071	.069	.971	1.030
Resilience	-.248	.056	-.175	-4.396	.000**	.065	.065	.063	.819	1.220

$R = .481^a$; $R^2 = .231$; Adjusted $R^2 = .226$; For Model $[F(4, 590) = 44.309, p = .000$

a. Dependent Variable: PTSD

*** p=,000*

Chapter 5

Discussion and Conclusions

In this chapter, the results obtained by statistical analyses are discussed according to the literature. Moreover, conclusions, limitations of study and recommendations for future studies and practical interventions were discussed.

5.1 Discussion of the Results

In this section, the findings obtained by testing the research questions are discussed respectively.

5.1.1 Discussion and interpretation of the results regarding the level of PTSD in terms of some variables. In order to answer the first research question "Is there any significant difference in the level of PTSD in terms of gender, marital status, occupational status, duration of living in Turkey, Age in Syrian refugees living in Turkey"; an independent samples t-test and one way Anova were applied. According to the results obtained, it was observed that PTSD did not change significantly depending on the gender of the individuals. In other words, no difference was found between male and female participants in PTSD scores. This finding verifies the results of many other sources in the literature. For instance, in the literature the researchers of some studies found that male and female individuals and PTSD did not show a significant difference (Taku, et al., 2007; Wang, et al., 2013). Another recent study that was done on the Syrian refugees in Hatay/ Turkey, verified that no significant difference was found between the gender, age and marital status of the refugees and the levels of PTSD (Cengiz et al., 2019). Similarly, in Marwa's study (2016) with Syrian refugees, no significant difference was found between PTSD and age, gender, and marital status.

There are different possible explanations illustrating these results. One of them is that the sample of this study consisted of Syrian refugees who immigrated to Turkey due to war. In this sense all of the participants were exposed to common traumas such as war and immigration regardless of their gender as male or female. In this way both men and women are expected to show some similarities in their levels of PTSD as a result of their shared traumatic experiences. Another explanation for the similarity between males and females in PTSD levels is related to their levels of resilience; Considering that resilience is a protective factor for PTSD. As some researchers found in their different studies that

there was no significant difference between gender and resilience, which might explain the similarity in PTSD levels in both genders (Petrowski, et al., 2014; Aydın & Egemberdiyeva, 2018; Tosunoğlu & Yıldırım, 2019).

However, it's important to note that some studies that examined the gender gap in civilian response to war traumas, had contradictories in their results regarding gender and PTSD. For instance, some researchers argued that males suffered from greater trauma than women, while other indicated that women were more likely to acquire PTSD than men (Eytan et al. 2004; Mollica et al. 1987; Potts 1994). The results of another study declared that men exhibited more PTSD than women (Thabet, Elhelou, & Vostanis, 2015). As well as in another study, it was seen that PTSD was higher in women than in men (Abo-Ayesha, 2017; Arikan & Karanci, 2012; Kılıç, et al., 2015; Linley & Joseph, 2004;Tedeschi & Calhoun, 1996). Similarly, a prior research has discovered a link between feminine gender and PTSD (Eytan et al. 2004; Brewin et al. 2000; Ozer et al. 2003). Also, a large sample size research (e996) found a strong link between female gender and the development of PTSD (Eytan et al. 2004). Another researcher explained the high level of PTSD more frequently in female by female's higher likelihood of being exposed to traumatic incidents, such as rape, the sudden loss of a spouse and children and being a single parent or a widow (Mollica et al. 1987).

On the other hand, regarding the relationship between marital status and PTSD, results of this present study showed that PTSD symptoms change based on an individual's marital status; Where married immigrants reported much lower levels of PTSD than singles. This result was also assured by other researches in the literature. For example, in their study with veterans, Maguen, Ren, Bosch, Marmar, and Seal (2010), found that single refugees showed more PTSD symptoms than married ones. Similarly, following Uganda's civil war, a study of PTSD-related variables among refugees found that being single and experiencing traumatic experiences were linked to PTSD (Roberts et al. 2008). Furthermore, there are research in the literature that suggest that post-traumatic growth (PTG) was greater in married people while PTSD is lesser (Cengiz, 2017; Wang, et al., 2013). These studies suggested some explanation of their results by emphasizing the negative correlation between post-traumatic growth and marriage with PTSD; Where marriage offers social support, strong ties with other, better emotional coping with

problems leading married traumatized people to have higher PTG; As a result, both marriage and PGT were considered as protective factors for PTSD which explains why married people had less PTSD in this current study as well.

Another possible explanation for this finding is that after a traumatic incident, it is critical that people do not feel alone and have social support. Loneliness was discovered to be positively related with PTSD (Şahin, et al., 2020), whereas social support was discovered to be negatively related to PTSD (Prati & Pietrantioni, 2009). As a consequence, the person's perceived social support was considered to be crucial, especially when he or she stays in a group or family system; As well as social support has been linked to higher resilience and lower PTSD, and is considered an effective factor for PTSD and recovery (Aydn & Egemberdiyeva, 2018; Fontes & Neri, 2015). Furthermore, it was yielded in certain studies in the literature that psychological resilience is stronger among married people (Ernas, 2017; Beutel, et al., 2009). According to Ni et al. (2015)'s research, marriage predicted women's resilience. As women in a marriage context, tend to have better communication with their spouses, greater emotional support, good sense of bonding with others, and deeper overall coping with adversities; All of this might result in higher resilience levels in married females which in return, offers another explanation of lower rates of PTSD in married people regarding their high resilience level.

In accordance with this study’s third finding regarding occupational status and PTSD, it was revealed that the degree of PTSD varied greatly depending on the refugee's employment; Where those who worked had low level of PTSD than those who they did not. Possible explanations for this finding by Jackson (2017) are that firstly, employment for refugees who have a job, might help them overcome the trauma they have suffered by changing their focus and providing them with new mental, psychosocial and financial resources. Secondly, work can boost individuals' characteristics such as self-esteem and self-efficacy, drive them to cling to life and wish to develop themselves more. Thirdly, is that individuals meet new people in the work environment and this social interaction with others can lead to an increase in their adaption to the new culture of their asylum and to increase their perceived social support, thus decreasing their level of PTSD.

Another suggested explanation for the results which was linked to resilience; was suggested by other studies, where researcher has found that levels of the resilience of the

employed participants were higher than the non-employed participants (Boell, Silva, & Hegadoren, 2016; Beutel, et al., 2009). These results were explained by the researchers by clarifying the positive impact that work have on people life's quality, life satisfaction, high level of self-esteem, self-sufficiency, integration into civilization, perceived social support from peers and teamwork, and boosted self-competence. Similarly, it was mentioned that the previous features are related to higher resilience and lower PTSD levels in the literature (Hildon, et al., 2010; Aydın & Egemberdiyeva, 2018; Kılınç, Yıldız & Kavak, 2019; Batool, et al., 2020). At the same way, while effective accumulation of resilience appears to improve access to health care, reduced resilience can limit a refugee's ability to acculturate effectively and integrate into new societies. Therefore, increasing the resilience of refugees can be an important element in facilitating acculturation and improving one's ability to access needed health/mental health services (Almedom, 2008; Smith, 2009).

It's worth mentioning that Turkish government had been supporting refugees financially by providing them with job opportunities and monthly aid for the families of orphans, disabled people and those who cannot work. This might have leaded to the enhancement of their resilience and coping with traumas and mental health issues including PTSD (kabadayi, 2019).

Another aspect of the results of this current study indicated that there was no statistically significant correlation between PTSD and the duration of being in asylum. This finding is also supported by other studies in literature such as the study of the warriors who fought in World War I; These warriors kept displaying symptoms of PTSD years after war had finished (Coleman, 2006). Also, in the years after World War II, many war victims, militaries and citizens, asked for help for their psychological problems, including PTSD symptoms and even though the fight was ended, and years have passed, their symptoms of PTSD kept in showing (Kaptanoğlu, 2001). Moreover, in another research of army, the occurrence of PTSD was found to be 12 percent when the soldiers returned from the 2nd Gulf War to the United States (Hoge et al., 2004); and it was found to be 16 percent one year later (Hoge, Terhakopian, Castro, Messer, & Engel 2007).

A probable clarification for this result might be explained by the preceding statement. As it is known, PTSD is a serious mental disorder that causes a real suffering

for a human and might be dangerous for his life and others, so in many cases, it may require medical and psychological treatment. That's why, when PTSD is left without a treatment, most probably it will continue to exist and remain at the same level. Simply because a person cannot treat himself while maintaining the same mentality and psychology of suffering, thus suffering cannot be healed by itself. In another word, as Albert Einstein said that the mind that created a problem cannot solve it (Adriansen & Knudsen, 2013). That's why unless people who were exposed to trauma were treated and had an efficient mental health care and therapy, their level of mental health issues including PTSD will not be expected to lessen.

Another probable clarification for the persistent level of PTSD in Syrian refugees despite their duration in the countries they immigrated to, is that the Syrian war as a trauma is still going on with its negative news of death, homicides, bombing, arrestment, losses proceeding in daily rhythm. Besides, migration in itself and living in a foreign country has its own ongoing challenges and perhaps includes other types of traumas such as rejection, bullying, poverty and racism. All of these might cause a reproduction of an ongoing traumatization for Syrian refugees, leading their level of PTSD to proceed.

A final result of this study for PTSD's relation with the descriptive statistics specified that the severity of PTSD varied greatly depending on the age group of the participants. Where, refugees aged 18-24 years old exhibited the most PTSD symptoms when compared to the other three older groups. As well as, participants between the ages of 25 and 40, as well as those beyond the age of 61, reported higher levels of PTSD than those between the ages of 40 and 60. Likewise, people between the ages of 40 and 60, on the other hand, had higher PTSD ratings than those above the age of 61. Ultimately, those above the age of 61 had the lowest level of PTSD.

These findings were supported by other studies in the field. For example, as a result of some studies (Weiss, 2004, Wooloff, 2014), age factor was associated negatively with PTSD. Besides, it was stated that younger individuals show higher PTSD levels (Manne, et al., 2004). Additionally, an alternative study which has included people who experienced war trauma and living in Croatia, has affirmed 52% of PTSD diagnosis probability using binary regression analysis was related with the factors: age, male gender, level of stress perceived by trauma, and the negative effects of trauma in life activities

(Crepulja et al. 2011).When the results of these studies were compared with the findings of this existing study, the findings seems to be equivalent and supporting each other.

A distinct point that is considered to be very important in explaining these results is the fact that Syrians have been experiencing war and war-related traumas since 2011; Which clarifies that refugees aged 18 to 24 who expressed the highest levels of PTSD were just 8 to 14 years old when the war started in Syria. This fact can explain how this group of participants were so young and fragile with less defensive mechanisms and coping strategies to deal with all of war and immigration related traumatic events. As a meta-analysis study by Brewin, Andrews, and Valentine (2000) explained that trauma's impact and PTSD presence are so much relevant to the age of onset and which phase of life, the ability to adjust, the proportion of social support and resilience extent, problem solving and coping techniques. This is also supported by another study that indicated that the severity levels of PTSD varied a lot depending on the level of trauma exposure, the time of onset, the amount of traumatization and the damage and negative effect of trauma on life (Noyes, 1998). All of these factors explains why Syrian young refugees who were exposed to trauma from a young age with an enormous amount of traumatic events through an ongoing ten years of war and immigration added to the lack of social support and shortage of psychological treatment can lead to higher levels of PTSD in youngsters then elderly people.

Equally important, it was discovered that the degree of secure attachment style improved significantly with age advancement (Abu-Ghazal and Falwah, 2014; Koser & Barut, 2020). This finding might be explained by the fact that as people get older, they are becoming more self-reliant, self-actualized, and have a strong sense of self, and elderly people may have an extra favorable perception of themselves, others, and the world, all of which proposed that they have a better degree of secure attachment style. Another parallel explanation is that people with older age tend to have a better adaptation, coping and problem-solving strategies, reaching for mental health assistance and capacity to integrate to change and overcome challenges (Abu-Ghazal and Falwah, 2014). That’s all explains what was found in this study, that elder people exhibited lower levels of PTSD than those who were younger. On the other hand, young Syrian refugees reported that education instills a tendency towards resilience, empowers them to make positive changes in society,

and has a positive impact on their lives (O'Keeffe and Niyonkuru, 2021). This emphasizes the importance of education on refugees' mental health and resilience.

5.1.2 Discussion and interpretation of the results regarding the regression analysis. To examine the hypothesis the third question of the research "Does the resilience and attachment styles have predictive role on PTSD", a multiple linear regression was applied. But before, a Pearson correlation was applied and statistically significant relationship between resilience, avoidant attachment, anxious attachment and secure attachment and PTSD was found. As well as, the relationship between anxious attachment style and PTSD was found to be positive while the relationship with resilience was negative. This finding is compatible with other studies (Karreman and Vingerhoets, 2012; Karaırmak and Güloğlu, 2014; İnan, 2015). Besides, many other studies have found a negative relationship between avoidant attachment style and resilience (Jenkins, 2016; Marriner, Cacioli, & Moore, 2014).

The findings also revealed that resilience, avoidant attachment, anxious attachment, and secure attachment all predicted PTSD significantly. Furthermore, variations in resilience, avoidant attachment, anxious attachment, and secure attachment explained 23% of PTSD. What's more, the findings of the multiple linear regression model revealed that resilience and secure attachment have negative influence on PTSD; In another word, when resilience or secure attachment are high, PTSD is expected to be low. On the other hand, anxious and avoidant attachment both have positive impact on PTSD. Which means that when participants have high levels of anxious or avoidant attachment, their level of PTSD is expected to be high as well.

In this context, the findings of the current study were consistent with the results of earlier studies. Many studies have shown that securely attached individuals had a high level of PTG and lower levels of PTSD (Bratkovich, 2010; Gleeson, et al., 2020; Salo, et al., 2005). At the same time, there are many studies in the literature that show a positive relationship between secure attachment style and resilience (Karaırmak & Güloğlu, 2014; Marriner, Cacioli, & Moore, 2014). To clarify these findings it's important to understand that the emergence of resilience as the ability to adjust and cope with adversity, there needs be a dangerous scenario and adversities(Block & Kremen, 1996). Besides, Secure

attachment is considered a protective factor linked to a number of good personality traits, whereas insecure attachment is a risk factor linked to a number of negative personality traits (Eagle, 1995). Similarly, Naderi, Akbari, and Abbasi-Asl (2016) found in their study that secure attachment style was a positive predictor of resilience, while avoidant and anxious attachment were negative predictors of resilience. In this context, it is thought that secure attachment style plays a protective role in increasing resilience and decreasing PTSD.

Likewise, the result of the current study regarding the negative relationship between secure attachment style, resilience and PTSD is consistent with the findings of previous studies. And a proper clarification of this might be that individuals with secure attachment and high resilience level have high job performance, self-confidence and success motivation, and are not afraid of failure and can establish healthy social relationships (Bassiouni & Al-hajjaji, 2019; Hazan & Shaver, 1990). In this context, it is thought that individuals with secure attachment and resilience can deal with mental health problems including PTSD better than individuals with other attachment styles.

At the same way, according to the results of a study, it was found that exposure to human-induced traumatic events is associated with persistent avoidant attachment tendencies in refugees (Morina, et al., 2016). Similarly Bilge (2019) emphasized that the lives of individuals exposed to human-induced traumas are more negatively affected by other types of traumas (natural or accidental traumas); Because, when people face traumatic experiences done by other humans, their trust in others is shaken, and they cause feelings such as hopelessness, shame and guilt. That's why he suggests that it may be related to the knowledge that overcoming such traumas is more difficult to cope with and to have a positive outcome. All of this gives an explanation for the study's result regarding the positive relationship between PTSD, anxious and avoidant attachment style.

Lastly, refugees are not only more likely to experience physical and mental health problems compared to the general population (Kinzie et al., 2008; Mills et al., 2008; Sabin et al., 2006), but also to access health services related to language and culture; They also encounter obstacles (Mizra et al., 2013; Morris et al., 2009; Saechao et al., 2011).

In fact, displaced people have been shown to have a high risk of mental illness, directly related to the amount of traumatic stress they experience (Steel et al., 2002). On

the other hand, displacement is often accompanied by a wide variety of additional traumatic events, such as exposure to war, violence from occupation forces, and war-related loss of relatives. In addition, displaced people often identified feelings of homesickness and longing, and the impossibility of returning to their homeland as some of their main grievances (Kuwert et al., 2007).

In conclusion, attachment styles, PTSD and resilience; These three variables were examined together, found to be related to each other and their effectiveness on each other was determined.

5.2 Conclusions

The aim of this study was to examine the relationship between attachment styles, resilience and posttraumatic stress disorder among Syrian refugees living in Turkey. The population of the study consisted of n=595 (321 females, 274 male) Syrian adult refugees above the age of 18 who came to live in Turkey after the start of war in Syria at 2011. In order to achieve the main purpose of the study, firstly; PTSD was examined according to some personal variables (gender, marital status, income level, occupational status, time of living in Turkey and age). Subsequently, the multiple linear regression analysis was conducted to examine to what extent attachment and resilience significantly predict post-traumatic stress disorder.

1. It was concluded that level of PTSD did not make a significant difference according to participants' gender. In another words, the level of PTSD was almost equal for both male and female participants.
2. Level of PTSD differed according to their marital status; Where married participants compared to those were single were found to be significantly lower in PTSD.
3. Level of PTSD differed significantly according to the occupational status of participants. Those who reported having a job were significantly lower in PTSD than those who reported not having a job.
4. It has been found that PTSD did not make a difference regarding the time of living in Turkey; where refugees who reported staying 0-5 years and those who lived for 5-10 years in Turkey scored nearly the same on the PTSD scale.

5. The findings of the analysis indicated that PTSD differed significantly according to the age group of the participants. Syrian refugees aged between 18-24 years old reported the highest levels of PTSD compared with other three elder groups. Also, those who ranged from 25-40 years old reported higher levels of PTSD than those who ranged from 40-60 years old and those who were over 61 years old. Similarly, those who ranged from 40-60 years old scored higher on PTSD than those who were over 61 years old. Finally, those who were over 61 years old reported the least level of PTSD.

The results revealed that resilience, avoidant attachment, anxious attachment and secure attachment are significantly correlated with and predicted PTSD. In addition, 23% of the variance in the PTSD variable was explained by the changes of resilience, avoidant attachment, anxious attachment, and secure attachment.

5.3 Recommendations

This section includes suggested recommedations for future researchers and for practioners in the fieled to benefit from it.

5.3.1 Recommendations for the researchers. A key recommendation for future researches is to explore more factors affecting the psychological resilience and mental health of refugees. As well as examining closely the relationship of the core variable of this current study by an experimental design to come with more efficient results. Another recommendation for researchers is to enlarge the study group to include Syrian refugees living in other neighboring countries such as Lebanon, Jordan and Iraq; Besides maybe comparing Syrian refugees' results with other refugees in other countries including other trauma types victims. In addition, researchers are recommended to initiate new PTSD studies that assess novel treatments, in the hope of finding efficient possible ways of treating PTSD and mental health issues related to refugees that are time and cost wise. A final recommendation would be, to make another detailed PTSD scan in Syrian refugees, especially after ten years of war and immigration and see how it is related to their mental and physiological issue. This would help coming up of new projects, ideas, and regulations related to refugees' life.

5.3.2 Recommendations for the Practitioners. Since many people are displaced during wars, it brings a huge responsibility to the hosting countries to deal with mental health issues while dealing with refugees. Similarly, it is also common to expect an increase in mental health disorders in Syrian refugees because of trauma and violence experienced during the war era. That is why, Turkish government has given attention to humanitarian aid, mental health treatment and psychological support provided for Syrian refugees hosted on the Turkish land. As well as Turkish government was highly supportive to Syrian refugees and allowed many national or international humanitarian relief organizations to provide different kinds of aid to Syrian refugees inside and outside camps. For instance, since March 2011, the IHH Humanitarian Relief Foundation has been the leading organization providing support to Syrians living outside the camps. Syrians have received essential necessities from the government through IHH services such as shelter, food, and healthcare. Also, the Turkish government has been delivering food packages for children and babies, as well as clothing, hygiene packages, wheelchairs, crutches, first aid kits, as well as linen, pillows, and blankets. Tents, containers, mats, and blankets have also been provided as shelter help.

On the medical side, Turkish government didn't only open its hospitals and medical centers for injured and sick Syrian refugees to be treated, but also provided them with medicine and helped with the transfer of some patients to other hospitals outside Turkey to receive better treatment. Moreover, the Turkish government didn't only support Syrian refugees on its land but also included others inside Syria and the neighboring countries. For example, 45% of the governmental aid has been distributed to Syrians in Turkey and in the other bordering countries and 55% has been distributed inside Syria.

Another example of the Turkish aid for Syrian refugees comes from Kimse Yok Mu (KYM) which is a Turkish Non-Governmental Organization. KYM delivers humanitarian aid to Syrian refugees mostly in Jordan and Lebanon based. KYM provided 5.5 tons of relief supplies to Syrian refugees in Jordan after negotiating with local authorities. KYM provided food, clothing, and blankets to 12,000 people in Antakya and 2,000 people in Kilis in Turkey. In Kilis, KYM also constructed temporary toilets, restrooms, rubbish containers, and play areas. KYM also operates a mobile kitchen in Gaziantep, where 1,000 Syrians are fed hot food on a daily basis. In September 2012,

KYM built a health care center in the region, staffed by two Syrian physicians, two nurses, and two pharmacists.

In addition to that, Syrians have also been given permission to work with Turkish NGOs to build humanitarian relief centers, schools, and health clinics; In order to be able to integrate and cope in a better way with their new life conditions in Turkey.

However, due to the large number of Syrian refugees, lack of resources and the very small number of Arabic speaking mental health professionals, it was highly important to explore and come up with an efficient way that is time and cost wise to solve trauma related mental health issues of Syrian refugees and help them to cope better and become more resilient against their tough experiences of war and the challenges that they counter in their displacement in a foreign land.

The findings of the study regarding refugees, attachment styles, resilience and PTSD are very valuable for professionals working in this field. In fact, findings of this study might be useful for psychological counselors and therapists, universities, workplaces, institutions, associations, communities and organizations where refugees and asylum seekers are an issue of subject.

One of the main recommendations for psychological counselors is to develop educational models for their patients that improve attachment styles and level of resilience. Hoping that this will lead to a higher resilience and psychological wellness among individuals in general. They can also develop activities to be applied in guidance and integration lessons for new coming refugees helping them to lessen their psychological sufferings, become more resilient and adapt to the new community the immigrated to. In addition, psychological counselors can establish workshops on these matters to help boosting the awareness of refugees and hosting communities about the psychological difficulties facing refugees and ways to deal with them.

Another recommendation for professionals from municipalities, public education centers is to teach people on the subject of this research and make public awareness by making seminars and workshops in the hope of increasing the tolerance and understanding of the members of the host community and refugees too.

Another environment where refugees and public members come together is universities. In fact, universities are environments where individuals from different

cultures gather. If the instructors and the students become aware of different challenges and characteristics of refugees, this can help them integrate and communicate in a tolerant humanistic basis; which in return will be reflected positively and fruitfully on the whole environment of the university.

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