



INTERNATIONAL
UNIVERSITY OF SARAJEVO

THE RELATIONSHIP BETWEEN REFUGEE MOTHERS'
DEPRESSION AND ANXIETY SEVERITY AND
SEPARATION ANXIETY LEVEL OF THEIR CHILDREN

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BY

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Master thesis submitted in partial fulfillment of the
requirements for the degree of Clinical Psychology, MA
Programme

Faculty of Arts and Social Sciences

International University of Sarajevo

2019

APPROVAL PAGE

I certify that I have supervised and read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a thesis for the degree of Master in Clinical Psychology

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DECLARATION

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graduate education seamlessly.

LIST OF ABBREVIATIONS

et al.	Et alia; and others
etc	ed cetera; and so forth
SAD	Separation Anxiety Disorder
BDI	Beck's Depression Inventory
BAI	Beck's Anxiety Inventory

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“An immigrant leaves his homeland to find greener grass. A refugee leaves his homeland because the grass is burning under his feet.” - Barbara Law

ABSTRACT

A lot of research exists when it comes to traumatization and depression. Despite this, there is a significant lack of scientific research about the level of mother's depression and anxiety and the level of separation anxiety of their children. The purpose of this study, first of all, is to examine the relationship between the Syrian refugee mother's depression and anxiety severity and separation anxiety level of their children. This study will be conducted at the Refugee Center in Sultanbeyli, where a considerable number of refugees have been registered. 57 families, which means 57 mothers and 57 children, 114 participants in total used for this study. This will be a quantitative study and it will draw on the following basic research question: Is there any relationship between mothers' depression/anxiety level and their children's separation anxiety level? In order to investigate the level of depression, Beck's Depression Inventory (BDI), to investigate the level of anxiety, Beck Anxiety Inventory (BAI), and to investigate the separation anxiety level of children, Severity Measure for Separation Anxiety Disorder were used.

Keywords: Refugee, maternal depression, maternal anxiety, separation anxiety

CHAPTER ONE

INTRODUCTION

1.1. Background of the Study

Previous research suggests that various developmental risk factors in early childhood are associated with anxiety disorders in children. Acculturative stress and other risk factors related to migration have been associated with anxiety in adolescents and adults (Leon, 2014). Trauma is defined in the Oxford English Dictionary as a strong shock that can effects the individual overwhelmingly and gives long-lasting results (Kinchin, 2004, p.2). PTSD is the most common psychiatric disorder after traumatic events and disasters (Gerritsen et al., 2006). It is indicated by Blake (2010), that denial is used as a definition of when the traumatic event has passed, and the patient clearly demonstrates PTSD symptoms and is diagnosed as having PTSD (p.13). According to Kinchin (2004), PTSD occurs when a person is exposed to a situation that is outside the normal range of human experience: an event that will cause significant distress for almost everyone (p.2).

UNHCR (2005), clarified that the number of global refugee population increase from 2.4 million in 1975 to 10.5 million in 1985 and 14.9 million in 1990. It was reached to peak after the end of Cold War with 18.2 million in 1993 and the global refugee population had decreased to 12.1 million in 2000 (as cited in Castles and Miller, 2003, p.103).

According to Türkoğlu (2011), refugees are those who have to leave their country for a variety of reasons beyond their own will. He explained the main causes of the

refugee movement like war, ethnic conflicts, internal conflicts, repressive and authoritarian regimes, natural disasters and environmental problems.

Castles and Miller (2003), indicated that there has been a high increase in the population of refugees worldwide since the middle of the 1980s. They explained two types of migrants that include forced migrants and voluntary migrants. Forced migrants moved to escape from cruelty, conflict, and war. Unlike the forced migrants, voluntary migrants move for economic or other benefits (p.102). Syrian civil war started in March with a brutal military coup against anti-government protesters and then displaced about 12 million people (Selçuk R. Sirin and Lauren Rogers Sirin, 2015, p.2). Furthermore, the researchers Selçuk R. Sirin and Lauren Rogers Sirin (2015), explained that children under the age of 18 represent half of the refugee population in Syria and about 40 percent are under 12 years of age (p.2). According to Birman & Tran (2008), refugee children are faced with different challenges from children subject to citizenship but often suffer from trauma from their own country (as cited in Allen, 2016).

USCR (2001), has reported that Afghanistan was the biggest source of refugees, 4.5 million Afghans accommodated in other countries mainly in Pakistan and Iran.

Burma, Iraq, Vietnam, China, Bhutan, East Timor, the Philippines, and North Korea are the other major refugee sources (Castles and Miller, 2003, p.172).

Immigration and resettlement experience Syrian refugee women may jeopardize their general mental well-being with their pregnancy and motherhood experiences. The immigration process may have added tremendous stress and uncertainty to women's lives, it may increase their vulnerability to depression especially during the time of women's giving birth (Racine & Lu, 2015).

1.2. Research Aim and Significance

The purpose of the present study is to examine the relationship between mothers' depression and anxiety severity and separation anxiety rating of their children. In addition, the study examines whether there is a significant difference between child separation anxiety scores related to child's age, gender, marital status of their mother and whether there is a significant interaction effect between these variables and mother's depression and anxiety on children's anxiety.



CHAPTER TWO

LITERATURE REVIEW

2.1. War in Syria

Themnér & Wallensteen (2011), has defined wars traditionally as major armed conflicts between two or more state military forces. However, in recent wars, it is becoming increasingly difficult to distinguish traditional wars from other forms of armed conflict. Fighting between states is exceptional, with nine of the ten fights being internal or internal wars.

First, Syrian protestors, who rebelled against Syrian President Bashar Assad's regime in 2011, adopted a nonsectarian approach. However, sectarian discourse and perceptions prevailed in ongoing conflicts. Within a month of the first wave of protest in mid-March 2011, sectarian identity has become an important and overwhelming element in the interpretation of violence (Wimmen, 2016).

Moreover, Humud et al. (2018), has explained that anti-government protests broke out in Syria in March 2011, which has been going on for forty years by the Asad family. The protest was spread and accompanied by the rise of violence and the formation of many political and armed opposition groups. Although the war takes place within the borders of the country, its reflections are felt in many parts of the world, in many people's lives. It was initially understood that this crisis, roughly regarded as the Syrian part of the Arab Spring. However, at a much larger scale over time and that its causes had deeper roots. This can be seen more clearly when examining the qualities and aims of opposition and pro-regime

groups (Özdemir, 2016). Özdemir (2016), has also added that, in 2000, although the promises and reforms that were given by Assad, in the beginning, were fulfilled, the problems started later on. With the bad situation of the economy, there were people who were subjected to oppressive rule in various regions, and people started to rebel and Arab Spring has become a turning point for these rebels. The demonstrations that started in Dera in 2011 spread to the whole country in a short time and it turned into a civil war with violent repression of this demonstration.

2.1.1. Being Refugee

For centuries people have suffered discrimination and are forced to escape from their homes due to conflict, political, racial and religious atrocities, natural disasters and inhuman treatments in their societies (Bacaian, 2011).

Human beings have started migration since the earliest societies. The first immigrants were tribal people who search for food, water, and resources.

However, they were not yet refugees or asylum seekers; they were collectors or hunters who began to explore new lands (Bacaian, 2011). Migration has described by Dedeoğlu & Gökmen (2011); Bhugda & Gupta (2011), as the process by which people go to another country, region or settlement where they have come to live as permanent. There might be some reasons for migration including the economic situation, education that attributes to the individual's wishes. However, causes such as war, conflict can be the reason of migration that the person does not volunteer to be migrant (Başterzi, 2017). There is great confusion about the difference between an asylum seeker and a refugee, and often the terms are replaced or misused. An asylum seeker is defined as a person

who requests international protection but has not yet been granted a refugee status request. On the contrary, a refugee is defined as a person recognized by the 1951 Convention on the status of refugees asylum (Philips, 2011). In addition, according to Başterzi (2017), asylum seeker or refugee; is a legal name given to persons who have to take shelter in another country or region for reasons such as war, conflict, political reasons.

When the United Nations High Commissioner for Refugees (UNHCR) was established in 1951, there were about 1.5 million refugees. By the end of 2009, an estimated 43.3 million people worldwide had been displaced, including 15.2 million refugees, 983 000 asylum seekers, and 27.1 million internally displaced persons. It is estimated that there are 25 million people displaced because of natural disasters. Moreover, in the 2013 report of the UN High Commissioner for Refugees, it was stated that the number of people displaced globally by the end of 2012 reached 45.2 billion and that this would be much more when considering those living in Syria (Philips, 2011). Four of all fifths refugees reside in developing countries, and three quarters are seeking asylum in neighboring countries. However, a significant number of refugees are also seeking asylum in Western countries (UNHCR, 2009a).

In the early stages of immigration and during migration, there are many studies in which psychiatric trauma is experienced both in this period and in lifetime risk of emergence of mental illnesses, especially post-traumatic stress disorder and depression (Başterzi, 2017). It is known that the frequency of mental illnesses is higher in immigrants, refugees and asylum seekers (Bhugra et al., 2011; Bhugra et al., 2014). A study with 7,000 refugees conducted by Fazel et al. (2007), has

indicated that there is a rate of 11% in refugee children, 9% in adults post-traumatic stress disorder 5% major depression, and 4% general anxiety disorder (Başterzi, 2017). In another study, it has been shown that the mental illnesses seen in the refugees show significant differences in different studies, conditions of the settled country, the war, the post-settlement stressful situations are related to the mental health. It has been reported that depression, PTSD, and anxiety disorders are seen in over 20% of each (Bogic et al., 2015).

2.2. Depression

Depression is a state of affliction for most of the day, characterized by sadness, emptiness, hopelessness, and loss of interest (American Psychiatric Association, 2013).

Mood disorders are the most common psychiatric disorders and the mood is defined as a common and constant feeling or emotional tone that affects one's behavior and perception of the world. Depression is one of the diseases classified as a mood disorder (Anushiravani et al., 2018). It is one of the five most common disorders worldwide and is expected to be the second most important cause of disability in 2020 (Rezaee et al., 2016). In addition, in another study conducted by March et al. (2004), it has been indicated that depression is one of the most important causes of morbidity in all countries. It is a common and devastating disease that both genders can be affected by (as cited in Rezaee et al., 2016). It is also a widespread but serious disease that can cause a person to fall off the capacity to enjoy life and to fall off the capacity to handle even the simplest everyday tasks. Apart from chronic nature, symptoms associated with this mental disorder are often recurrent and life-threatening. (Fakadu et al., 2017).

Depression has defined by Peacock (2000), as a mood disorder that is caused by extreme sadness and hopelessness (p.4). The author also expresses that depression is a kind of medical illness just like cancer or heart disease. It is possible to identify or diagnose and treat this illness. However, if depression is not treated, this may cause serious consequences (p.6). The diagnoses of depression can be given when a certain period of time has been met for certain criteria and distress or dysfunction has occurred (Callahan et al., 1994).

Depressive disorders in DSM-5 include depressive disorder due to destructive mood disturbance, major depressive disorder, Persian depressive disorder, premenstrual dysphoric disorder, depressive disorder induced by substance/drugs and other medical conditions and the common feature of these situations is the existence of a sad, empty or irritable mood that, together with certain cognitive and somatic indications, leads to significant distress or deterioration in functioning. (Maina et al., 2016). According to Grguric et al., (2009), stressful life events come before or after the onset of a depressive disorder. The incidence of adverse life events is much more common during the war (p.474).

According to the DSM V diagnostic criteria for depression, the following five or more symptoms are present for two weeks, such as depressive mood during the day, reduced taste, weight loss or weight gain and decrease or increase in all activities appetite, insomnia or hypersomnia, psychomotor agitation, fatigue or loss of energy, worthlessness or excessive or inappropriate guilt, reduced ability to think or concentrate, or indecisiveness and repetitive thoughts of death. All of these symptoms affect many important areas of the individual's life. (Khan et al., 2017)

Recent investigations have identified that post-traumatic stress disorder and depression are the two most common disorders in the refugee population (Steel, Silove, Phan, & Bauman, 2002). In addition to this one study by Lindert et al., (2009), reported that there is a prevalence rate for depression of 44% in 24,051 refugees. Furthermore, it has been shown by Glidden & Schoolcraft (2003), that children of depressed mothers have a variety of problems in cognitive, linguistic and social functioning when compared to children whose mothers are not depressed. In addition, another study says that mothers are the main ‘attachment figure’ for their children. However, if the mother shows depressive indications, interaction problems may occur between child and mother. Also, children whose mother shows depressive symptoms may have more risk to be anxious and develop insecure attachment (Velders et al., 2011)

It is reported by the researchers that academic performance and the way a person feels, sleep and behave are affected by depression (Ali et al., 2014). According to Hirsch et al. (2011) & Klemenc-Ketis et al, (2011), young people with depression have risks such as academic difficulties, school dropouts, interruptions to family and friends, and medical problems that continue during later adulthood (Ali et al., 2014).

Maternal depression has significant negative effects on the development of children. This is especially true for critical periods of brain development in infancy and early childhood that children use to support their brain development, their interactions, and their cognitive and behavioral skills (Burrow, 2016). Studies conducted by Anderson & Hammen (1993); Beck (1999); Carler et al. (2001); Goodman (2011) & Zahn-Waxler et al. (2002), have found strong links between mother's depression and children's cognitive and language development. Maternal depression also affects

socio-emotional competence, including internalizing and externalizing behavior problems of children (as cited in Burrow, 2016). Moreover, a study by Sullivan et al. (2000), indicated that children with a parent who has depressive symptoms are three times more likely to develop depression than the children of non-depressed parents.

2.2.1. Sign and Symptoms of Depression

Uher et al. (2014), indicated that depression is a syndrome characterized by various signs and symptoms and diagnosed according to psychiatric disease criteria (as cited in Rezaee et al., 2016). According to Anushiravani et al. (2018), depressive patients show symptoms such as loss of energy and interest, guilt, difficult concentration, loss of appetite and death or suicidal thoughts. Other signs and symptoms of depression include changes in cognitive abilities, activity level, biological functions and speech like sleep patterns or sexual activity. In other studies conducted by Darabadi et al. (2004); Hawthorne et al. (2008); & Mokhtaripoor et al. (2008), sign and symptoms of depression pointed out like loss of energy and passion, concentrating problems, feelings of guilt, anorexia and suicidal thoughts (as cited in Rezaee et al., 2016). Also, American Psychology Association states that there are some indicators of depression that include losing or gaining weight, insomnia or hypersomnia, fatigue/energy loss, psychomotor agitation or retardation, feelings of worthlessness, extreme guilt, concentration deficits, death thoughts and suicidal thoughts (American Psychology Association, 2013). If these symptoms affect psychological, physical, or interpersonal functions for at least two weeks, a diagnosis of depression may be given (Kahn, 2001). The World Health Organization (WHO) (2011), depressive feelings and symptoms may be acute or chronic, often repeated, and can significantly

impair one's ability to perform activities of daily living. In the most extreme cases, depression can lead to suicide and result in about 850,000 deaths each year.

Furthermore, there's no only one reason for depression. The determinants of depression include age, race, gender, educational level, and marital status. A spouse's death, job loss, and possibly urban life can also affect people to show depressive symptoms. (Kahn, 2001). Wells et al. (1989), demonstrated that patients with depression perceived their general health and social and occupational functioning more deteriorated than patients with other chronic medical conditions.

According to Paulson et al. (2009), in part, it appears that maternal depressive symptoms have harmed children by discouraging consistent, careful, sensitive, and responsive care that supports optimal development (as cited in Burrow, 2016). A number of studies show that mothers with mental illness are less emotional, less likely to be positive towards their children, and more likely to reject discipline strategy (Oyserma et al., 2000). When mothers have depressive symptoms, their tolerance toward problem behaviors might be less and they may respond more punitively to mild misbehavior than they would before (Lahey et al., 1984).

Moreover, it is demonstrated that, compared to the parents who do not show any depressive symptoms, the mothers living with the depression statement are more likely to have "compelling" interactions with the children (Gartstein & Fagot, 2003).

2.2.2. Major Depressive Disorder

The evidence for Major Depressive Disorder is in thousands of years. In the fourth century BC, Hippocrates mentioned major depressive disorder as a group of

symptoms such as loss of appetite, insomnia, flatness, and loss of nervousness (Jackson, 1978).

As described in the Mental Diagnostic and Statistical Manual Disorders, 5th edition (DSM-V), a distinctive feature of major depression disorder (MDD) is the formation of depressive mood (dysphoria) and disappearance of interest in activities that have been quite enjoyable for at least two weeks in the past. These symptoms should be accompanied by at least four of the following symptoms, such as appetite or weight changes, sleep patterns, altered psychomotor activity, feeling of worthlessness or guilt, concentration difficulty or decision making and recurrent death or suicidal thoughts. (Fekadu et al., 2017). According to Machado-Vieira et al. 2008, major depressive disorder (MDD) is a severe, recurrent, and inhibitory disease that is very common worldwide and often has a negative effect on medical health, quality of life, and productivity (as cited in Gulec, 2012). Patients with a major depressive disorder often exhibit dysphoric mood and anhedonia with physical changes such as weight loss or gain, increased or decreased appetite, changes in sleep patterns and persistent fatigue. The vast majority of these symptoms are present almost daily and cause significant distress and deterioration of social life and professional performance (Fekadu et al., 2017).

Moreover, DSM-IV-TR diagnosed major depressive disorder by the presence of some symptoms including psychological, behavioral, cognitive and somatic/physical symptoms. Sadness can be an example of psychological symptoms, suicidality is an example of a behavioral symptom, having difficulty with concentration is cognitive symptoms and sleeping problems, loss of energy and psychomotor problems are the example of somatic/physical symptoms. Symptoms should not be related to

substance use, medical condition, other mental disorder, or mourning. It is important to point out that those with a major depressive disorder are more likely to have an increased risk of developing comorbidities such as anxiety, phobia, impulse control or substance abuse. (American Psychiatric Association, 2000). Furthermore, the American Psychiatric Association (2000), stated that the risk of developing the major depressive disorder is 25% for women and 12% for men. Another study conducted by Bromet et al. (2011), reported that major depressive disorder is twice common in women than men and affects approximately 6% of the adult population in the world (as cited in Otte et al., 2016).

If the symptoms are reversed within the next 6 months of remission or response, it is considered a recurrence and a recurrence means a separate major depressive episode that occurs after 6 months (Nierenberg, Petersen & Alpert, 2003). Furthermore, Bromet et al. (2011) have indicated that major depressive disorder is associated with diseases such as diabetes mellitus, heart disease, and stroke, which further increases the burden of the disease (as cited in Otte et al., 2016).

Moreover, the World Health Organization (WHO) (2016), stated that major depressive disorder can lead to death by suicide. It is estimated that 50% of the 800,000 suicides per year in the world are in depressed episodes and Chesney et al. (2014), reported that the likelihood of major depressive disorder patients to die by suicide is 20 times higher than the general population (as cited in Otte et al., 2016).

According to the studies conducted by Rush (2006) & Thase (2006), for the treatment of major depressive disorder both psychotherapy and psychopharmacology are effective. However, even after several treatment trials, about 30% of patients do not show remission of major depressive disorder

2.3. Anxiety

According to Olofsdotter (2017), in modern society there is always something to worry and anxiety for children, adolescents and adults, but events or situations that one perceives as stressful may not be a concern for the other because we do not experience and respond to events in the same way, we all have individual levels of anxiety. Especially for people who experience stressful life events, it can contribute to the anxiety by creating the feeling that the world is unpredictable and difficult (Kerns et al., 2011).

Anxiety disorders in different species. A common feature of all anxiety disorders is avoidance behavior. Another common feature among anxiety disorders is an emotional state, a danger or an individual's threat, characterized by anxiety and tension. (Carr, 2016).

Anxiety is the anticipation of the emergence of a threatening but somatic event in a tense manner; an uncomfortable feeling of tension (Rachman, 2013). Ali et al. (2014), claimed that anxiety is considered a state of restlessness, a physical response to a perceived danger that may be real or imaginary and triggered by the individual's thoughts, beliefs, and emotions (as cited in Syed et al., 2018). Ollendick & King (1998), has defined anxiety as the most prevalent psychiatric disorders in childhood, with general anxiety disorder, special phobia, separation anxiety disorder are more frequent than and other anxiety disorders. In addition, it is a comorbid diagnosis that anxiety disorders are related to other behavioral and emotional problems such as depression and disruptive behavior disorders (Ollendick, King, & Muris, 2002).

Reports by Waite & Creswell (2014); Kendall et al. (2010), has shown that the prevalence of individual anxiety disorders varies with age. For example, the

prevalence of separation anxiety disorder is high among children and rare among adolescents, on the contrary, the prevalence of social anxiety, panic disorder, and agoraphobia is higher among adolescents compared to the children.

Anxiety disorders are more common in women than in men. However, the research literature suggests that there may be a change in the sex ratios by age; for this reason anxiety in young children is more prevalent in boys than in girls, and anxiety in older children and adolescents is more common in girls than boys (Vasey & Ollendick, 2000). Moreover, in another study conducted by Beesdo et al. (2009), it was stated that anxiety disorders are more common in women than in men and Craske (2003), added that this difference between man and women is likely to increase with age.

Parental stress can affect caregiving behavior and can lead to externalization and internalization in children. Early diagnosis of stressful parent-child systems is important to initiate appropriate prevention programs that can reduce mental health problems during childhood and adolescence (Abidin, 1995). In this context, the research considers maternal stress level as a possible factor related to children's concerns. Also, two aspects of anxiety-related parent-child relationships are the safety and parental quality of children's attachment. Attachment studies are based on Bowlby's (1982) theory that the absence of a secure base can lead to free-floating anxiety. In particular, it is expected that children who are able to use parents as a safe base and who can rely on their parents' future availability are less likely to have anxiety compared to the children who lack a secure base (Kerns et al., 2011). It has been suggested that the parental model of anxiety avoidance and catastrophic thinking is associated with the treatment and etiology of anxiety disorders in children (Wood, McLeod,

Sigman, Hwang, & Chu, 2003). In a study conducted with parents and 208 2-14 years aged children who seek anxiety treatment, it was found that there was a significant relationship between anxious self-talk in mothers and anxious self-talk in youth (Wei, Cummings, Villabo, & Kendall, 2014)

It is thought that various parental factors contribute to the development and maintenance of anxiety disorders during childhood and adolescence. These are including parent psychopathology, especially parents who have anxiety disorder increase the anxiety risk of their children and predict a worse treatment result (Li et al., 2008; Wei & Kendall 2014). In a study of 964 adolescents selected from the birth cohort, a significant relationship was found between the number of anxiety disorders in adolescents aged 14-16 years and the risk of suicidal behavior, major depression, anxiety disorder and substance abuse later in life that between the age of 16-21 (Woodward & Fergusson, 2001).

Some evidence shows that childhood negativity and life events are linked to anxiety disorders (Beesdo et al., 2009). It was found that people who experienced anxiety disorders during childhood affected psychopathology in adolescence, including anxiety and other psychiatric disorders (Bittner et al., 2007). Furthermore, the studies conducted by Costa & Weems (2005); Shamir-Essakow et al. (2005), has shown that there is a link between maternal anxiety and child anxiety (as cited in Kerns et al., 2011). In another study by Beidel & Turner (1997), it is stated that children of anxious parents were almost five times more likely to meet criteria for an anxiety disorder than were children whose parents do not diagnose with an anxiety disorder. The results from epidemiological studies have shown that there is an association between anxiety disorders and other mental disorders as well as divorced

parent, losing caregivers and sexual and physical abuse in childhood (Beesdo et al., 2009). Also, Shimada-Sugimoto et al. (2015), has indicated that both genetic and environmental factors have seen as an important contributor to the development of anxiety disorders. In addition, through environmental and genetic factors, gene-environment correlations and gene-environment interactions can act together in the development and maintenance of anxiety disorders (Zavos et al., 2013)

2.3.1. Sign and Symptoms of Anxiety

Anxiety and fear are seen as emotional and behavioral reactions and they are a warning threat that comes from infancy and is necessary for survival. There are physical, cognitive and behavioral reactions of anxiety. Physical reactions include muscle tension, increased heart rate, sweating. Thinking about suspected dangers is the cognitive reaction of anxiety and behavioral reactions include avoiding anxiety-provoking situations. These reactions are considered to be incompatible and reflect different types of anxiety disorders, depending on the triggering stimuli, they negatively affect normal everyday functioning (Olofsdotter, 2017).

It is also well known that family contexts, anxious parents, or other aspects, such as exposure to adverse life events, are associated with anxiety symptoms in children.

Behavioral genetic research suggests that anxiety might be a genetic trait and that the existence of an anxious parent at home may be a genetic risk for anxiety (Albano et al., 2003). Barrett, Rapee, Dadds, & Ryan (1996), has indicated that an anxious parent can also be a model for anxious behavior or respond to the child's anxious behavior differently (as cited in Kerns et al., 2011).

In a study conducted by 230 children and their parents, 178 children diagnosed with anxiety disorder and 52 of them have no symptom of anxiety, has shown that parents of anxious children show three times more criteria for anxiety disorder than parents of children with no disorder (Hughes, Furr, Sood, Barmish, & Kendall, 2009). Moreover, parents' attitude towards their children has a quite important role for children to show anxiety symptoms. To prove this idea, the study by Bögels & Brechman-Toussaint (2006); Ginsburg & Schlossberg (2002), can be given as an example. The results of the study have shown that insecure attachment in parents, parenting of anxious behaviors, parental beliefs about children's anxious behaviors, parent psychopathology, and parental reinforcement of adverse behavior in children are defined as possible factors that may contribute to child anxiety (as cited in Lium, 2017).

2.3.2. Separation Anxiety

Boyd et al. (2000); Costello et al. (2003) indicated that anxiety disorders are probably the most common psychopathology among young people. Prevalence estimates range from 5% to 25% worldwide but have a much lower percentage treatment rate.

Separation anxiety disorder is characterized by abnormal reactivity to actual or imagined separation from the attachment figure that interferes significantly with day-to-day activities and developmental tasks. In order to meet DSM-IV-R diagnostic criteria, anxiety should go beyond what is expected for the child's level of development, which last for four weeks, start before the age of 18 and cause significant distress or impairment (American Psychiatric Association, 2000).

Moreover, according to Shear et al. (2006), separation anxiety disorder is considered to be a widespread and extremely debilitating disorder that can persist in adulthood

and Kossowsky et al. (2013) has indicated that it has a "pacemaker" function, increases the risk of anxiety and other mental disorders in later developmental stages, and has been shown to be a predictor of panic disorder in many cases.

Separation anxiety is defined by Kearney et al. (2003), as a response to the separation from the caregiver and it usually contains the normal limits of the physiological response. The behavior usually starts with the recognition of strangers in the sixth month of the baby, and after two years of age the symptoms decrease; sometimes, separation anxiety can also persist in the early period. Dysregulation of attachment patterns in infants is one of the strongest preserved evolutionary behaviors (Shear et al, 2006). Allen et al. (2010); Mohr & Schneider (2012), has defined separation anxiety disorder that characterized by developmentally inappropriate, extreme and persistent anxiety for separation from the child's attachment figure. The most commonly reported symptoms are difficulty with separation, avoiding being alone/absent, and staying away from caregivers or family members. According to the American Psychiatric Association (2000), it is required to be diagnosed SAD if the individual suffers from three of nine symptoms and if it interferes daily functioning. Milrod et al., (2014), clarified that it is normal and adaptive to have anxiety when separated from attachment figure concerned in the early childhood period that includes 3 to 5 years. However, if this distinct emotional state continues until the late childhood adolescence and adulthood that means separation anxiety is increasingly linked to pathological self-perception (p.34). In addition, Costello & Angold (1995), stated that separation anxiety disorder has an early onset age, the highest onset is between 7 and 9 years and the prevalence of separation anxiety level is 3% and 5% in childhood and adolescents but decreases with age.

American Psychiatric Association (2000), has reported that separation anxiety disorder has a heterogeneous clinical presentation. Cardinal symptoms consist of major or unfit difficulties or extreme and unrealistic fear for separation from the attachment figures (usually parents) or leaving the home. Anxiety disorders were the most common disorders that followed by behavior, mood, and substance use disorders and separation anxiety disorder is the most common anxiety disorder for children. However it is the seventh common is life-long impairment, because it often resolves before puberty. One study estimated that 50% of 8-year-olds experience separation anxiety disorder symptoms that do not cause serious deterioration. In addition, some researchers in the US suggest that separation anxiety disorder may be a little more in women, in African-Americans, and in families with low socioeconomic status (Kesser et al., 2011).

Attachment theory is a joint work of John Bowlby and Mary. John Bowlby has formulated the basic principles of theory and has innovated by considering the child's attachment to the mother. Mary Ainsworth's innovative methodology and observational studies strengthen Bowlby's basic concepts of attachment theory (Bretherton, 1992). Attachment theory offers basic explanations for and describes the psychological aspects of separation anxiety. Infants learn how to regulate their emotions using strategies that maintain closeness to the attachment figure (Dallaire & Weinraub, 2005). According to Bowlby (1958), attachment is a stable emotional bond in a person's life. He suggested that early experience of a child has significant effects in a child's development and his later life. There are three phases of separation responses that are identified by Robertson & Bowlby in 1952, including protest (about separation anxiety), despair (about grief and age), and denial or separation (defensive mechanisms, especially repression) (Bretherton, 1992).

Separation anxiety is a disease that can also be seen in adults. Studies conducted by Manicavasagar et al. (2000); Silove et al (2010), stated that Adult Separation Anxiety Disorder was first investigated in clinical settings and prevalence rates ranging from about 20% to 40% were investigated (as cited in Carmassi et al., 2015).

Epidemiological studies indicate that adult Separation Anxiety Disorder is highly associated with other psychiatric disorders and is associated with a significant deterioration in the functioning of the role even after controlling for comorbidity (Shear et al., 2006).

The WHO Mental Health Study also found that there was a significant association between Separation Anxiety Disorder and other disorders, including internal disorders like major depression, specific and social phobia, bipolar disorder, generalized anxiety disorder, and post-traumatic stress disorder, but at the same time externalizing ones that include attention deficit hyperactivity disorder, defiant disorder and conduct disorder. It supports the hypothesis that separation anxiety disorder represents a general risk factor for common mental illnesses (Carmassi, 2015).

Considering the fact that the Separation Anxiety Disorder is characterized by severe anxiety and fear of separation or damage from attachment figures and recently, an increasing interest has been devoted to a pattern of comorbidities involving Separation Anxiety Disorder, PTSD, and pathological grief reactions. Some literature by Goenjian et al. 1994; Hoven et al. 2005 have shown the likelihood of separation anxiety disorder is high in children and adolescents with traumatic experience (as cited in Carmassi, 2015). Finally, an analysis of the Worldwide World Mental Health

Survey data set showed that the Separation Anxiety Disorder was one of the few previous disorders that were statistically related to the onset of PTSD (Brückl, 2007).

2.4.Existing Studies

Murray et al. (2009), reported that there is a significant association between parental anxiety and child anxiety. Mothers are the primary factors in the development of their children from the infancy. The findings by Gunnar (1998), and Bugental et al. (2003), are consistent with this, indicating that, mothers or primary caregivers have a major impact on the neurobiological and psychological development of children. They buffer the stresses of the baby's inner and outer world.

The present results showed that children's anxiety problems, ADHD problems, and oppositional challenge problems scores were associated with significantly explaining the heightened stress scores of mothers. Moreover, scores of children's anxiety and ADHD problems given by their teachers show that it is significantly associated with mother's high-stress level scores (Anderson, 2007). Previous studies which have done by Belsky et al. (1996), Carter et al. (2004), Johnston & Mash (1986), shown that daily stress of mother, marital disagreement and low parenting effectiveness are associated with externalization behaviors in young children (as cited in Yaman et al., 2010). In addition to these studies Pianta et al. (1990), indicate that there is an association between maternal stress and children's externalization and internalization problems.

Another study which existed in Canada shows that one of the most important features is depression for Syrian refugee women. The results show that approximately two-thirds of respondents were positive for possible depression (Fisher et al., 2011).

According to some studies done by Behnke, McDermid, Coltrane, & Parke, (2008) ;

K. J. Conger, Rueter, & Conger, (2000); Hodges, London, & Colwell, (1990);

Woody, (1984), parents who have higher levels of stress are more likely to have poor parenting style as well as poor child adjustment (as cited in Leon, 2014).



CHAPTER THREE

METHODOLOGY

3.1. Model of Study

This study is a quasi-experimental design study. Quantitative research methods used to find out the relationship between variables and we need to quantify data and generalize results from a sample of the population of interest. Quantitative research designs are either descriptive or experimental. This research is descriptive research and a correlational design has been used. Correlational research is a study of the relationship between two or more variables in the same population or the relationship between the same variables in two populations (Leedy & Ormrod 2010).

3.2. Hypothesis

- 1) The separation anxiety level of children increases when the depression severity of mothers' are higher.
- 2) The separation anxiety level of children increases when the anxiety severity of mothers' are higher.
- 3) The separation anxiety level of children can be predicted by the depression severity of mothers'.
- 4) The separation anxiety level of children can be predicted by the anxiety severity of mothers'.

3.3.Scope

This study conducted at the Refugee Reception Center in Sultanbeyli in Turkey, where a considerable number of refugee women and their children have been registered. This research is to contribute to social science literature and especially to the literature on psychology.

3.4.Participants

The study conducted among 57 refugee families in Turkey which means 57 women and 57 children. There were 114 participants in total. Children participants' age will range from 11 to 17 years old. All participants were Syrian when asked ethnicity

3.5.Instruments

In this study, inventories made use of along with personal information forms: demographical characteristics as well as Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI) and Severity Measure for Separation Anxiety Disorder. Moreover, this study conducted among Syrian refugees, therefore the Arabic version of the Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI) and Severity Measure for Separation Anxiety Disorder were used.

3.6.Model of Data Analysis

Variables were checked for the assumptions of parametric statistical testing by the visual analyses of distribution plots and Shapiro-Wilks tests. Frequency and descriptive statistics were used. To explore the relationships between clinical variables we performed Pearson correlations. In the second step, multiple linear regression analysis was conducted with significant variables detected in the correlation analysis.

The criteria for statistical significance (p) was set to 0.05 and all analyses were performed with a commercially available statistical analyses software (IBM Corp., Armonk, NY. SPSS Statistics 21.0.).



CHAPTER FOUR

RESULTS

Firstly, the descriptive statistics of the dependent variables of the study are presented. Then, explore the relationship between the level of the mother's depression and anxiety and the level of their children's separation anxiety. Later, were examined the correlation between mother's depression and anxiety and children's separation anxiety level and the other dependent variables. In this research were used the statistical measures, the number of respondents (N), a percentage in the examined population (%), mean and standard deviation (S.D.)

Table 1.

Socio-demographical Characteristics of Children

	<i>N</i>	<i>%</i>	<i>Mean</i>	<i>S.D</i>
Age	57	100	12.60	1.55
Gender	57			
Female	33	58		
Male	24	42		
Passed time in Turkey	57		3.21	1.26
School	57			
Yes	52	91		
No	5	9		
Lost one	57			
Yes	36	63		
No	21	37		
Mistreatment	57			
Yes	12	21		
No	45	79		
Witness of torture	57			
Yes	24	42		
No	33	58		
Witness of death	57			

Yes	11	19		
No	46	81		
Population of house	57		5.54	2.17

The results shown in the previous table, point to data related to children. From column N we see that the total sample of children is 57 examinees. A total number of surveyed children were 33 girls (58%) while the number of boys was 24 and 42% respectively. The percentage of children who are attending school is 91%, ie. 52 children. Out of the total number of them, 5 are not included in the educational process or 9%.

A total of 36 respondents lost one family member, accounting for 63% of all those surveyed, and a total of 21 children did not lose a family member.

Other data are related to various forms of abuse, and maltreatment of children, and their previous experiences. The data that are extremely worrying is related to "maltreatment" where a significant number of children 21% (12 children) say that they have been victims of some form of harassment in their past life. The other percentage of children, 79%, do not testify to some form of mistreatment or other inhuman behavior.

Here, in this survey, is also a high percentage of children, so 24 or 42% of children reported that they were witnesses of abuse and torture in the past. The other percentage of children or 58% of them do not testify to these procedures in relation to them. A total of 19% (11) children witnessed the death of a certain number of persons from their surroundings, while 81% of children did not have this experience in their upbringing.

These data are extremely alarming and give a very negative picture of the children treatment, as well as their continued exposure to various forms of inhumane acts and

actions. Children need support from all actors in the community, but this support is very absent, and children are burdened by actions such as our basic human rights and freedoms.

Below are the descriptive data relating to the parents of children, that is, the mothers who made the sample of this research

Table 2.

Socio-demographical Characteristics of Mothers

	<i>N</i>	<i>%</i>	<i>Mean</i>	<i>S.D</i>
<i>Age</i>	57	100	34.65	4.53
<i>Gender</i>				
<i>Female</i>	57	100		
<i>Passed time in Turkey</i>	57	100	3.25	1.26
<i>Financial Status</i>	57			
<i>Low income</i>	12	21		
<i>Mid-income</i>	43	76		
<i>High income</i>	2	3		
<i>Marital status</i>	57			
<i>Married</i>	39	68		
<i>Separated</i>	2	4		
<i>Divorced</i>	3	5		
<i>Widow</i>	13	23		
<i>Lost one</i>	57			
<i>Yes</i>	43	75		
<i>No</i>	14	25		
<i>Mistreatment</i>	57			
<i>Yes</i>	24	42		
<i>No</i>	33	58		
<i>Witness of torture</i>	57			
<i>Yes</i>	29	51		
<i>No</i>	28	49		
<i>Witness of death</i>	57			
<i>Yes</i>	24	42		
<i>No</i>	33	58		
<i>The population of the house</i>	57	100	5.61	2.05

Results related to years show the values of the Mean 34.65, while the standard deviation of the obtained results was 4.53. The data relating to the socio-demographic gender variable confirm that all tested respondents are females.

All respondents are from Turkey, and the obtained mean value of the result is 3.25, with a S.D. = 1.26.

Examining the financial status of the family, data showed that out of a total of 57 respondents, 12 (21%) had low incomes. The average income is recorded by 43 respondents or 76% of them, while only 2 respondents account for extremely high incomes or 3% of them. The obtained results confirm that most respondents perceive their material status as a medium material status.

When it comes to data related to marital status, the results clearly indicate that the percentage of 68% (39) of the respondents is in a marital union. Currently, two respondents (4%) are separated from their spouses, while 3 women are divorced (5%) and no longer live in a marital union. A significant percentage of research is made up by widows who in this sample of the survey 13 or 23%.

When it comes to the loss of one family member, the respondents gave the following answers, of which 43 (75%) had so far lost one person in the family, and 14 (25%) had no such tragic experiences.

Some of the forms of harassment experienced a total of 42% of female examinees or 24 of them. A percentage of 33 (58%) women did not have this experience in the past.

Witnesses of some form of torture had a total of 29 women surveyed or 51% of them. The other 28 of them did not testify to these behaviors. In contrast to this, eyewitnesses of fatal outcomes were 24 women or 42%, while others did not testify to such scenes. Finally, responses related to the population in the home, confirming that all female households live with other family members. The mean value of the obtained results is Mean = 5.61, and S.D. = 2.05.

After the descriptive data presented for the basic socio-demographic characteristics of the sample of children and their births, in this case, the mother was examined the relationship between depression and anxiety in the mother and the level of separation anxiety in children.

The exploration of the relationship between mothers' depression and anxiety and children's separation anxiety level is shown by the Pearson correlation coefficient (r) in the following table.

Table 3.

Correlation Analyses Between Mothers' Depression/Anxiety Level and Children's Level of Separation Anxiety

		Separation total	Depression total	Anxiety total
Separation total	R	1	.154	.291*
Depression total	R		1	.631***
Anxiety total	R			1

* $p < .05$, ** $p < .01$, *** $p < .001$

As it can be seen in Table 3, we can conclude that there was a statistically significant correlation between children's separation anxiety and mother's anxiety subscale ($r = .291$, $p = .030$, $p < .05$), indicating that mother's high level of anxiety accompanied

high level of separation anxiety for children. On the other hand, with mothers' depression and children's separation anxiety statistically, significance was not found.

Table 4.

Correlation Analyses of Age, Time spent in Turkey and Household population on the Level of Children's Separation Anxiety

		<i>Age</i>	<i>Passed time in Turkey</i>	<i>The population of the house</i>	<i>Separation total</i>
<i>Age</i>	<i>r</i>	1	-.13	-.32	-.16
<i>Passed time in Turkey</i>	<i>r</i>		1	.18	-.34*
<i>Population of the house</i>	<i>r</i>			1	-.07
<i>Separation total</i>	<i>r</i>				1

*p< .05, **p< .01, ***p< .001

As it can be seen in Table 4, we can conclude that there was a statistically significant correlation between separation anxiety and passed time in Turkey subscale ($r = .034$ $p = .010$ $p < .05$), suggesting that decreases of passed time in Turkey associated with a high level of separation anxiety for children. What is significant to note is that the connection obtained is negative, which in concrete results means that the time spent in Turkey is negatively linked to separation. These results would mean that with increasing time in Turkey, the separation anxiety and vice versa will be reduced. In other subscales, statistically, significance was not found with separation anxiety of children.

Table 5.

Correlation Analyses between Age, Time Spent in Turkey, Household Population with the Level of Mother's Depression and Anxiety

		<i>Age</i>	<i>Passed time in Turkey</i>	<i>Population of the house</i>	<i>Depression total</i>	<i>Anxiety total</i>
<i>Age</i>	<i>r</i>	1	.12	.14	.00	-.08
<i>Passed time in Turkey</i>	<i>r</i>		1	.19	-.01	.03
<i>Population of the house</i>	<i>r</i>			1	-.14	-.04
<i>Depression total</i>	<i>r</i>				1	.63
<i>Anxiety total</i>	<i>r</i>					1

*p< .05, **p< .01, ***p< .001

Results related to mother-related data showed that there was no statistically significant association of variables at any level of significance considering the comparable variables. These results confirm that there is no correlation between the age of respondents, their time spent in Turkey, as well as individuals in the household with depression and anxiety, that is, the results obtained by this study did not hinder the existence of a link with statistical significance. Considering that these results were compared with the aim of verifying the third hypothesis that was published "The separation of the anxiety level of children can be predicted by the depression severity of mothers", the obtained results did not confirm the statistically significant association with any of the tested variables, and the set hypothesis is rejected.

If separation anxiety entered as the dependent variable and all other variables are entered as predictors in a multiple regression prediction models then the following conclusions may be drawn from the analysis shown in Tables 6.

Table 6.

Regression Analysis of Mothers' Level of Anxiety, Gender, Ages and Time Spent in Turkey on the Level of Children's Separation Anxiety

n=114	B	t	R Square	F
Constant			0.20	4.40
Anxiety total	.22	2.34*		
Gender	-1.29	-.59		
Age	-1.03	-1.46		
Passed time in Turkey	-2.57	.39*		

*p< .05, **p< .01, ***p< .001

We can see that there are 4 predictors which are anxiety level of mothers, gender, age, and time spent in Turkey and two of them have statistically predicted. Regression analysis was used to test if the anxiety level of the mother, gender, age and time spent in Turkey significantly predicted children rating of separation anxiety. The results of the regression indicated the four predictors explained 20% of the variance ($R^2=.20$, $F(4, 51)=4.40$, $p< .05$). Mother's level of anxiety significantly predicted children's rating of separation anxiety, $\beta= .22$, $t= 2.34$, $p< .005$. The result of regression also showed that time spent in Turkey significantly predicted children's rating of separation anxiety, $\beta = -2.27$, $t= .39$, $p< .05$.

Gender, age, time spent in Turkey and the mother's level of anxiety were entered as independent predictors of the child's rating of separation anxiety entered as the dependent variable. Results showed that mothers' level of anxiety and time spent in

Turkey are significant predictors for children's separation anxiety, while other variables are not statistically significant with separation anxiety of children. It means that children whose mothers show anxiety symptoms and children who passed less time in Turkey compared to the others that passed more time in Turkey are more vulnerable to show separation anxiety symptoms. On the other hand, according to the results, the mothers' depression is not found as a significant predictor for the separation anxiety of children.

So, conclusively, we can say that H2 and H4 partially supported. According to the results, the anxiety severity of mothers is a significant predictor for separation anxiety level in children. Participants whose mother have a high score on anxiety have a high level of separation anxiety.

CHAPTER FIVE

DISCUSSION

This research was created as a need to consider in different way facts that have been known in practice for many years. The study sought to clarify the relationship between mother and child anxiety by examining maternal depression/anxiety that might contribute to separation anxiety of children. Results indicated that maternal depression does not uniquely contribute to child separation anxiety. However, there was a unique relationship between maternal anxiety and child separation anxiety. The current study conducted in Sultanbeyli in Istanbul, where a considerable number of refugees have been staying. For the study 57 families used, which means 57 mothers and 57 children, 114 participants in total.

The purpose of the present study is to examine the relationship between mothers' depression and anxiety severity and separation anxiety rating of their children. In addition, the study examines whether there is a significant difference between child separation anxiety scores related to child's age, gender, marital status of their mother and whether there is a significant interaction effect between these variables and mother's depression and anxiety on children's anxiety. The results showed that mothers' anxiety significantly contributes to children's separation anxiety while the depression severity of mothers has no significant contribution to children's separation anxiety level.

Although the literature is limited, the present findings suggest that being a refugee or being a child whose parents are refugee can increase the risk of an individual experiencing mental health problems (Bronstein & Montgomery, 2011). The separation of the family is an important obstacle to the positive psychological

consequences of refugees. Research has shown that anxiety for family overseas is linked to anxiety and somatization in refugee groups (Schweitzer et al., 2006).

Anxiety disorders in children are common. The investigators Costello EJ, Mustillo S, Erkanli A, Keeler G, Angold A (2003), in the American Great Smoky Mountains Study found that, In a 3-month period, 2.4% of children between 9 and 16 years of age met the diagnostic criteria for an anxiety disorder. Similar rates were found in a study of Ford T, Goodman R, Meltzer H (2003), that indicated in the British Mental Health Survey, in which 3.7% of 5- to 15-year-olds had a current anxiety disorder. In the Dunedin birth cohort study, approximately 52% to 55% of young adults anxiety met the diagnostic criteria for a mental health disorder before the age of 15 years.

Furthermore, studies have found a positive correlation between maternal anxiety and anxiety in children (Valadao Dias et al., 2016; Mofrad et al., 2009; Pillay, 2008; McClure et al., 2001; Kertz et al., 2008). Mofrad et al. (2009), emphasized that relatively few studies focused on separation anxiety. In the previous studies by Hb & Maytal, (2005); Moore, Whaley & Sigman, (2004); McClure, Brennan, Hammen & Brocque, (2001), indicated that, in general, studies on anxious children and mothers have shown that anxious children are more likely to have anxious mothers. Children of mothers who diagnosed with anxiety disorder have a higher risk of diagnosing anxiety disorders (as cited in Mofrad et al., 2009).

The results obtained were related to the first hypothesis that was published:“ The separation anxiety level of children increases when the depression severity of mothers is higher” did not show statistically significant to the tested population. Results could be influenced by giving socially acceptable answers. These results corroborate previous findings that mothers with other forms of psychopathology (such as

depression) did not effect on separation anxiety level (Cohn, Campbell, Matias, & Hopkins, 1990; Cummings & Davies, 1994; DeMulder & RadkeYarrow, 1991; National Institute of Child Health and Human Development Early Child Care Research Network, 1999). Some studies have indicated that depressive parents are more negative, less supportive and intrusive to their children (Cummings & Davies, 1994). As a result of this, these children may likely to have negative psychological problems. In the literature, maternal depression mostly linked to other psychological problems rather than separation anxiety for the children. For example, it was stated by Hammen et al. (198), that children of depressed parents are at increased risk of psychopathology, including affective (mostly depression) and behavioral disorders. Another study by Weissman et al. (1997), observed that there are higher rates of major depression, phobias, panic disorder and alcohol dependence in the offspring of the depressed parents than in the non-patient comparison group. Maternal depression has been shown to contribute to many developmental problems in early childhood, including cognitive impairment, difficulty with social and academic functioning. It may also cause adjustment problems, including mood disorders for children (Cummings & Kouros, 2009).

Also, researchers have reported that the risk for childhood anxiety disorders appeared to be highest in the presence of comorbid maternal anxiety and depressive disorders (McClure et al., 2001). Against that it was indicated by Beardslee et al. (2003), children of depressed parents have long been identified to have a higher risk than the average for the development of psychological difficulties. Other researchers have reported that children with depressed mother more likely to have anxiety or depressive symptomatology (Goodman et al., 1994). Krain and Kendall (2000) found a significant relationship between the depressive symptoms of the mother and the child's anxiety.

The correlation between maternal anxiety and child anxiety is consistent with the findings of Ketz et al. (2008) which indicated that children whose parents suffer from anxiety disorder are at a high risk of developing an anxiety disorder. Studies by Bayer, Sanson & Hemphill (2006); Roelofs, Cor-ter-Huurn, Bamelis & Muris (200), indicated that there is a positive relationship between mother's anxiety and child anxiety (Mofrad et al., 2009). Furthermore, research that focused more on mothers has shown that the mothers of children with anxiety disorders had significantly higher levels of anxiety and depression than mothers of the non-clinical child (Suveg, Zeman, Flannery-Schroeder and Cassano, 2005).

Separation anxiety is a relatively normal and healthy process seen by researchers and clinicians and is seen as a fundamental human order. This term refers to the concerns of a child or parent about the loss of important persons in their lives (Hock & Lutz, 1998). According to Velting, Setzer, and Albono (2004), it is estimated that approximately 5 to 20% of children and adolescents experience any anxiety disorder that may have a significant impact on their lives (Valadao et al., 2016). Mofrad et al. (2009), has reported that sometimes normal separation anxiety can be intensive and destructive in the life of the child. This is called Separation Anxiety Disorder (SAD), which is characterized by inappropriate and excessive anxiety related to separation from home or from an attachment figure. By testing the results of the research in order to verify the second hypothesis that was published: "The separation anxiety level of children increases when the anxiety severity of mothers' are higher." there was a statistically significant correlation between children's separation anxiety and mother's anxiety subscale, indicating that mother's high level of anxiety accompanied high level of separation anxiety for children. The results confirmed the existence of a statistically significant correlation between the results, which confirmed the established

hypothesis. These results are in line with the results carried out of some previous studies. For example, a study by Pianta et al. (1990), has indicated that there is an association between maternal stress and children's externalization and internalization problems. Similar to this, Murray et al. (2009), reported that there is a significant association between parental anxiety and child anxiety. Furthermore, the literature describes the relationship between parents' anxiety and child anxiety and concludes that there is a strong relationship between these two variables (Cooper et al., 2006). A similar result was found by Cobham, Dadds and Spence (1998), has indicated that parents' anxiety is the most contributing factor to children's anxiety. In a controlled study of adults with anxiety disorders and their offspring, Beidel and Turner (1997) found that children of anxious parents had a five-fold higher prevalence than children whose parent has no diagnostic criteria for anxiety disorder (McClure et al., 2001). Frick, Silverthorn, and Evans (1994), found that 76% of anxious children had a mother who has a history of anxiety disorder. In addition, parent and child anxiety reports in children was linked to the history of the mother's anxiety. Chapman, Petrie, Vines, and Durrett (2012) found in a study that based on 100 African American parents and their biological children, children with an anxious parent were four times more likely to meet the criteria for both anxiety disorder and other psychopathological disorders.

Parents often provide many of their learning experiences to children throughout their development, but the degree of providing anxiety-related learning experiences can be an important factor in the development of children's anxiety (Fisak & Grills, 2007). According to Bandura, there is evidence that children can learn about fear reactions by observing these reactions from their parents, siblings peers (Valadao et al., 2016). According to May (2013), children's observation of their parent's anxiety may affect the development of the child's own anxiety. Muris, Steerneman, Merckelbach, and

Meesters (1996), found a significant positive relationship between the fear of the mother and the fear of the child. Modeling anxious behaviors probably mediates this relationship; the mothers who express their fears have children with the highest fear level, uniquely taking into account a proportion of the variance of the child's fears. Another study conducted by Muris et al. (1996), found an important relationship between the anxiety of the parents and the children's anxiety, but only the fears of mothers have associated with the fears of children and this relationship was dependent on the expression of the fears of mothers.

The third hypothesis: "The separation anxiety level of children can be predicted by depression severity of mothers", has not been confirmed. The results related to the prediction of separation anxiety of children based on the level of maternal depression showed that there was no statistically significant connection of the variables at any level of significance. This result corroborates previous findings that mothers' depressive disorder alone does not significantly provide the risk of developing anxiety disorders for their children (McClure et al., 2001). The study also found that the elevation of risk for children of mothers with anxiety disorder alone, but not in those with comorbid depressive disorders, it is suggested that at least the mother-to-child is a possible transmission for disorders within the anxious spectrum. Also, Kertz et al. (2008), emphasize the importance of maternal sensitivity on children's psychological well-being. The study suggests that a higher level of maternal sensitivity is correlated with a lower level of anxiety and depression of children. It is also indicated by the researchers that maternal sensitivity, the anxiety of mothers and maternal depression have a significant effect on children's anxiety and depressive symptoms at 2 and 3 years of age, but only for boys. For the girls, the anxiety of mother and maternal depression are the only important predictors of child anxiety. Moreover, in the

literature on depression, maternal sensitivity has been shown to decrease negative child outcomes associated with maternal depression (Kertz et al., 2008). However, in another study, it is suggested that more depressive mothers are more likely to perceive their children as maladjusted (Griest, Wells, & Forehand; 1979). Similarly, it was also reported by Teti et al. (2012), that the children of depressed mothers were at significant risk for maladjustment and cognitive delays. According to Goodman & Gotlib (2002), although maternal depression appears to be prone to children's predisposition to depression, these children are also at high risk for the full spectrum of externalization disorders such as oppositional defiant disorder and conduct disorder. Not surprisingly, these children are also at risk for poor academic performance and difficulties in interpersonal relationships, anxiety disorders and substance abuse (Teti et al., 2012).

Lastly, the fourth hypothesis of the study "the separation anxiety level of children can be predicted by the anxiety severity of the mothers " showed a significance, and the level of separation anxiety in children can be predicted based on the severity of expressed anxiety in mothers and the model is accepted. Results showed that a mother's level of anxiety and time spent in Turkey are important predictors of separation anxiety, while other variables are not statistically significant with separation anxiety of children. It means that children whose mothers show anxiety symptoms and children who passed less time in Turkey compared to the others that passed more time in Turkey are more vulnerable to show separation anxiety symptoms. Therefore, based on the obtained results, the hypothesis is partially accepted, that is, one of the tested variables proved to be a significant predictor. According to these results, we can say that the time spent in Turkey has an impact on mental health for refugees. Similarly, one study that conducted in Germany shows that, compared to asylum seekers with mental distress, those without mental distress experienced a less traumatic event and

spent more time in Germany (Georgiadou et al., 2018). Also, it has reported by Steel et al. (2002), that mental illness that related to trauma decreases steadily over time. However, Nickerson et al. (2010), reported that the duration of residence in the host country increases the possibility of mental disorders of refugees.

Moreover, increased time spent in Turkey, consequently, the provision of basic needs and sense of safety may cause reducing anxiety level among refugees. According to Yilmaz (2018), during their process of migration, from pre-migration to resettlement process, they faced difficult situations which could arise from a traumatic experience. Involuntary migration puts refugees at greater risk and may cause them to be exposed to cumulative traumas until they reach a safe place.

Furthermore, the results that show a significant correlation between mothers' anxiety and children's separation anxiety is consistent with the previous studies. Mofrad et al. (2009), found that mothers' higher level of anxiety is associated with children's high level of separation anxiety disorder. Researchers indicated that mother's anxiety appeared to be most significantly associated with separation anxiety of the child. The result showed that 22% of children with symptoms of SAD had mothers with psychological disorders. A study conducted by Valadao et al. (2016), showed that mothers' anxiety has a significant contribution to child anxiety. According to Biederman et al. (2007); Biederman, Faraone, Hirshfeld, Friedman, Robin, & Rosenbaum (2001), mothers whose children diagnosed with separation anxiety disorder show an increased risk of a diagnosis of anxiety disorder or major depression (Mofrad et al., 2009). The study conducted by Feigon, Waldman, Levy & Hay (2001), has shown that family, environment and parental psychopathology have an important impact on separation anxiety disorder of children.

According to Cabrera et al. (2000); Torres, (2002), the role of women is more common in family life than in men who support the existence of "proximity space" in which children perceive and share mothers' experiences of anxiety. Anxiety increases the worry and expectation of a negative situation. Anxious people have difficulty to control their signs and manage their emotions. In this sense, it is obvious that children are vulnerable to the anxiety of their mothers (Valadao et al., 2016).

According to Herren, In-Albon & Schneider (2013), parents' beliefs have an important impact on their children. Researchers explained it as parents' beliefs about anxious responses in their children affect their reactions. Which means that even after parental anxiety and depression control, parent dysfunctional beliefs related to child anxiety and parenting self-efficacy were found to be positively associated with child anxiety. Similarly, Valadao et al. (2016), found that there is a strong positive relationship between the positive thoughts of children and the positive attributions of mothers. While the anxiety of the mother is negatively related to their positive attributions, it is positively related to their fears.

Children with serious current or past medical problems may be overprotected by their parents, and this may mean more risk for separation anxiety disorder (Grover et al., 2005). Similarly, Chorpita & Barlow (1998), indicated that the reason for this finding which shows a positive correlation between maternal anxiety and child anxiety may be due to the characteristics of mothers with high levels of anxiety controlling their children, which leads to loss of self-control. Feigon, Waldman, Levy & Hay (2001), reported that environmental factors, such as family, environment and parental psychopathology, can lead to the development of anxiety for children. It was found by Lieb et al. (2000), that excessive protection and rejection of the parents were

significantly associated with higher anxiety and social phobia rates in children and adolescents (Mofrad et al., 2009). Wood (2006) found that parental intervention specifically associated with a separation anxiety disorder in the clinical sample. In addition, it was demonstrated by Gastel, Legerstee, and Ferdinand (2009) that there was a positive relationship between parental overprotection and anxiety in children. Chorpita, Brown & Barlow (1998), indicated that over-control parenting represents the over-protection of children from adverse consequences and encourages children to be unnecessarily dependent on parents. When mothers continue to show high protection in subsequent development periods, children's thoughts about their ability to control their environment or their abilities may be affected. In this case, an external locus of control or a feeling of helplessness can be improved by the child (Chorpita et al., 1998).

The current study was carried out with the refugee population. The possibility of losing a family member is high due to the war in Syria. So, this might increase the risk of separation anxiety symptoms of children. The study conducted by Teramoto et al. (2005), found that although parents' education and high levels of income may reduce behavioral problems in children, disease of a parent and death may cause an increase in risk ratio of SAD. A previous study indicated that parental psychopathology has an impact on child anxiety. They found %36 of mothers had a history of physical illness and 53% of mothers had a history of psychological illness. They added that the high disease rate may be due to stressful living conditions such as the Iraq-Iran war and Iraq-Kuwait war. Such situations may have affected people and raised anxiety levels.

The results of many research in the literature has shown that there is a positive correlation between maternal anxiety and child anxiety. However, there is a lack of

study in the literature that found no relationship between maternal anxiety and child anxiety. The study conducted by Krain and Kendall (2000), has shown that parental anxiety has no significant impact on children's anxiety symptoms. The finding of this study supports the hypothesis that parents' emotional distress, especially depressive symptoms, plays an important role in a child's anxiety.

In short, our findings point to increased anxiety and depression symptoms among refugee mothers and their children who are currently living in Turkey after leaving in the conflict zone. These conditions, which may last for a lifetime and lead to negative medical and psychiatric consequences, need to find a way of detection by various mental health institutions and clinical assessments for treatment. Solving problems within the family can be the most effective way of providing intervention. Clinically significant separation anxiety disorder in childhood causes panic disorder and other anxiety disorders in adults in the later period of their lives (Milrod et al., 2013).

Eventually, it is very important to deal with this ever-present and widespread topic and to point out the possible pathological consequences for the development of children. Working with children and their families, providing adequate support is just plenty of the ways in which it is possible to prevent the variety of emotional consequences of development.

According to Beesdo & Knappe (2012), determination of risk factors for childhood anxiety is an important step towards detection, prevention, and improvement of early intervention. These findings can be used to determine anxiety in children by reporting the development of a broader approach to the symptom-based psychosocial assessment of risk factors. Evidence of the importance of psychological distress of the mother from birth to 5 years old is supported by the recommendations of the national pediatric

associations during child visits and the mother's mental health screening is carried out (Kingston et al., 2015). May (2013), has indicated that exposure-based therapies are the treatment that the most efficacious for anxious children. However, it is hard to do clinic-based exposures when treating children who suffer from a separation anxiety disorder. So, this makes very important to do parent-led and home-based exposure to reduce separation anxiety. The researcher also added that educating parents is one of the most important things when treating anxiety in children. They should be educated to learn how to regulate their own anxiety so as not to show their anxiety to the child. If a mother learns how to manage her anxiety, the possibility of developing separation anxiety in the future might be avoided for that child. In future treatment studies, maternal anxiety should be measured and its effects on the children's separation anxiety level should be examined. Future research should also aim to solve the early life effects on childhood anxiety in prenatal, postnatal and early childhood periods. The importance of maternal mental health should be emphasized on children's psychological well-being. It must be understood the underlying mechanisms, and evaluate the effectiveness of maternal anxiety and depression on child anxiety

5.1. Limitations of the Study

It is important to consider the limitations of this study and recommend caution when interpreting the results. First, self-report measures were used. This is particularly important to examine the results of the study. However, this is a limitation due to the inability to determine whether the mother is truly exhibiting their anxious behaviors, or the children may be tempted to give correct answers and tend to show themselves less anxious than they are.

Another limitation of the study was that the diagnostic interview was not performed and the diagnosis status could not be determined. The cost and time required to conduct a clinical interview for the current study were preventive. In addition, the separation anxiety scale on the Severity Measure for Separation Anxiety Disorder did not show good internal consistency for the current study. It was difficult to understand the questions for some children. Therefore, caution should be exercised when generalizing the results to a clinical population.

Sampling was another limitation. The sample consisted of Syrian mothers and their children between the ages of 11-17 years. 57 mother, 57 children in a total of 114 participants used for the current study. The small sample may limit the generalizability of these results. Moreover, only mothers were used to examine the children's anxiety level. In future studies, paternal anxiety should be examined it might be effective to work with fathers as well to see whether if fathers have an effect on children's anxiety level.

Lastly, the language was a quite important limitation for this study. Syrian population used for the study and the tests were translated into the Arabic language. Translators were used when applying tests to mothers and children. Thus, probably errors due to translation might be a confounding factor in our study.

CHAPTER SIX

CONCLUSION

The current study investigated to attempt a better understanding of the contribution of maternal psychological distress on children's level of separation anxiety disorder. The results of the study indicate that maternal anxiety contributed significantly to the children's separation anxiety level while maternal depression has no effect on children's level of separation anxiety.

Anxiety over separation from the caregiver is a big problem that affects many children and their families. Also, it may cause long-term problems for both children and their parents. It is important to determine the factors that influence the development of anxiety. It is also important to know that maternal psychological distress is an important factor that may influence children's psychological well-being. So, educating the parents has essential importance at this point. Future studies should focus on the impaired fields which were shown to have an impact on the development of separation anxiety in different populations as well as paternal factors that may influence this disorder.

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APPENDIX A

Beck Anxiety Inventory (BAI)

Below is a list of common symptoms of anxiety. Please carefully read each item on the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom

	Not at all	Mildly, but it didn't bother me much	Moderately – it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling				
Feeling hot				
Wobbliness in legs				
Unable to relax				
Fear of worst happening				
Dizzy or lightheaded				
Heart pounding/racing				
Unsteady				
Terrified or afraid				
Nervous				
Feeling of choking				
Hands trembling				
Shaky/unsteady				
Fear of losing control				
Difficulty in breathing				
Fear of dying				
Scared				

Indigestion				
Faint/lightheaded				
Face flushed				
Hot/cold sweats				

Arabic Version of Beck's Anxiety Scale:

BAI القلق بيك قائمة

م	أعراض القلق	لا تزعجني أبدا	تزعجني قليلا	تزعجني باعتدال ولكن أستطيع تحملها	تزعجني كثيرا ولا أستطيع تحملها
1	(.الخدار) التتميل				
2	الإحساس بالحرارة				
3	رجفة في الساقين (اهتزاز الأرجل)				
4	على الاسترخاء القدرة عدم				
5	الخوف من أن يحدث الأسوأ				
6	الإحساس بالدوخة (الإغماء الخفيف)				
7	ضربات القلب عنيفة أو متسارعة				
8	عدم الاستقرار أو الثبات				
9	الرعب (الخوف الشديد)				
10	التوتر				
11	الإحساس بالاختناق				
12	ارتعاش اليدين				
13	الشعور بالاهتزاز (الرجفة)				
14	الخوف من فقد السيطرة				

				صعوبة التنفس	15
				الخوف من الموت	16
				الفرع (الخوف)	17
				سوء الهضم	18
				الإغماء	19
				تدفق الدم إلى الوجه	20
				العرق (دون أن يكون الجو حارا)	21



APPENDIX B

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.	0	I do not feel sad
	1	I feel sad
	2	I am sad all the time and I can't snap out of it
	3	I am so sad and unhappy that I can't stand it
2.	0	I am not particularly discouraged about the future
	1	I feel discouraged about the future
	2	I feel I have nothing to look forward to
	3	I feel the future is hopeless and that things cannot improve
3.	0	I do not feel like a failure
	1	I feel I have failed more than the average person
	2	As I look back on my life, all I can see is a lot of failures
	3	I feel I am a complete failure as a person
4.	0	I get as much satisfaction out of things as I used to
	1	I don't enjoy things the way I used to
	2	I don't get real satisfaction out of anything anymore
	3	I am dissatisfied or bored with everything
5.	0	I don't feel particularly guilty
	1	I feel guilty a good part of the time
	2	I feel quite guilty most of the time
	3	I feel guilty all of the time
6.	0	I don't feel I am being punished
	1	I feel I may be punished
	2	I expect to be punished
	3	I feel I am being punished
7.	0	I don't feel disappointed in myself
	1	I am disappointed in myself
	2	I am disgusted with myself
	3	I hate myself
8.	0	I don't feel I am any worse than anybody else
	1	I am critical of myself for my weaknesses or mistakes
	2	I blame myself all the time for my faults
	3	I blame myself for everything bad that happens
9.	0	I don't have any thoughts of killing myself
	1	I have thoughts of killing myself, but I would not carry them out
	2	I would like to kill myself
	3	I would kill myself if I had the chance
10.	0	I don't cry any more than usual
	1	I cry more now than I used to

	2	I cry all the time now
	3	I used to be able to cry, but now I can't cry even though I want to
11.	0	I am no more irritated by things than I ever was
	1	I am slightly more irritated now than usual
	2	I am quite annoyed or irritated a good deal of the time
	3	I feel irritated all the time
12.	0	I have not lost interest in other people
	1	I am less interested in other people than I used to be
	2	I have lost most of my interest in other people
	3	I have lost all of my interest in other people
13.	0	I make decisions about as well as I ever could
	1	I put off making decisions more than I used to
	2	I have greater difficulty in making decisions more than I used to
	3	I can't make decisions at all anymore
14.	0	I don't feel that I look any worse than I used to
	1	I am worried that I am looking old or unattractive
	2	I feel there are permanent changes in my appearance that make me look unattractive
	3	I believe that I look ugly
15.	0	I can work about as well as before
	1	It takes an extra effort to get started at doing something
	2	I have to push myself very hard to do anything
	3	I can't do any work at all
16.	0	I can sleep as well as usual
	1	I don't sleep as well as I used to
	2	I wake up 1-2 hours earlier than usual and find it hard to get back to sleep
	3	I wake up several hours earlier than I used to and cannot get back to sleep.
17.	0	I don't get more tired than usual
	1	I get tired more easily than I used to
	2	I get tired from doing almost anything
	3	I am too tired to do anything
18.	0	My appetite is no worse than usual
	1	My appetite is not as good as it used to be
	2	My appetite is much worse now
	3	I have no appetite at all anymore
19.	0	I haven't lost much weight if any, lately
	1	I have lost more than five pounds
	2	I have lost more than ten pounds
	3	I have lost more than fifteen pounds
20.	0	I am no more worried about my health than usual
	1	I am worried about physical problems like aches, pains, upset stomach, or constipation
	2	I am very worried about physical problems and it's hard to think of much else

	3	I am so worried about my physical problems that I cannot think of anything else
21.	0	I have not noticed any recent change in my interest in sex
	1	I am less interested in sex than I used to be
	2	I have almost no interest in sex
	3	I have lost interest in sex completely

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
Over 40	Extreme depression

Arabic Version of Beck's Depression Scale:

استبيان بيكز للاكتئاب

في هذا الاستبيان يجب حساب درجاتكم بنفسكم , مقياس الدرجات موجود في نهاية الاستبيان.

1.

- 0 أنا لا أشعر بالحزن.
- 1 أنا أشعر بالحزن.
- 2 أنا حزين في كل الأوقات ولا أستطيع الخروج من حزني.
- 3 أنا حزين وغير سعيد لأنني لا أستطيع تحمله.

.2

- 0 لست مستاءً بشكل خاص بشأن المستقبل.
- 1 أشعر بالإحباط بشأن المستقبل.
- 2 أشعر أنه ليس لدي ما أتطلع إليه للمستقبل.
- 3 أشعر أن المستقبل مئوس منه وأن الأمور لا يمكن أن تتحسن.

.3

- 0 لا أشعر بالفشل.
- 1 أشعر أنني فشلت أكثر من الشخص العادي.
- 2 عندما أنظر إلى حياتي ، كل ما أستطيع رؤيته هو الكثير من الإخفاقات.
- 3 أشعر أنني إنسان فاشل تمامًا.

.4

- 0 أحصل على الكثير من الارتياح من الأشياء التي اعتدت عليها.
- 1 أنا لا أستمتع بالأشياء التي اعتدت عليها سابقاً.
- 2 أنا لا أحصل على الرضا الحقيقي من أي شيء بعد الآن.
- 3 أنا مستاء أو ضجر من كل شيء.

.5

- 0 لا أشعر بالذنب بشكل خاص.
- 1 أشعر بالذنب في الأوقات الجيدة.
- 2 أشعر بالذنب معظم الوقت.
- 3 أشعر بالذنب طوال الوقت.

.6

- 0 لا أشعر أنني معاقب.
- 1 أشعر أنني قد أتعرض للعقاب.
- 2 أتوقع أن أعاقب.
- 3 أشعر أنني معاقب.

.7

- 0 لا أشعر بخيبة أمل في نفسي.
- 1 أشعر بخيبة أمل في نفسي.
- 2 أشعر بالاشمئزاز من نفسي.
- 3 إنا اكره نفسي.

.8

- 0 لا أشعر بأنني أسوأ من أي شخص آخر.
- 1 أنا أنتقد نفسي بسبب نقاط ضعفي أو أخطائي.
- 2 ألوم نفسي طوال الوقت على أخطائي.
- 3 ألوم نفسي على كل شيء سيئ يحدث.

.9

- 0 لا تتوارد أي أفكار عن قتل نفسي.
- 1 تتوارد في ذهني فكرة الانتحار ولكن لا أريد تنفيذها.
- 2 أود أن أقتل نفسي.

3 كنت سأقتل نفسي لو أتاحت لي الفرصة.

.10

- 0 أنا لا أبكي أكثر من المعتاد.
- 1 أنا أبكي الآن أكثر من السابق.
- 2 أنا أبكي طوال الوقت الآن.
- 3 اعتدت أن أكون قادر على البكاء ، ولكن الآن لا أستطيع البكاء على الرغم من أنني أريد ذلك.

.11

- 0 أنا لست غاضب من أي شيء.
- 1 أنا أشعر بالغضب الآن أكثر من المعتاد.
- 2 أنا منزع جدا أو غاضب كثيرا معظم الأوقات.
- 3 أشعر بالغضب طوال الوقت.

.12

- 0 لم أفقد الاهتمام بأشخاص آخرين.
- 1 أنا أقل اهتماما بالآخرين مما كنت عليه.
- 2 لقد فقدت معظم اهتمامي بالآخرين.
- 3 لقد فقدت كل اهتمامي بالآخرين.

.13

- 0 أنا أتخذ القرارات حول ما يمكن أن أفعله.
- 1 أقوم بتأجيل اتخاذ القرارات أكثر من استخدامها.
- 2 أجد صعوبة أكبر في اتخاذ القرارات أكثر من استخدامها.
- 3 لا أستطيع اتخاذ قرارات على الإطلاق بعد الآن.

.14

- 0 لا أشعر بأنني أبدو أسوأ مما كنت عليه.
- 1 أنا قلقة من أنني أتقدم في العمر أو غير جذابة.
- 2 أشعر أن هناك تغييرات دائمة في مظهري تجعلني أبدو غير جذابة.
- 3 أعتقد أنني أبدو قبيحة.

.15

- 0 أستطيع أن أعمل كما كنت في السابق.
- 1 يتطلب الأمر جهدا إضافيا للبدء في القيام بشيء ما.
- 2 علي أن أضغط على نفسي بشدة لأفعل أي شيء.
- 3 لا أستطيع القيام بأي عمل على الإطلاق.

.16

- 0 أستطيع النوم كالمعتاد.
- 1 أنا لا أنام كما كنت سابقاً.
- 2 أستيقظ قبل ساعة أو ساعتين من المعتاد ، وأجد صعوبة في العودة إلى النوم.
- 3 أستيقظ قبل عدة ساعات مما كنت عليه في السابق ولا أستطيع العودة إلى النوم.

.17

- 0 لا أشعر بالتعب أكثر من المعتاد.
- 1 أشعر بالتعب بسهولة أكبر مما اعتدت عليه.
- 2 أشعر بالتعب من القيام بأي شيء تقريباً.
- 3 أنا متعب جدا لفعل أي شيء.

.18

- 0 شهيتي ليست أسوأ من المعتاد.
- 1 شهيتي ليست جيدة كما كانت عليه من قبل.
- 2 شهيتي هي أسوأ بكثير الآن.
- 3 ليس لدي أي شهية على الإطلاق بعد الآن.

.19

- 0 أنا لم أفقد الكثير من الوزن في الأونة الأخيرة.
- 1 لقد فقدت أكثر من خمسة أرطال.
- 2 لقد فقدت أكثر من عشرة أرطال.
- 3 لقد فقدت أكثر من خمسة عشر رطلاً.

.20

- 0 أنا لست أكثر قلقاً على صحتي من المعتاد.
- 1 أنا قلق من مشاكل جسدية مثل الأوجاع ، الآلام ، اضطراب المعدة ، أو الإمساك.
- 2 أنا قلق جداً من المشاكل الجسدية ومن الصعب التفكير في أمور أخرى.
- 3 أنا قلق جدا من مشاكل جسدية ولا أستطيع التفكير في أي شيء آخر.

.21

- 0 لم ألاحظ أي تغيير حديث في اهتمامي بالجنس.
- 1 أنا أقل اهتماماً بالجنس مما كنت عليه.
- 2 ليس لدي أي اهتمام تقريباً بالجنس.
- 3 لقد فقدت الاهتمام بالجنس تماماً.

تفسير استبيان بيكز للاكتئاب:

الآن بعد أن أكملت الاستبيان ، قم بإضافة النقاط لكل سؤال من الأسئلة الواحد والعشرين من خلال حساب العدد على يسار كل سؤال قمت بوضع علامة عليه. سيكون أعلى مجموع ممكن للاختبار كله ثلاثة وستين. هذا يعني أنك اخترت رقم ثلاثة في جميع

الأسئلة واحد وعشرين. وبما أن أقل درجة ممكنة لكل سؤال هي صفر ، فإن أقل درجة ممكنة للاختبار ستكون صفراً. هذا يعني أنك وضعت دائرة حول الصفر لكل سؤال. يمكنك تقييم الاكتئاب الخاص بك وفقاً للجدول أدناه:

مجموع النقاط _____ مستويات الاكتئاب

10-1 _____ تعتبر هذه الارتفاعات والانخفاضات طبيعية.

16-11 _____ اضطراب مزاج خفيف.

20-17 _____ بداية الاكتئاب.

30-21 _____ الاكتئاب المعتدل.

40-31 _____ اكتئاب حاد.

أكثر من 40 _____ الاكتئاب الشديد.



APPENDIX C

Severity Measure for Separation Anxiety Disorder—Child Age 11–17

Name:

Age:

Sex: Male Female

Date:

Instructions: The following questions ask about thoughts, feelings, and behaviors that you may have had about being separated from home or from people who are important to you. Please rate how often the following statements are true for you. Please respond to each item by marking (II or x) one box per row.

During the PAST 7 DAYS, I have...	Never	Occasionally	Half of the time	Most of the time	All of the time	Item score
felt moments of sudden terror, fear, or fright when separated						
felt anxious, worried, or nervous about being separated						
had thoughts of bad things happening to people important to me or bad things happening to me when separated from them (e.g., getting lost, accidents)						
felt a racing heart, sweaty, trouble breathing, faint, or shaky when separated						
felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping when separated						
avoided going places where I would be separated						
when separated, left places early to go home						
spent a lot of time preparing for how to deal with separation						
distracted myself to avoid thinking about being separated						

needed help to cope with separation (e.g., alcohol or medications, superstitious objects)						
---	--	--	--	--	--	--

Instructions to Clinicians

The Severity Measure for Separation Anxiety Disorder—Child Age 11–17 is a 10-item measure that assesses the severity of symptoms of separation anxiety disorder in children and adolescents. The measure was designed to be completed by the child upon receiving a diagnosis of a separation anxiety disorder (or clinically significant separation anxiety disorder symptoms) and thereafter, prior to follow-up visits with the clinician. Each item asks the child to rate the severity of his or her separation anxiety disorder during the past 7 days.

Scoring and Interpretation

Each item on the measure is rated on a 5-point scale (0=Never; 1=Occasionally; 2=Half of the time; 3=Most of the time, and 4=All of the time). The total score can range from 0 to 40, with higher scores indicating greater severity of separation anxiety disorder. The clinician is asked to review the score of each item on the measure during the clinical interview and indicate the raw score for each item in the section provided for “Clinician Use.” The raw scores on the 10 items should be summed to obtain a total raw score. In addition, the clinician is asked to calculate and use the average total score. The average total score reduces the overall score to a 5-point scale, which allows the clinician to think of the severity of the child’s separation anxiety disorder in terms of none (0), mild (1), moderate (2), severe (3), or extreme (4). The use of the average total score was found to be reliable, easy to use, and clinically useful to the clinicians in the DSM-5 Field Trials. The average total score is calculated by dividing the raw total score by a number of items in the measure (i.e., 10).