The Psychosocial Impact of the Syrian War on Syrian Refugee Children in Jordan

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Abstract

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In many countries, violence is among the top five causes of death (Hernandez, 2002). Years of armed conflict and political crisis in Latin American countries have perpetuated political violence. This situation has led to a concern for the mental health of immigrants who arrive from these countries and have been exposed to political violence and endured psychological trauma (Asner-Self & Marotta, 2005). Unfortunately, immigrants often continue to suffer upon arrival to the U.S. – for example, they end up living in neighborhoods with high levels of poverty and violence (Crowley, Lichter, & Qian, 2006) and experience much discrimination (Buvinic, Morrison, & Shifter, 1999). The physical and mental health consequences of political violence do not necessarily end when immigrants cross the border into the country of asylum. Rather, these negative health effects are often exacerbated by the immigration process and the challenging experience of adapting to a new culture (Blank et al., 2003; Crowley et al., 2006; Rousseau & Drapeau, 2004). The political violence context and its implications are complex. For example, one particular research study has shown that immigrants from various backgrounds are 54% more likely to develop clinical symptoms than the general population (Eisenman, Gelberg, Liu, & Shapiro, 2003).

 The type and intensity of exposure to political violence may vary by the country’s political climate and the social status of individuals in their country of origin. It is additionally related to social and political conditions, as well as the particular circumstances of war (Hernandez, 2002). Regardless, exposure to political violence has been shown to be associated with mental health disorders, particularly post-traumatic stress disorder, anxiety disorders, and depression (Eisenman et al., 2003; Rousseau & Drapeau, 2004). Eisenman and colleagues (2003) found that Latino patients who were exposed to political violence reported more chronic pain, poorer physical functioning, and a decreased quality of life as compared to those who were not exposed to political violence. The combination of exposure to political violence along with a lack of detection by healthcare providers has a major impact on the health, diagnoses, and access to treatment in this vulnerable population (Barcelona & Mendoza, 2001). In regard to immigrants and refugees, it is important to consider the additional consequences of immigration, the circumstances that caused them to leave their country of origin, and the potential implications of these factors for their mental health while, at the same time, taking into account the stressors associated with a loss of social support and social status, acculturation, and displacement from their homes.

Different types of exposure to political violence, and the varied backgrounds of individuals, have an impact on the mental health needs and use of services across the various sub-groups (US Census Bureau, 2000). A comprehensive study investigated adolescents’ psychological responses to war and political violence. Results indicated that exposure to violence and high stress may increase the likelihood of psychopathology, in addition to post-traumatic stress disorder (PTSD), mood disorders, externalizing behaviors, and somatic symptoms (Al‐Krenawi, Graham, & Sehwail, 2007). Due to repeated and recurrent exposure to political violence, post-traumatic stress disorder (PTSD) and trauma are likely to be chronic conditions. Studies have also found that, in the presence of conflict and political violence, typical social structures are disrupted, and tension, instability, and insecurity ensue. Each of these consequences harm adolescents’ social and emotional development. Additionally, they have implications for their overall health and well-being, as well as for their social connections, including with family, peers, and the community (Al‐Krenawi, Graham, & Kanat-Maymon, 2009).

Refugee children consistently report high levels of trauma as a result of war, which have profound negative effects on children’s mental health, including mood and anxiety disorders, post-traumatic stress disorder, adjustment disorder, as well as behavioral problems (Fazel, Reed, Panter-Brick, & Stein, 2012; Howard& Hodes, 2000). In one sample of participants, children and adolescents reported varied and repeated exposure to trauma. Everyone was exposed to political violence or war. In addition, the historical trauma profiles of refugee children reflected a high prevalence of forced displacement, traumatic loss, and domestic violence. Multiple adversities are common among children and those who are exposed to trauma (Cohen, Berliner, & Mannarino, 2003). This is especially true among children who were affected by the war and were exposed to multiple traumas and upheavals in life (Betancourt, Borisova, de la Soudiere, & Williamson; Fazel et al., 2012). The psychological consequences of children’s and caregivers’ exposure to war have immense implications for interpersonal relationships. The majority of families are uprooted from their homes and separated from one another, and the emotional stress is likely to impair adults’ abilities to provide care and nurturance to their young children (Lai, Hadi, & Llabre, 2014). The refugee child must adapt to a new world – a new school, new friends – and may even need to take the responsibility of adult roles. Additionally, they will need to learn the language of the new country in order to acclimate to the surrounding culture, and deal with issues surrounding being an orphan and lacking resources for the family, as well as the difficulty of connecting with others. The structures meant for assisting refugee children may not solve all the difficulties that the children suffer (Fazel & Stein, 2002).

 The war in Syria began in March 2011. The UNICEF reports (UNICEF, 2014; 2016) presented descriptions of violations against children in conflict zones in Syria. In the early years of conflict, most of the children that were recruited by armed forces and groups were adolescent boys between the ages of 15-17, and they were used mostly in support positions away from the front lines. However, since 2014, all sides of the conflict recruited much younger children, as young as 7, and often without the consent of their parents. More than 50% of children recruited in 2015 were under the age of 15. These children received military training and participated in combat, or occupied life-threatening positions on the front lines, including carrying and safeguarding weapons, manning checkpoints, and treating and evaluating wounded soldiers. The families described the ways in which they imprisoned their children and pulled them out of their homes, schools or hospitals, or even from the streets and search points. Some of the detained children were tortured or sexually assaulted, for the sake of humiliation, or to get them to confess or to pressure them to find their relatives.

Ozer’s (2012) study described the Syrian refugee children’s conditions in Turkey and identified the psychological effects from which they suffered, and found that, on the bright side, 71% of girls and 61% of boys reported strong relationships with their families and received help from their relatives. On the other hand, 74% of the children observed the death of someone close to them, and 50% were victims of more than 6 cases of violence. The psychological effects and difficulties associated with the war were very grave – 60% of the participants had signs of depression, 45% of the children showed symptoms of PTSD, 22% of the participants showed signs of aggression, and 65% of the participants presented with psychological symptoms that decreased their functioning, and the majority of the children suffered from two or more health problems. It was also found that the provision of social support reduced the negative psychological effects experienced by refugee children. Despite the large presence of support among the refugees, there is still a sizeable group of refugee children that need additional protection and support. Additionally, the school context is important as is strengthening the relationships between the children. Finally, the strength of parents is reflected in their ability to protect their children and their relationships with them.

 In another study, Montgomery (2008) found that the political will and the important changes concerning the absorption and treatment of the refugees protected against psychological disorders in refugees. The examination of trauma and psychological health profiles of refugee children and adolescents may shed light on the need for services, such as those that are being researched, and the differences between them. Such efforts can guide the development, implementation, and evaluation of treatment among the mental health population, while, at the same time, informing mental health workers in order to fund the agencies and policy-makers (Betancourt et al., 2011).

**Research Aims**

The study aimed to identify the psychosocial effects of the Syrian war on the Syrian refugee children in Jordan. The experience of the Syrian war and of the refugees are ongoing, current, extensive, powerful. We attempted to examine, identify, and discover the associations between sociodemographic background variables (such as: gender, level of religiosity, satisfaction with educational achievements, and parental employment) of Syrian refugee children in Jordan and their psychosocial functioning in order to provide the children with the appropriate treatment and response, which will increase the possibility of recovery before too much time has passed. By identifying and uncovering which sociodemographic variables are negatively associated with psychosocial functioning among refugee children, and which variables are positively, or not at all, associated, findings may promote the discovery of solutions and programs to promote recovery and rehabilitation within the community.

**Research Questions**

1. What is the association between the gender of the Syrian refugee children in Jordan and their psychological functioning?
2. What is the association between the gender of the Syrian refugee children in Jordan and their social functioning?
3. What is the association between satisfaction with the educational achievements of the Syrian refugee children and their psychological functioning?
4. What is the association between satisfaction with the educational achievements of the Syrian refugee children and their social functioning?
5. What is the association between the economic status of the families of the Syrian refugee children in Jordan and their psychological functioning?
6. What is the association between the economic status of the families of the Syrian refugee children in Jordan and their social functioning?

**Hypotheses**

1. It is expected that the Syrian refugee boys will be more negatively affected by the Syrian war in terms of their psychological functioning (somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobias, paranoid thinking) than the Syrian refugee girls.
2. It is expected that the Syrian refugee boys will be more negatively affected by the Syrian war in terms of their social and family functioning (will find more symptoms of psychosis and lower social and family functioning) than the Syrian refugee girls.
3. It is expected that there will be a positive association between the degree of satisfaction with their educational achievements among the Syrian refugee children in Jordan and their psychological functioning.
4. It is expected that there will be a positive association between the degree of satisfaction with their educational achievements among the Syrian refugee children in Jordan and their social functioning.
5. It is expected that there will be a positive association between the economic status of the families of the Syrian refugee children in Jordan and their psychological functioning.
6. It is expected that there will be a positive association between the economic status of the families of the Syrian refugee children in Jordan and their social functioning.

**Method**

**Participants**

Two-hundred and fifty participants were recruited for this study. After excluding 45 participants due to lack of complete information, the final participant sample was 204. Of the participants 101 were boys and 104 were girls. All of the participants were Syrian refugees who were in refugee camps in Jordan. Recruitment was carried out in the refugee camps, with particular help from treatment centers, aid centers, and schools there. The children who were recruited for the study were between the ages of 12-18.

**Measures**

The current study was a quantitative study. A number of questionnaires were used to collect data on demographics, psychological functioning, and social functioning.

**Demographic Information**. A socio-demographic self-report questionnaire was used to collect data on gender, age, level of religiosity, socioeconomic status, family composition, parental employment, educational achievements, years of parental education etc.

**The Brief-Symptom Inventory (BSI)**. The BSI examines a person’s overall level of psychological distress, as expressed through a wide range of symptoms. The questionnaire is a shortened version of a longer measure, the R-90-SCL, which was developed by Derogatis (1977). The questionnaire consists of 53 items, which are illustrative of different psychological symptoms. Respondents are asked to rate the degree to which they suffer from each symptom in the past month using a 5-point scale ranging from 1 (not at all) to 5 (very much). The questionnaire includes nine dimensions: somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.

**Rosenberg Self-Esteem Scale** (Rosenberg, 1979). This questionnaire is comprised of 10 items that measure global self-worth by assessing positive and negative views of the self. Each item is measured on a 4-point Likert-scale ranging from 1 (strongly agree) to 4 (strongly disagree). The Cronbach’s alpha for this measure was 0.76.

**The McMaster Family Assessment Device (FAD)**. This questionnaire, developed by Epstein, Baldwin, and Bishop (1983), consists of 12 items that aim to assess respondents’ perceptions of their relationships within their family and the ways in which family members interact with one another; or, in other words, family functioning. All of the items were measured on a 4-point Likert-scale.

**Foa’s Post-Traumatic Stress Disorders (PTSD) Scale**. The PTSD scale is a 17-item tool that was developed by Foa. Its purpose is to provide a short, reliable, and self-report measure of PTSD symptoms that can be used in both clinical and research settings.

**Social Functioning** (Hudson, 1982). This questionnaire consists of 25 questions assessing social relationships. The questionnaire refers to a person’s subjective feelings about his/her relationships with others in a variety of social settings. The questionnaire consists of a number of items, such as, “I get along well with my friends.” The response options are on a 5-point scale. In terms of reliability, Cronbach’s alphas range from 91.0 to 98.0. In terms of validity, this tool distinguishes between groups that have extreme difficulties in social interactions to groups that do not have any difficulties.

Comparisons between boys and girls will be examined using chi-squares and t-tests.

**Results**

A comparison between the group of boys and group of girls revealed no differences in any of the following sociodemographic variables: age, number of rooms in the home, religious, religious orientation, parental years of education, parental employment status, and the asylum country in Jordan. However, the group of boys and girls differed in their number of siblings and parental marital status such that the boys reported having fewer siblings than the girls and more of their parents were married (94 married parents among the boys v. 85 married parents among the girls). Additionally, more girls than boys were orphans (one of the parents had died). In addition, the boys were more satisfied with their educational achievements and reported higher family socioeconomic status than the girls. Chi-square tests revealed that there was a gender difference in father employment (*p* < .05) and satisfaction of educational achievements (*p* < .05).

T-tests for independent groups were conducted to identify differences between the group of Syrian refugee boys and girls in regard to the effects of the war. As such, we compared their psychological and social functioning – results are displayed in Table 2. Significant differences were found for all of the psychological functioning variables and in all of the dimensions of the BSI questionnaire, such that the group of boys scored higher on each dimension than the group of girls: somatization (*p* < .001), obsession-compulsion (*p* < .001), interpersonal sensitivity (*p* < .05), depression (*p* < .01), anxiety (*p* < .001), hostility (*p* < .001), phobic anxiety (*p* < .001), paranoid ideation (*p* < .01), and psychoticism (*p* < .001). In addition, the boys scored higher than the girls on the Global Severity Index (GSI) of the BSI questionnaire (*p* < .001) and on the PTSD scale (*p* < .01). In regard to social functioning, the girls scored higher than the boys on the self-esteem scale (*p* < .001) and the social functioning scale (*p* < .001). As shown in Table 2, there were also significant gender differences in the family functioning scale (FAD) such that the girls scored higher than the boys (*p* < .01).

Finally, Pearson correlations were conducted to examine the associations among the sociodemographic variables and the psychosocial functioning and social functioning variables. There were significant associations between somatization and family socioeconomic status (*r* = 0.32, *p* <.001) and somatization and degree of satisfaction with educational achievements (*r* = -0.25, *p* <.05). As shown in Table 3, there were significant associations between anxiety and family socioeconomic status (*r* = 0.25, *p* <.01) and anxiety and satisfaction with educational achievements (*r* = -0.29, *p* <.05). In regard to phobic anxiety, we found significant associations with family socioeconomic status (*r* = 0.32, *p* <.001), gender (*r* = -0.27, *p* <.05) and degree of satisfaction with educational achievements *(r* = -0.31, *p* <.05). Results showed significant associations between psychological functioning as measured by the BSI and family socioeconomic status (*r* = 0.22, *p* <.05), gender (*r* = -0.22, *p* <.05), and degree of satisfaction with educational achievements (*r* = -0.29, *p* <.05). Family functioning, as measured by the FAD, was significantly associated only with religious orientation (*r* = -.023, *p* < .01).

In addition, results showed that PTSD was significantly associated with degree of satisfaction with educational achievements (*r* = .50, *p* < .001), and whether one’s father worked (*r* = .87, *p* < .05). Obsession-compulsion was significantly associated with maternal employment (*r* = .18, *p* < .001) and family socioeconomic status (*r* = .20, *p* < .001). As depicted inTable 3, hostility was significantly associated with two variables – gender (*r* = .29, *p* < .01) and family socioeconomic status (*r* = .20, *p* < .05). Further, psychoticism was significantly associated with three variables; namely, gender (*r* = -.02, *p* < .05), religious orientation (*r* = .02, *p* < .05), and satisfaction with educational achievements (*r* = .30, *p* < .05).

Finally, the results showed that self-esteem was significantly associated with gender (*r* = 0.30, *p* <.01) and satisfaction with educational achievements (*r* = 0.29, *p* <.05). Interpersonal sensitivity was significantly associated with maternal employment (*r* = 0.20, *p* <.05) and satisfaction with educational achievements (*r* = -0.27, *p* <.05). Additionally, depression was significantly associated with satisfaction with educational achievements (*r* = -0.36, *p* <.01) and religious orientation (*r* = 0.167, *p* <.05).

**Discussion**

The majority of our discussion is organized around the meaning and influence of “political violence,” a term defined by the World Health Organization as a form of collective violence undertaken by a civil society or state group against an individual, group, or community based on ethnic, geographic, or racial identities (Al-Krenawi & Graham, 2012). Taking into account the comprehensive study that investigated adolescents’ psychological responses to wear and political violence (Al‐Krenawi et al., 2007), the current study examined different levels and symptoms related to psychopathology such as, somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, anxiety phobia, paranoid thinking, and social alienation.

 Our results showed that the group of refugee boys were more negatively affected in terms of psychological functioning than the group of refugee girls. This pattern can be explained by the UNICEF reports (UNICEF, 2014; 2016) that described the violations against children in conflict zones in Syria. In the early years of the conflict, the majority of the children that were recruited by the armed forces and groups were adolescent boys between the ages of 15-17, and they served mostly in support positions away from the front lines. However, since 2014, all parties involved in the conflict recruited children of much younger ages – as young as 7 years old – and often without the consent of their parents. More than 50% of the children recruited in 2015 were under the age of 15. These children received military training and took part in combat, or occupied life-threatening positions on the front lines, including carrying and safeguarding weapons, manning checkpoints, and treating and evaluating wounded soldiers, The families described the ways in which they imprisoned their children and pulled them out of their homes, schools or hospitals, or even from the streets and search points. Some of the detained children were tortured or sexually assaulted, for the sake of humiliation, or to get them to confess or to pressure them to find their relatives.

 Unlike Ozer’s (2012) study, most of the participants in our study were not exposed to the death of a close other. However, similar to his findings, the majority of the participants in our study were affected by the war such that the refugees reported symptoms of psychological issues that reduced their functioning. In addition, the Syrian refugee children showed a decline in self-esteem and social functioning, which is in support of previous studies in the literature (e.g., Lai et al., 2014) that report that psychological consequences of children’s exposure to war have grave implications for interpersonal relationships. The majority of families were uprooted from their homes and separated from one another, and the emotional stress likely impaired adults’ abilities to provide care and nurturance to their young children, which explains the decline in social functioning and self-esteem.

 The decline in psychological and social functioning among the refugee children can be explained by the need to adapt to a new world (of the country of absorption) – school, friends, and even responsibility of adult roles. Additionally, they will need to learn the language of the new country in order to acclimate to the surrounding culture, and deal with issues surrounding being an orphan and lacking resources for the family, as well as the difficulty of connecting with others. The structures meant for assisting refugee children may not solve all the difficulties that the children suffer (Fazel & Stein, 2002).

**Conclusion**

The present study is a starting point for future studies that investigate and compare the effects of war, political violence, and refugee conditions on the psychosocial functioning among Syrian refugee boys and girls between 12-18 years old who reside in refugee camps in Jordan. The examination of trauma and psychological health profiles of refugee children and adolescents may shed light on the need for services, such as those that are being researched, and the differences that there are between them. Such efforts can guide the development, implementation, and evaluation of treatment among the mental health population, while, at the same time, informing mental health workers in order to fund the agencies and policy-makers (Betancourt et al., 2011).

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Table 1

*Means, Standard Deviations, and Frequencies of Sociodemographic Variables by Gender*

|  |  |  |
| --- | --- | --- |
|  | **M (*SD*)** |  |
|  | **Boys (*n* = 101)** | **Girls (*n* = 104)** | ***t*-value** |
| **Age** | 14.55(2.73) | 14.30(1.91) | 0.89 |
| **# of siblings** | 3.72(1.60) | 4.54(1.99) | -1.69 |
| **# of rooms in home** | 2.65(0.61) | 2.92(1.11) | -1.26 |
|  | ***n* (%)** |  |
|  | **Boys (*n* = 101)** | **Girls (*n* = 104)** | **χ²(df)** |
| **Religion** |
|  Muslim | 101 (100%) | 98 (94%) | 1.02 |
|  Christian | 0 (0%) | 1 (1%) |
|  Other | 0 (0%) | 5 (5%) |
| **Religious orientation** |
|  Orthodox | 12 (11%) | 15 (14%) | 1.60 |
|  Religious | 41 (41%) | 51 (49%) |
|  Traditional | 48 (48%) | 34 (33%) |
|  Secular | 0 (0%) | 4 (4%) |
| **Paternal years of education** |
|  Less than 8 years | 33 (33%) | 21 (20%) | 2.73 |
|  8-9 years | 12 (11%) | 25 (27%) |
|  12 years | 16 (16%) | 18 (18%) |
|  13+ years | 40 (40%) | 38 (37%) |
| **Paternal work status** |
|  Unemployed  | 50 (50%) | 37 (36%) | 10.70\* |
|  Employed (in area of  expertise) | 11 (11%) | 33 (34%) |
|  Employed (outside area  of expertise) | 40 (39%) | 20 (22%) |
|  Retired | 0 (0%) | 5 (5%) |
| **Maternal years of education** |
|  Less than 8 years | 44 (44%) | 31 (29%) | 3.40 |
|  8-9 years | 16 (16%) | 27 (27%) |
|  12 years | 23 (22%) | 16 (15%) |
|  13+ years | 18 (18%) | 30 (29%) |
| **Maternal work status** |
|  Unemployed  | 89 (89%) | 84 (83%) | 1.37 |
|  Employed (in area of  expertise) | 6 (5%) | 7 (6%) |
|  Employed (outside area  of expertise) | 0 (0%) | 6 (5%) |
|  Retired | 6 (6%) | 2 (1%) |
| **Parental marital status** |
|  Married | 94 (94%) | 85 (85%) | 2.08 |
|  Divorced | 7 (6%) | 6 (5%) |
|  Separated | 0 (0%) | 4 (3%) |
|  Mother is a widow | 0 (0%) | 7 (6%) |
|  Father is a widow | 0 (0%) | 2 (1%) |
| **Socioeconomic status** |
|  Great | 0 (0%) | 11 (11%) | 8.41 |
|  Very good | 23 (22%) | 12 (11%) |
|  Good | 61 (61%) | 38 (38%) |
|  Almost good | 11 (11%) | 27 (26%) |
|  Bad | 6 (6%) | 10 (9%) |
|  Very bad | 0 (0%) | 6 (5%) |
| **Satisfaction with educational achievements** |
|  Not at all satisfied | 0 (0%) | 7 (6%) | 10.00\* |
|  Not satisfied | 0 (0%) | 13 (12%) |
|  A little bit satisfied | 11 (11%) | 18 (18%) |
|  Satisfied | 73 (72%) | 37 (36%) |
|  Very satisfied | 17 (17%) | 29 (28%) |

\**p* < .05.

Table 2

*Gender Differences in Psychological and Social Functioning Variables*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Boys (*n* = 101) | Girls (*n* = 104) | *t*-value |
| Mean | *SD* | Mean | *SD* |
| Somatization | 2.95 | 0.23 | 2.14 | 0.86 | 3.99\*\*\* |
| Obsession-compulsion | 3.14 | 0.37 | 2.40 | 0.82 | 3.77\*\*\* |
| Interpersonal sensitivity | 2.92 | 0.51 | 2.40 | 0.89 |  2.44\* |
| Depression | 2.92 | 0.27 | 2.23 | 0.93 | 3.11\*\* |
| Anxiety | 3.01 | 0.32 | 2.31 | 0.84 | 3.50\*\*\* |
| Hostility | 2.99 | 0.39 | 2.19 | 0.82 | 4.05\*\*\* |
| Phobic anxiety | 3.13 | 0.31 | 2.22 | 0.85 | 4.54\*\*\* |
| Paranoid ideation | 2.93 | 0.42 | 2.37 | 0.88 | 2.67\*\* |
| Psychoticism | 2.93 | 0.48 | 2.17 | 0.86 | 3.70\*\*\* |
| GSI  | 3.00 | 0.18 | 2.27 | 0.72 | 4.28\*\*\* |
| Self-esteem | 2.58 | 0.21 | 3.15 | 0.46 | -5.24\*\*\* |
| FAD  | 2.55 | 0.15 | 3.15 | 0.45 | -2.71\*\* |
| PTSD  | 2.90 | 0.32 | 1.9 | 0.71 | \*\*2.85 |
| Social functioning  | 3.04 | 0.15 | 3.90 | 0.74 | -4.88\*\*\* |

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

Table 3

*Linear Regression – Pearson Correlation: Sociodemographic Variables as Predictors of Psychological Functioning and Social Functioning*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Gender | Religious orientation | Parental work status | Maternal employment | Parental marital status | Family socioeconomic status | Place of residence | Satisfaction with educational achievement |
| Somatization | -0.14 | 0.09 | -0.04 | 0.04 | -0.16 | 0.32\*\*\* | 0.25 | -0.25\* |
| Obsession- compulsion | -0.13 | 0.16 | 0.01 | 0.18\* | -0.17 | 0.20\* | 0.17 | -0.21 |
| Interpersonal sensitivity | -0.16 | 0.14 | -0.07 | 0.20\* | 0.01 | 0.15 | 0.20 | -0.27\* |
| Depression | -0.07 | 0.20\* | -0.01 | 0.17 | -0.06 | 0.19 | 0.21 | -0.36\*\* |
| Anxiety | -0.15 | 0.06 | 0.14 | 0.15 | -0.21 | 0.25\*\* | 0.21 | -0.29\* |
| Hostility | -0.29\*\* | 0.12 | -0.15 | 0.12 | 0.16 | 0.20\* | 0.04 | -0.01 |
| Phobic anxiety | -0.27\* | 0.14 | -0.06 | 0.05 | -0.07 | 0.32\*\*\* | 0.12 | -0.31\* |
| Paranoid ideation | -0.22 | 0.19 | -0.15 | 0.18 | 0.03 | 0.06 | -0.05 | -0.14 |
| Psychoticism | -0.22\* | 0.20\* | 0.01 | 0.17 | -0.06 | 0.12 | 0.15 | -0.30\* |
| BSI | -0.22\* | 0.17 | -0.04 | 0.16 | -0.10 | 0.22\* | 0.17 | -0.29\* |
| Self-esteem | 0.30\*\* | -0.05 | -0.03 | 0.10 | -0.05 | -0.03 | -0.13 | 0.29\* |
| FAD | 0.10 | -0.23\*\* | 0.07 | -0.08 | -0.14 | -0.11 | -0.17 | 0.15 |
| PTSD | 0.05 | 0.15 | 0.09\* | 0.18 | 0.04 | 0.14 | 0.14 | -0.50\*\*\* |
| Social functioning | 0.16 | -0.14 | 0.23 | -0.06 | -0.10 | 0.03 | -0.28 | 0.16 |

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