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Psychological Effects and Coping Strategies among Palestinian Adolescents Exposed to War on Gaza

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Psychological Effects and Coping Strategies among Palestinian Adolescents Exposed to War on Gaza

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بسم الله الرحمن الرحيم

قالوا سبحانك لا علم لنا إلا ما علمتنا إنك أنت العليم الحكيم

صدق الله العظيم

سورة البقرة (آية 32)

DEDICATION

MY APPRECIATION AND GRATITUDE TO THESE PEOPLE WILL BE WITH ME ALWAYS:

TO MY FAMILY
FOR THEIR PATIENCE AND UNDERSTANDING

TO MY TEACHERS
FOR THEIR SUPPORT AND HELP

TO MY FRIENDS

Omar H. EL-Buhaisi

Declaration

I Certify that this thesis submitted for the degree of Master is the result of my own research, except where otherwise acknowledged, and that this thesis (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Signed----------

Omar Hamdan EL-Buhaisi

Date ----------

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Researcher

Omar H. EL-Buhaisi

Abstract

This study aims to examine the psychological effects of Gaza War on Palestinian adolescents living in Gaza Strip and their coping strategies. The researcher defined Gaza War, as all Acts of violence committed by Israel against Palestinian people in Gaza Strip. A stratified cluster random sample survey of 358 adolescents; 158 (44.1%) males and 200 (55.9%) females aged 15-18 years were assessed. The researcher used descriptive analytical design to represent the entire sample of population. However, the researcher used some of modified scales which; Sociodemographic status questionnaire, War on Gaza Traumatic Events Checklist, Spence Children's Anxiety Scale (SCAS), Dépression Self- Rating Scale (DSRS), UCLA PTSD Index for DSM-IV: Adolescent Version, and A-Cope Adolescent - Coping Orientation for Problem experiences. The major findings were: The mean exposure to traumatic events was (13.34) events, while the highest traumatic event (90.8%) of study sample watching mutilated bodies on TV, 86.6% of study sample didn't feel save at home, while 90.8% were unable to protect themselves, 81.8% of study sample were unable to protect their families during the war, and 79.6% don't think that others were able to protect them., and showed that there were significant differences in traumatic events according to sex in favor to males, and there were significant difference in traumatic events according to type of residence in favor to village. The results showed that the total weight mean for Anxiety (37.0%), and the highest score for obsessive compulsive subscale (49.4%), then (45.8%) for Generalized Anxiety subscale, social phobia subscale (38.8%), physical injury fears subscale (36.5%), and then separation Anxiety subscale (34.2%), and the least score for panic/Agoraphobia subscale (20.0%), and there were significant differences in Anxiety and its subscales according to sex in favor to females, this means that girls suffer from Anxiety and its subscales more than boys. The results showed that 76.3% of study sample were suffer from depression manifestations (cutoff point >=17) while 23.7% of study sample were not depress (cutoff point <17), and showed that there were significant differences in depression according to sex actual probability in favor to boys, this means that males suffer from depression more than girls. The results showed that 25 of study sample have no PTSD (6.7%), 74 of study sample have one symptoms (20.5%), 125 of study sample have partial PTSD (35.1%), while 134 of study sample have full PTSD (37.6%) according to DSM-VI, and there were significant differences in PTSD according to sex in favor to females, this means that girls suffer from PTSD more than boys, and there were significant differences in PTSD subscales (Re-experiencing, Increase arousal) in favor to females, while there were no significant differences in PTSD subscale (avoidance) according to sex. The results showed that the most frequent coping items among study sample, the item "try to improve yourself (get body in shape, get better grades, etc.) 58.9%, and the total Weight mean of ACOPE scale was (56.5%), while, the highest subscale of coping was "developing social support" (66.8%) among study sample, and showed that there were no significant differences in coping strategies among males and females, that's means both boys and girls use coping strategies equally. While there were significant differences in coping strategies subscales (developing social support, solving family problems,

being humorous) in favor to females, that's means girls use these strategies more than boys, as well as the results showed that there were significant differences in coping strategies subscales (avoiding problems, investing in close friend, seeking professionals support) in favor to male, that's means boys use these strategies more than girls. And showed that there were relative significant effect for independent variable (traumatic events) on Anxiety, which means that independent variables (hearing the sonic sounds of the jetfighters, hearing shelling of the area by artillery, hearing of arrest of someone or a friend, witnessing assassination of people by rockets, Forced to leave your home during the war) have significant effect on Anxiety, this model shows that 37% of Anxiety scores among adolescents due to the previous traumatic events items, while 63% of Anxiety scores due to others factors, and there were relative significant effect for independent variable (traumatic events) on depression, which means that independent variables (Hearing of arrest of someone or a friend, Witnessing killing of a friend, Witnessing assassination of people by rockets, Forced to leave your home during the war) have significant effect on depression, this model shows that 27% of depression scores among adolescents due to the previous traumatic events items, while 73% of depression scores due to others factors, while there were relative significant effect for independent variable (traumatic events) on PTSD, which means that independent variables (hearing the sonic sounds of the jetfighters, hearing of arrest of someone or a friend, witnessing the signs of shelling on the ground, forced to leave your home during the war) have significant effect on PTSD, this model shows that 37% of PTSD scores among adolescents due to the previous traumatic events items, while 73% of PTSD scores due to others factors. The results showed that there were no significant correlation between Anxiety and total coping strategies, while there were positive significant correlation between Anxiety and coping strategies subscales; (ventilating feelings, developing social support, engaging in demanding activities), this mean increase of Anxiety among adolescents will lead to increase of using of these coping strategies. Also the result shown that there were negative significant correlation between Anxiety and coping strategies subscale; (seeking spiritual support), and there were positive significant correlation between depression and total coping strategies, this mean increase of depression among adolescents will lead to increase of using of coping strategies and vice versa, while there were no significant correlation between PTSD and total coping strategies, and there were positive significant correlation between PTSD and coping strategies subscale; (ventilating feelings, developing social support, and avoiding problems), this mean increase of PTSD among adolescents will lead to increase of using of these coping strategies and vice versa, and there were negative significant correlation between PTSD and (solving family problems).

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Abbreviations

APA	American Psychiatric Association
ACTH	Adrenal Coticotropic Hormone
ANS	Autonomic Nervous System
BDNF	Brain Derived Neurotropic Factor
CFTA	Culture and Free Thought Associating
CRF	Corticotrophins Release Hormone
CRTES	The Child's Reaction to Traumatic Events Scale
DD-NOS	Depressive- Disorder Not Otherwise Specified
DSRS	Depression Self-Rating Scale
DSM-IV	Diagnostic and Statistic Manual of Mental Disorder 4^{th} edition
DSM-IV-TR	Diagnostic and Statistic Manual of Mental Disorder-Revised
ETV	Exposure to Trauma\ Violence
GAD	Generalized Anxiety Disorder
HTQ	Harvard Trauma Questionnaire
ICD-10	International Classification of Diseases-10th edition
MAS	Manifest Anxiety Scale
NUG	National Unity Government
OCD	Obsessive-Compulsive Disorder
PLC	Palestinian Legislative council
PTSD	Post-traumatic Stress Disorder
PTSS	Post-traumatic Stress Syndrome
PRISM	The Pictorial Representation of Illness and Self-Measure
RBD	Recurrent Brief Depression
SCAS	Spence Children's Anxiety Scale
SPSS	The Statistical Package for social Science
UNRWA	The United Nation for RELIEF & Work Agency
WHO	The world Health Organization

Chapter 1

*I*ntroduction

Chapter 1
Introduction

1.1 Background

Violence has probably always been part of the human experience. Its impact can be seen, in various forms, in all parts of the world. Each year, over 1.6 million people worldwide lose their lives due to violence. Violence is among the leading causes of death for people aged 15-44 years worldwide, accounting for 14% of deaths among males and 7% of deaths among females. For every person who dies as a result of violence, many more are injured and suffer from a range of physical, sexual, reproductive and mental health problems. Moreover, violence places a massive burden on national economies, law enforcement and lost productivity. Violence by young people is one of the most visible forms of violence in society. Around the world, newspapers and the broadcast media report daily on violence by gangs, in schools or by young people on the streets. The main victims and perpetrators of such violence, almost everywhere, are themselves adolescents and young adults, The problem of youth violence cannot be viewed in isolation from other problem behaviors. Violent young people tend to commit a range of crimes. They also often display other problems, such as truancy and dropping out of school, substance abuse, compulsive lying, reckless driving and high rates of sexually transmitted diseases. However, not all violent youths have significant problems other than their violence and not all young people with problems are necessarily violent There are close links between youth violence and other forms of violence. Witnessing violence in the home or being physically or sexually abused, for instance, may condition children or adolescents to regard violence as an acceptable means of resolving problems. Prolonged exposure to armed conflicts may also contribute to a general culture of terror that increases the incidence of youth violence (WHO, 2002).
The violence cruelty of conflict are associated with a range of psychological and behavioral problems, include depression and anxiety, suicidal behavior, alcohol abuse, and post traumatic stress disorder. Furthermore, psychological trauma may become evident in disturbed and antisocial behavior, such as family conflict and aggression towards others. This situation is often exacerbated by the availability of weapons and by people becoming inured to violent after long exposure to conflict. The impact of conflicts on mental health is, however, extremely complex and unpredictable. It is influence by a host of factors such

as the nature of the conflict, the kind of trauma and distress experienced, the cultural context, and the communities bring to bear on their situation (Summerfield, 1991).

The September 1993 Israel-PLO Declaration of Principles on Interim Self-Government Arrangements provided for a transitional period of Palestinian self-rule in the West Bank and Gaza Strip. Under a series of agreements signed between May 1994 and September 1999, Israel transferred to the Palestinian Authority (PA) security and civilian responsibility for Palestinian-populated areas of the West Bank and Gaza. Negotiations to determine the permanent status of the West Bank and Gaza stalled following the outbreak of an intifada in September 2000, as Israeli forces reoccupied most Palestinian-controlled areas. In April 2003, the Quartet (US, EU, UN, and Russia) presented a roadmap to a final settlement of the conflict by 2005 based on reciprocal steps by the two parties leading to two states, Israel and a democratic Palestine. The proposed date for a permanent status agreement was postponed indefinitely due to violence and accusations that both sides had not followed through on their commitments. Following Palestinian leader Yasir ARAFAT's death in late 2004, Mahmud ABBAS was elected PA president in January 2005. A month later, Israel and the PA agreed to the Sharm el-Sheikh Commitments in an effort to move the peace process forward. In September 2005, Israel unilaterally withdrew all its settlers and soldiers and dismantled its military facilities in the Gaza Strip and withdrew settlers and redeployed soldiers from four small northern West Bank settlements. Nonetheless, Israel controls maritime, airspace, and most access to the Gaza Strip (world factbook, 2008).

A November 2005 PA-Israeli agreement authorized the reopening of the Rafah border crossing between the Gaza Strip and Egypt under joint PA and Egyptian control. In January 2006, the Islamic Resistance Movement, HAMAS, won control of the Palestinian Legislative Council (PLC). The international community refused to accept the HAMAS-led government because it did not recognize Israel, would not renounce violence, and refused to honor previous peace agreements between Israel and the PA. HAMAS took control of the PA government in March 2006, The PLC was unable to convene throughout most of 2006 as a result of Israel's detention of many HAMAS PLC members and Israeli-imposed travel restrictions on other PLC members. Violent clashes took place between Fatah and HAMAS supporters in the Gaza Strip in 2006 and early 2007, resulting in numerous Palestinian deaths and injuries. ABBAS and HAMAS Political Bureau Chief MISHAL in February 2007 signed the Mecca Agreement in Saudi Arabia that resulted in the formation of a Palestinian National Unity Government (NUG) headed by HAMAS

member Ismail HANIYA. However, fighting continued in the Gaza Strip, and in June, HAMAS militants succeeded in a violent takeover of all military and governmental institutions in the Gaza Strip. ABBAS dismissed the NUG and through a series of Presidential decrees formed a PA government in the West Bank led by independent Salam FAYYAD. HAMAS rejected the NUG's dismissal and has called for resuming talks with Fatah, but ABBAS has ruled out negotiations until HAMAS agrees to a return of PA control over the Gaza Strip (The world factbook, 2008).

The last six month of 2006 were characterized by the escalation of the crisis after the capture of an Israeli soldier by a Palestinian militant group in Gaza. Consequently, Israel started numerous of campaigns and imposed closure by sealing off the entire Gaza Strip. As result Gaza suffered from shortage of food, fuel and medical supplies, and the destruction of the infrastructure. There is also a sharp increase of the state of lawlessness, insecurity and misuse of weapons which resulted of clashes between Fatah and Hamas, and resulted in the death of more than 20 people. This has led to paralysis in governmental and civil institutions (Thabet et al. 2008).

On 27th. December 2008 Israel waged the bloodiest war against Gaza since the 1967 war for more than 23 days. More than 1300 people were killed and thousands more wounded. Large parts of the infrastructure were destroyed, official buildings, agricultural lands, civilian houses, hospitals and mosques, As a result, some areas were completely flattened to the ground, while the population of Gaza had no where to escape. As per a report by OCHA issued on the 19th of January 2009, 50,896 persons were displaced. Overall, at the height of the crisis, an estimated 100,000 people were displaced including those in shelters and with host families. One issue which the media focused on was the indiscriminate use of white phosphorus shells by the Israeli army. White phosphorus is a highly incendiary weapon. Landing on skin, it burns deeply through muscle and into the bone, until deprived of oxygen. White phosphorus is supposed to provide a smokescreen for troop movements. The Israeli army used it in attacks against the vicinity of the UNRWA compound and against the al-Quds hospital in Gaza city. The war affected the entire Gaza population, men, women, and children, and resulted in immediate psychological problems such as fear, anxiety, panic attacks, feeling of insecurity, sleeping and eating disturbances, depression and sadness, and expecting death any minute . Finally, the United Nations Security Council passed Resolution 1860 calling for "an immediate, durable and fully respected cease-fire", but the resolution was ignored by both sides. Due to the war, inner-factional violence in

Gaza reached a new peak by Hamas who intensified its incursions against Fatah activists (Culture and Free Thought Association, 2009).

Nowadays political violence increasingly affects civilians population, as result of armed conflicts. Consequently, there are social and economical derivation, which have sever effects on Palestinian well-being including children, women and adolescents.

1.2 Problem statement

Nowadays political violence increasingly affects civilians population, as result of armed conflicts. Consequently, there are social and economical derivations, which have sever effects on Palestinian well-being including children, women and adolescents.

The war affected the entire Gaza population, men, women, and children, and resulted in immediate psychological problems such as fear, anxiety, panic attacks, feeling of insecurity, sleeping and eating disturbances, depression and sadness, and expecting death any minute (CFTA, 2009).

So this study will give answers about the most common types of traumatic events, and mental health problems among Palestinian adolescents experiencing of political violence. and to examine types of coping strategies used by the Palestinian adolescents to overcome violence.

1.3 Study justification

The researcher choose this topic, because within the past few decades, children and adolescents have been increasingly subjected to greater traumatic experiences emanating from military and political violence. The literature shows a dramatic increase in number of studies devoted to the impact of war, political oppression, and combat violence on well-being of children (Allwood, 2002).

and because, Each year, over 1.6 million people worldwide lose their lives to violence. Violence is among the leading causes of death for people aged 15-44 years worldwide, accounting for 14% of deaths among males and 7% of deaths among females. For every person who dies as a result of violence, many more are injured and suffer from a range of physical, sexual, reproductive and mental health problems. Moreover, violence places a massive burden on national economies, law enforcement and lost productivity (WHO, 2002).

Since the Israeli occupation of West Bank and Gaza-Strip in June 1967, life for Palestinians has been characterize by multiple social problems. The onset of the Intifada in December 1987 added prolonged exposure to staggering array of extreme political stressors, ranging from relentless to pervasive traumatic experiences, to loss of life or limb, loss of freedom, and loss of property (e.g. demolition of houses) (Khamis, 2000).

Since the beginning of Al Aqsa Intifada over 2859 Palestinians were killed, at least 85% were civilians and 22% were children. Over 41,000 were injured, according to UNICEF 7000 of whom were children. Since the 29th of March 2002, 15,000 Palestinians have been detained, 6000 of who remains in prison and 350 Palestinian children are currently held in Israeli prisons. We have an accumulated knowledge about the children's responses to air raids, bombardment shelling, loss of family member and being target and witnessing killing and destruction. Children's responses to danger and life-threat include anxiety, somatization and withdrawal symptoms, and especially among younger children regression to the earlier stages of development and clinging to parents. Family's ties are considered one of the most important protectors of the child mental health in war conditions. It is important to note that the atmosphere of political violence creates a state of disorganization inside the Palestinian family. Especially frightening is when parents are unable to protect their children and appear to be helpless victims in front of their children (Qouta , El Sarraj , Punamaki, 2003).

There is also a sharp increase of the state of lawlessness, insecurity and misuse of weapons which resulted of clashes between Fatah and Hamas, and resulted in the death of more than 200 people. This has led to paralysis in governmental and civil institutions (Thabet et al. 2008).

A December 2009 Israeli Army started its war on Gaza, calling it *'Operation Cast Lead'*. On the first day more than 100 bombs were dropped on 50 targets of Hamas infrastructure killing between 225 and 292 Palestinians. In the Arab world this attack was called the 'Massacre of the Black Saturday'. Tens of thousands of people in Gaza fled their homes amidst artillery and gunfire, and flooded into the heart of Gaza city. (Culture and Free Thought Association, 2009).

The Palestinian- Palestinian conflict is not exception. As victims, children and women appear to carry the brunt of chronic violence. The long term psychological effects of such evidence are often so serious, making the prospects of peace more difficult than ever before in the eyes of Palestinian adolescents.

1.4 Purpose of the study

This study highlights the mental health status among Palestinian adolescents living in Gaza Strip, by examining the severity and identifying the types of mental health problems and other factors that affected by both direct and indirect exposure to war and possible coping strategies developed by Palestinian adolescents, in order to enhance our understanding of the deleterious outcomes that war may have on adolescents, which may help in planning for better management plan for the treatment and intervention of the adolescents.

1.5 Objectives

1.5.1 General objective

The current study aims to examine the psychological effects of Gaza War on Palestinian Adolescents and Coping Strategies in Gaza Strip

1.5.2 Specific objectives

1- To determine the most common types of traumatic events among Palestinian adolescents living under impact of Gaza War.
2- To investigate the most common mental health problems resulted out of Gaza War experiencing among Palestinian adolescents.
3- To examine types of coping strategies used by the Palestinian adolescents to cope with War on Gaza.
4- To find the relation between Gaza War experiencing and mental health problems among Palestinian adolescents.
5- To find the relation between mental health problems and types of coping strategies used by Palestinian adolescents.

1.6 Study questions

The study addresses the following questions:

1- What are the most common types of traumatic events among Palestinian adolescents expose to Gaza War?
2- What are the main mental health problems among Palestinian adolescents expose to Gaza War?
3- What are the types of coping strategies used by Palestinian adolescents to cope with traumatic events?
4- What are the relation between experiencing of Gaza War and mental health problems among Palestinian adolescents?
5- What kind of coping strategies used by Palestinian adolescents suffering from various mental health problems?

1.7 Definitions

Definition of political violence & war

Badrawi, Defined the political violence, as different behaviors that include the use of force or threatening to assault individuals and demolished their properties to achieve direct political goals or economical, social, cultural goals which is a political trends. (Badrawi, 2000).

Researcher operational definition:

The researcher defines Gaza War as:

Israeli violence: Acts of violence committed by Israel against Palestinian people in Gaza Strip.

Mental health

The essential dimension of mental health is clear from the definition of health in the WHO constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Mental health is an integral part of this definition. Mental health can be conceptualized as a state of well-being in which the

individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO, 2OO2).

Depression

In the fields of psychology and psychiatry, the terms depression or depressed refer to both expected and pathologically chronic or severe levels of sadness, perceived helplessness, disinterest, and other related emotions and behaviours (APA, 2000).

Anxiety

Anxiety is a physiological and psychological state characterized by cognitive, somatic, emotional, and behavioral components. These components combine to create the painful feelings that are typically recognized as uneasiness, apprehension, or worry (Seligman, Walker, & Rosenhan, 2001).

Posttraumatic stress disorder

Post traumatic stress disorder (PTSD) is an anxiety disorder that can develop after exposure to one or more terrifying events that threatened or caused grave physical harm. It is a severe and ongoing emotional reaction to an extreme psychological trauma. This stressor may involve someone's actual death, a threat to the patient's or someone else's life, serious physical injury, or threat to physical or psychological integrity, overwhelming usual psychological defenses coping (Brunet, Akerib, & Birmes , 2007).

Definition of coping strategies

Coping strategies refer to the specific efforts, both behavioral and psychological, that people employ to master, tolerate, reduce, or minimize stressful events. Two general coping strategies have been distinguished: problem-solving strategies are efforts to do something active to alleviate stressful circumstances, and emotion-focused coping strategies involve efforts to regulate the emotional consequences of stressful or potentially stressful events. Research indicates that people use both types of strategies to combat most stressful events (Folkman & Lazarus, 1980).

Gaza strip

Gaza strip is a narrow piece of land lying on the coast of the Mediterranean sea. Its position on the crossroads from Africa to Asia made it a target for occupiers and conquerors over the centuries. The last of these was Israel who occupied the Gaza strip from Egyptians in 1967.Gaza Strip is very crowded place with area 365
sq. Km and constitute 6.1% of total area of Palestinian territory land. In mid year of 2005 the population number is to be 1,389,789 mainly concentrated in the cities, small village, and eight refugee camps that contain two thirds of the population of Gaza Strip. In Gaza Strip, the population density is 3,808 inhabitants/km2 that comprises the following main five governorates:

North of Gaza constituted 17% of the total area of Gaza strip and 1.0% of total area of Palestinian territory area with area 61 sq. Km. The total number of population living in North Gaza is to be 265,932 individuals in 2005 with capita per sq Km 4,360.

Gaza City constituted 20.3% of the total areas of Gaza strip and 1.2% of total area of Palestinian territory area with area 74 sq. Km. The total number of population living in Gaza City is 487,904 individuals in 2005 with capita per sq Km 6,593.

Mid-Zone constituted about 15% of the total area of Gaza Strip and 1.0% of total area of Palestinian territory area with area 58 sq. Km The total number of population living in Mid-Zone is 201,112 individuals in 2005 with capita per sq Km 3,467.

Khan younis constituted about 30.5% of the total area of Gaza strip and 1.8% of total area of Palestinian territory area with area 108 sq. Km. The total number of population in Khan younis is 269,601 individuals in 2005 with capita per sq Km 2,496.

Rafah constituted about 16.2% of the total area of Gaza strip and 1.1% of total area of Palestinian territory area with area 64 sq. Km. The total number of population in Rafah is 165,240 individuals in 2005 with capita per sq Km 2,582 (MOH, 2006). (Annex 1)

1.8 General view of the study chapters

This study consist of six chapter. The first chapter present a background for study subject. Problem, objectives, and study questions. The second chapter present a conceptual framework, and views the literature that is related to the study subject, which was collected from scientific researchers, published magazine, and other scientific ways. The third chapter views the operations of study, the important operations are distribution of the

sample and study design and instrument that used in data collection. In the chapter four the researcher views the results and its table. These the results will be discussed in details in the fifth chapter followed by a conclusion about the study as well as a recommendations.

Chapter 2

Conceptual Framework
&
Literature Review

Chapter 2

Conceptual Framework & Literature Review

2.1 Introduction

Adolescents living in war zones are at high risks for developing post - traumatic stress disorder and other emotional disorders like depression and anxiety. About 2 million have been killed during the past decade and anthers 10 million have been traumatized by war traumatic events (UNICEF, 1996).

Research assumes that experiences related to political violence and war indeed constitute a serious risk for the well functioning individual. Most of this research has been conducted with children, and given that some of these mental health problems are more prevalent among adolescents (Reynolds & Mazza, 1994).

In this chapter the researcher will review the theoretical framework in four broad categories; the first is about violence, the second is about anxiety including Generalized Anxiety Disorder (GAD) and Posttraumatic Stress Disorder (PTSD), where the third axis is about Depression, and the fourth is about coping strategies, as shown in the following figure. Also the researcher will show the literature reviews in four main axis, the first axis is about violence theory, the second axis divide into two sections; the first is about theories of depression, the second is about theories of anxiety. Where the third axis is about the theory of coping and the fourth axis is about the previous studies that related to the field of this study.

Figure 1: Conceptual Framework Diagram

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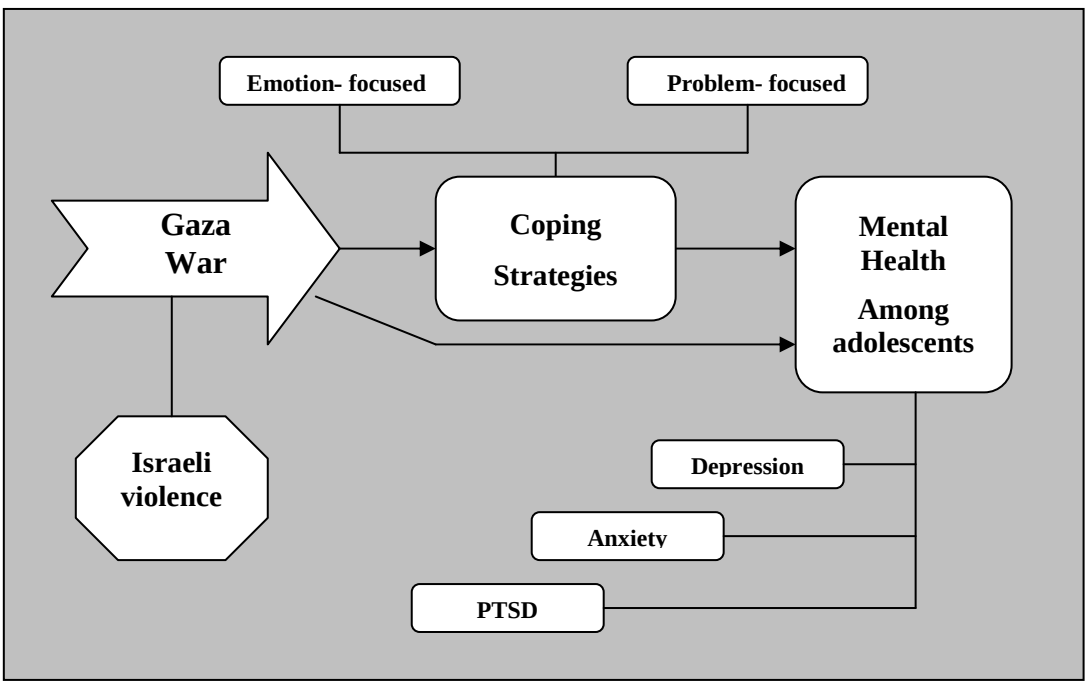

2.2 Violence & War

2.2.1 Background

Violence has probably always been part of the human experience. Its impact can be seen, in various forms, in all parts of the world. Each year, more than a million people lose their lives, and many more suffer non-fatal injuries, as a result of self-inflicted, interpersonal or collective violence. Overall, violence is among the leading causes of death worldwide for people aged 15–44 years (WHO, 2002).

2.2.2 Definition of violence

The World Health Organization defines violence as: The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal -development or deprivation.

This definition covers a broad range of outcomes – including psychological harm, deprivation and mal-development. This reflects a growing of the need to include violence that does not necessarily result in injury or death, but that nonetheless poses a substantial burden on individuals, families, communities and health care systems worldwide. Many forms of violence against women, can result in physical, psychological and social problems that do not necessarily lead to injury, disability or death. These consequences can be immediate, as well as latent, and can last for years after the initial abuse (WHO, 2002).

Badrawi, defined the political violence as, different behaviors that include the use of force or threatening to assault individuals and demolished their properties to achieve direct political goals or economical, social, cultural goals which is a political trends" (Badrawi, 2000).

2.2.3 Types of violence

The World Health Organization develop a typology of violence that characterized the different types of violence and the links between them. The typology proposed here divides violence into three broad categories according to characteristics of those committing the violent act:

- *Self-directed violence:* Self-directed violence is subdivided into suicidal behaviour and self-abuse. The former includes suicidal thoughts, attempted suicides – also called

‘‘parasuicide’’ or ‘‘deliberate self-injury’’ in some countries – and completed suicides. Self-abuse, in contrast, includes acts such as self-mutilation.

- *Interpersonal violence:* Interpersonal violence is divided into two subcategories:

  * Family and intimate partner violence – that is, violence largely between family members and intimate partners, usually, though not exclusively, taking place in the home.

  * Community violence – violence between individuals who are unrelated, and who may or may not know each other, generally taking place outside the home.

- *Collective violence:* Collective violence is subdivided into social, political and economic violence. Unlike the other two broad categories, the subcategories of collective violence suggest possible motives for violence committed by larger groups of individuals or by states. Collective violence that is committed to advance a particular social agenda includes, for example, crimes of hate committed by organized groups, terrorist acts and mob violence. Political violence includes war and related violent conflicts, state violence and similar acts carried out by larger groups. Economic violence includes attacks by larger groups motivated by economic gain – such as attacks carried out with the purpose of disrupting economic activity, denying access to essential services, or creating economic division and fragmentation (Foege, 1995).

2.2.4 Risk Factors of Violence

No single factor explains why some individuals behave violently toward others or why violence is more prevalent in some communities than in others. Violence is the result of the complex interplay of individual, relationship, social, cultural and environmental factors. Understanding how these factors are related to violence is one of the important steps in the public health approach to preventing violence.

Individual factors: At the individual level, factors that affect the potential for violent behaviour include biological, psychological and behavioural characteristics. These factors may already appear in childhood or adolescence, and to varying degrees they may be influenced by the person’s family and peers and by other social and cultural factors.

Biological characteristics: Among possible biological factors, there have been studies on injuries and complications associated with pregnancy and delivery, because of the suggestion that these might produce neurological damage, which in turn could lead to violence.

Psychological and behavioural characteristics: Among the major personality and behavioural factors that may predict youth violence are hyperactivity, impulsiveness, poor behavioural control and attention problems. Nervousness and anxiety, though, are negatively related to violence.

Relationship factors: Individual risk factors for youth violence, do not exist in isolation from other risk factors. Factors associated with the interpersonal relations of young people – with their family, friends and peers – can also strongly affect aggressive and violent behaviour and shape personality traits that, in turn, can contribute to violent behaviour.

Family influences: Parental behaviour and the family environment are central factors in the development of violent behaviour in young people. Poor monitoring and supervision of children by parents and the use of harsh, physical punishment to discipline children are strong predictors of violence during adolescence and adulthood.

Peer influences: Peer influences during adolescence are generally considered positive and important in shaping interpersonal relationships, but they can also have negative effects. Having delinquent friends, for instance, is associated with violence in young people.

Community factors: The communities in which young people live are an important influence on their families, the nature of their peer groups, and the way they may be exposed to situations that lead to violence. The presence of gangs, guns and drugs in a locality is a potent mixture, increasing the likelihood of violence. The degree of social integration within a community also affects rates of youth violence. Social capital is a concept that attempts to measure such community integration. It refers, roughly speaking, to the rules, norms, obligations, reciprocity and trust that exist in social relations and institutions Young people living in places that lack social capital tend to perform poorly in school and have a greater probability of dropping out altogether as result increasing the likelihood of violence.

Societal factors: Several societal factors may create conditions conducive to violence among young people. Much of the evidence related to these factors, though, is based on cross-sectional or ecological studies and is mainly useful for identifying important associations, rather than direct causes.

Demographic and social changes: Rapid demographic changes in the youth population, modernization, emigration, urbanization and changing social policies have all been linked with an increase in youth violence

Income inequality: Research has shown links between economic growth and violence, and between income inequality and violence.

Political structures: The quality of governance in a country, both in terms of the legal framework and the policies offering social protection, is an important determinant of violence. In particular, the extent to which a society enforces its existing laws on violence, by arresting and prosecuting offenders, can act as a deterrent against violence.
Cultural influences: Culture, which is reflected in the inherited norms and values of society, helps determine how people respond to a changing environment. Cultural factors can affect the amount of violence in a society – for instance, by endorsing violence as a normal method to resolve conflicts and by teaching young people to adopt norms and values that support violent behaviour (WHO, 2002).

2.2.5 Responses to violence

The most common responses to violent events are:

1. *Fear:* the most commonly expressed fears are of the security forces, of future attacks especially on the children's homes.

2. *Emotional changes:* feelings of emotional numbing, powerlessness, of extreme vulnerability and lack of safety. Anxiety, restlessness and irritability. Having no interest in life, feeling guilt or bad to be alive. No energy and feeling tired all of the time. Changing quickly from one mood to another.

Younger children often act much younger than they are by clinging to their mother all the time and beginning to wet their beds again, for example. Older children tend to get depressed and withdraw into themselves.

3. *Difficulties with sleeping and dreaming:* nightmares about attacks and fear of falling asleep.

4. *Difficulties with thinking:* Constantly thinking about and re-experiencing the traumatic experience. Not being able to concentrate and to remember properly. Children's thoughts are negative and they find it difficult to be creative.

5. Social difficulties: not wanting to be social with other children, being aggressive with others.

6. *Eating problems:* refusal to eat and loss of appetite.

7. *Somatic complaints:* mainly in the form of headaches and stomach aches (Stavrou, 1993).

2.2.5.1 Developmentally age appropriate responses

0 - 5 years: The main developmental orientation of pre-schoolers is towards their families. Because they are so emotionally and physically dependent upon the adults who care for them, they can be expected to react most strongly to stressors which influence these adults and which can result in any alteration to the stability or functioning of the family. So in political conflict, the type of event to which preschool children may be most vulnerable include death, disappearance or detention of a parent. Although these very young children have an in-built protection because of their limited capacity for understanding threat in abstract terms, they may pick up feelings of distress and anxiety from their parents and turn these into terrifying fantasies about their own injury and death. Reactions to stress at this age include very disruptive behaviour, e.g. becoming very naughty and aggressive. Children can act much younger than their age (regression) by, for example, becoming very dependent and always clinging to their mothers, wetting their beds again and suffering fear of the dark.

6 - 11 years: Children in the middle phase of childhood have a better understanding of what it means to be threatened, both for themselves and for others, but are still not able to really make sense of the situation around them. They are able to look beyond themselves and their family, into the broader society, but they are not yet independent enough to be able to change the things around them in order to make the situation safer and lessen their fears. Thus they may experience anxieties related to the realistic threats of the loss of prized possessions, the loss of and the threats facing family and friends. Because these children are more socially oriented, the emotional problems they may have in reaction to stress are related to social relationships. They may withdraw from social interactions and isolate themselves from any social contact. Any deep fears and anxieties experienced at this age may result in more serious emotional disturbances, like depression, for example.

12 - 18 years: Adolescents have increasing needs for independence from their families and seek to rediscover their identities through their friendship groups. They are fully capable of understanding the meaning of both current and future threats and violent situations and are able to get involved in the situations which are potentially violent. The new independence

teenagers have in forming relationships with people other than family members means that they can get involved in activities which may lead them into situations for which they are emotionally unprepared, like involvement in political activity which may result in court-cases and detention. However, as discussed earlier, involvement in such political activity gives a sense of meaning to threatening circumstances which may protect the teenagers against the effects of stress. Stress reactions in teenagers take the form of depression, with isolation or social withdrawal. Teenagers may also show anti-social behaviour (Gibson, 1989).

2.2.5.2 Emotional and behavioural responses

1. Lack of ability to trust and to love. Violent acts directed against children send the message that people are not to be trusted because they may harm you in a very fundamental way. A child who has committed violence also believes this because if they can do this, so can anybody else. The implications of this are sad and politically very serious - a person who is unable to trust is generally unable to create lasting and respectful relationships. This is true, not only in terms of love relationships, but also in friendships, political alliances and working relationships.

2. Loss of self-esteem and feelings of personal power. Children report that the feelings of helplessness and inability to change the violent situation, makes some of them want to avoid all future situations which may result in conflict and possibly violence. The long-term effect of this may be that young people feel that they do not have much internal strength and the power to control their own lives, and so feel generally weakened in their ability to cope and succeed in the future.

3. Dehumanization and desensitization. As children are constantly exposed to violence and deteriorating social conditions, so they become emotionally insensitive or desensitized to acts of violence. Constantly seeing dead bodies on the TV and movie screens, and in our lives, results in children losing their fear of the results of violence and gradually losing their respect for the value of life. This especially comes about in a social context where the value of certain people's lives is not respected by those in power - the lives of the "masses", whether these masses be poor or black.

4. The "culture of violence". Studies show that children learn to believe that aggressive attitudes and violent behaviour are normal and acceptable in an environment where violence is viewed as an acceptable way to get and maintain power and to solve problems. Now this is not to say that children who see a lot of violence on TV and/or on their streets will automatically adopt violent behaviour themselves. There is an enormous difference between what we see around us, what we believe in and what behaviour we chose to adopt. Studies show that children tend to adopt violent behaviour themselves when they have been exposed to many forms of violence over a period of time. Especially when their parents have been inflicting violence on others, and especially when this occurs within the home.

5. Children becoming violent. Children are also perpetrators of violence. The young comrades of the political struggle and the housebreakers and car thieves of the criminal gangs, are both perpetrators and victims of violence. The increased availability of firearms is helping make children the perpetrators of violent crimes at a much earlier age than before. Aggressive behaviour in schools ranges from bullying to stabbings during gang fights, the intimidation of school teachers and different forms of sexual abuse.

6. Self-destructive behaviour. Childhood experiences of violence, abuse and neglect can also lead not only to outwardly directed aggressive behaviour, but also to self-destructive behaviour, for example, suicide, drug and alcohol abuse, promiscuity which may result in emotional and physical damage and depression and social withdrawal (Simpson,1992).

2.3 Depressive Disorders

2.3.1 Overview

In the fields of psychology and psychiatry, the terms depression or depressed refer to both expected and pathologically chronic or severe levels of sadness, perceived helplessness, disinterest, and other related emotions and behaviours. The Diagnostic and Statistical Manual of Mental Disorders (DSM) states that a depressed mood is often reported as feeling depressed, sad, helpless, and hopeless. In traditional colloquy, "depressed" is often synonymous with "sad," but both clinical and non-clinical depression can also refer to a

conglomeration of more than one feeling. Such a mixture can include (but is not limited to) anger, fear, anxiety, despair, guilt, apathy, and/or grief, in addition to what many people would describe as typical "sadness". It is harmful for the human body and can affect proper functioning of the brain (Sadock, & Sadock, 2007).

2.3.2 Demographics

Estimates of the numbers of people suffering from major depressive episodes and Major Depressive Disorder (MDD) vary significantly. Between 10% and 25% of women and between 5% and 12% of men will suffer a major depressive episode. Fewer people, between 5% and 9% of women and between 2% and 3% of men will have MDD, or full-blown depression. Depression occurs nearly twice as often in adolescent and adult females as in males, and the peak period of development is between the ages of 25 and 44 years. Onset of major depressive episodes or MDD often occurs to people in their mid-20s, and less often to those over 65. Prepubescent girls and boys are affected equally (Barlow, 2007).

2.3.3 Symptoms and Sign of Depression

There's a vast difference between "feeling depressed" and suffering from clinical depression. The despondency of clinical depression is unrelenting and overwhelming. Some people describe it as "living in a black hole" or having a feeling of impending doom. They can't escape their unhappiness and despair. However, some people with depression don't feel sad at all. Instead, they feel lifeless and empty. In this apathetic state, they are unable to experience pleasure. Even when participating in activities they used to enjoy, they feel as if they're just going through the motions. The signs and symptoms vary from person to person, and they may wax and wane in severity over time.

Feelings of helplessness and hopelessness: A bleak outlook—nothing will ever get better and there's nothing you can do to improve your situation.

Loss of interest in daily activities: No interest in or ability to enjoy former hobbies, pastimes, social activities, or sex.

Appetite or weight changes: Significant weight loss or weight gain—a change of more than 5% of body weight in a month.

Sleep changes: Either insomnia, especially waking in the early hours of the morning, or oversleeping (also known as hypersomnia).

Psychomotor agitation or retardation: Either feeling "keyed up" and restless or sluggish and physically slowed down.

Loss of energy: Feeling fatigued and physically drained. Even small tasks are exhausting or take longer.

Self-loathing: Strong feelings of worthlessness or guilt. Harsh criticism of perceived faults and mistakes.

Concentration problems: Trouble focusing, making decisions, or remembering things (Barlow, 2007).

2.3.4 Causes and Risk Factors

Some medical illnesses have a specific biological or chemical cause, making treatment, like a medication or surgery, more straightforward. Depression is more complicated. It is not just a result of a chemical imbalance, and is not simply cured with medication. What makes depression so difficult to treat is what seems like depression may actually be something else. If you are stuck in a dead end job and feel hopeless and helpless, for example, the best treatment might be finding another job which challenges you more. And if you are new to an area and feeling lonely and sad, the best treatment might be finding new friends at work or through a hobby. In those cases, the depression is situational and is remedied by changing the situation.

Clinical depression is thought to be caused by a combination of biological, psychological and social factors. There are certain risk factors that may make you more vulnerable. Learning what the risk factors are and making lifestyle changes might help reduce the risk of developing depression.

- **Genetics.** If you have family members who have suffered from depression, you may have a greater risk of developing depression yourself, although there is currently no direct gene that has been found to cause depression.
- **Early childhood trauma or abuse.** Emotional trauma and abuse has a powerful effect on the psyche. If you had traumatic early life experiences, you may be more at risk to develop depression during or after a stressful life event.

- **Loneliness and lack of social support.** A key risk factor for depression is isolation and loneliness. Lack of support, whether it is family, friends or colleagues, makes coping with stress all the more difficult. Having marital and relationship problems can also make you feel alone and frustrated.
- **Recent stressful or traumatic life experiences.** Some events, like losing a loved one, are clearly stressful and cause enormous disruption and strain in our lives. However, anything that causes change can be a stressful life experience, even if it is normally considered a happy event such as a big work promotion, a wedding or childbirth.
- **Alcohol and drugs.** Alcohol and drugs can cause strong depression symptoms on their own. They can also make you more vulnerable to depression even if you decide to stop using them. Some people try to treat themselves with alcohol and drugs to self medicate, but this only worsens the problem.
- **Finances and employment.** Financial strain can be an enormous stressor. Struggling to pay the bills or mortgage, or suddenly becoming unemployed, is a very stressful life event. Being unemployed can be a blow to self confidence and can be a very difficult adjustment, especially for men.
- **Health problems or chronic pain.** Health problems and chronic pain may reduce your mobility, your ability to work or your spare time. They can chip away at supportive relationships and make you feel hopeless and frustrated. (Elkin, 1999).

2.3.5 Classification Depressive Disorders

Depression comes in many shapes and forms. In some, depression can persist at a low level for months and even years. In others, the symptoms are so strong that life grinds to a halt and suicide can be a real concern. Depression can be triggered or aggravated by personal and interpersonal events, hormonal changes (like after childbirth), and can even be triggered by lack of sunlight.

Episodes of depressed mood are a core feature of the following psychological disorders, as specified by the DSM-IV:

- **Major depressive disorder**, commonly called Major depression or unipolar depression, where a person has two or more major depressive episodes. Depression without periods of mania is sometimes referred to as *unipolar depression* because

the mood remains at one emotional state or "pole". Diagnosticians recognize several subtypes or course specifiers:

- *Atypical depression* is characterized by mood reactivity (paradoxical anhedonia) and positivity, significant weight gain or increased appetite ("comfort eating"), excessive sleep or somnolence (hypersomnia), an sensation of heaviness in limbs known as leaden paralysis, and significant social impairment as a consequence of hypersensitivity to perceived interpersonal rejection. Difficulties in measuring this subtype have led to questions of its validity and prevalence.

- *Melancholic depression* is characterized by a loss of pleasure (anhedonia) in most or all activities, a failure of reactivity to pleasurable stimuli, a quality of depressed mood more pronounced than that of grief or loss, a worsening of symptoms in the morning hours, early morning waking, psychomotor retardation, excessive weight loss (not to be confused with anorexia nervosa), or excessive guilt.

- *Psychotic depression* is the term for a major depressive episode, particularly of melancholic nature, where the patient experiences psychotic symptoms such as delusions or, less commonly, hallucinations. These are most commonly mood-congruent (content coincident with depressive themes).

- *Catatonic depression* is a rare and severe form of major depression involving disturbances of motor behavior and other symptoms. Here the person is mute and almost stuporose, and either immobile or exhibits purposeless or even bizarre movements. Catatonic symptoms also occur in schizophrenia, a manic episode, or be due to neuroleptic malignant syndrome.

- *Postpartum depression* is listed as a course specifier in DSM-IV-TR; it refers to the intense, sustained and sometimes disabling depression experienced by women after giving birth. Postpartum depression, which has incidence rate of 10–15%, typically sets in within three months of labor, and lasts as long as three months.

- *Seasonal affective disorder* is a specifier. Some people have a seasonal pattern, with depressive episodes coming on in the autumn or winter, and resolving in spring. The diagnosis is made if at least two episodes have occurred in colder months with none at other times over a two-year period or longer.

- **Dysthymia**, which is a chronic, milder mood disturbance where a person reports a low mood almost daily over a span of at least two years. The symptoms are not as severe as those for major depression, although people with dysthymia are vulnerable to secondary episodes of major depression (sometimes referred to as *double depression*).

- **Depressive Disorder Not Otherwise Specified** (DD-NOS) is designated by the code *311* for depressive disorders that are impairing but do not fit any of the officially specified diagnoses. According to the DSM-IV, DD-NOS encompasses *"any depressive disorder that does not meet the criteria for a specific disorder."* It includes the research diagnoses of *Recurrent brief depression*, and *Minor Depressive Disorder* listed below.

- **Recurrent brief depression** (RBD), distinguished from Major Depressive Disorder primarily by differences in duration. People with RBD have depressive episodes about once per month, with individual episodes lasting less than two weeks and typically less than 2–3 days. Diagnosis of RBD requires that the episodes occur over the span of at least one year and, in female patients, independently of the menstrual cycle. People with clinical depression can develop RBD, and vice versa, and both illnesses have similar risks.

- **Minor depression** which refers to a depression that does not meet full criteria for major depression but in which at least two symptoms are present for two weeks (American Psychiatric Association, 2000).

2.3.5.1 Major depressive disorder

Major depressive disorder (also known as major depression, unipolar depression, unipolar disorder, or clinical depression) is a mental disorder typically characterized by a pervasive low mood, low self-esteem, and loss of interest or pleasure in usual activities. The diagnosis of major depressive disorder is based on the patient's self-reported experiences, behavior reported by relatives or friends, and mental state. There is no laboratory test for major depression, although physicians generally request tests for physical conditions that may cause similar symptoms. The most common time of onset is between the ages of 30 and 40 years, with a later peak between 50 and 60 years. Major depression occurs about twice as frequently in women than men, although men are at higher risk for suicide (Barlow, 2007).

Symptoms and signs

Major depression is a serious illness that affects a person's family, work or school life, sleeping and eating habits, and general health The impact of depression on functioning and well-being has been equated to that of chronic medical conditions such as diabetes. A person suffering a major depressive episode usually experiences a pervasive low mood, or loss of interest or pleasure in favored activities. Depressed people may be preoccupied with feelings of worthlessness, inappropriate guilt or regret, helplessness or hopelessness. Other symptoms include poor concentration and memory, withdrawal from social situations and activities, reduced libido (sex drive), and thoughts of death or suicide. Insomnia is common: in the typical pattern, a person wakes very early and is unable to get back to sleep. Hypersomnia, or oversleeping, is less common. Appetite often decreases, with resulting weight loss, although increased appetite and weight gain occasionally occur. The person may report persistent physical symptoms such as fatigue, headaches, digestive problems, or chronic pain; this is a typical presentation of depression, according to the World Health Organization's criteria of depression, in developing countries. Family and friends may perceive that the person is either agitated or slowed down. Older people with depression are more likely to show cognitive symptoms of recent onset, such as forgetfulness and to show a more noticeable slowing of movements. In severe cases, depressed people may experience psychotic symptoms such as delusions or, less commonly, hallucinations, usually of an unpleasant nature (Sadock, & Sadock, 2007).

Diagnosis

A diagnostic assessment may be conducted by a general practitioner or by a psychiatrist or psychologist, who will record the person's current circumstances, biographical history and current symptoms, and a family medical history to see if other family members have suffered from a mood disorder, and discuss the person's alcohol and drug use. A mental state examination includes an assessment of the person's current mood and an exploration of thought content, in particular the presence of themes of hopelessness or pessimism, self-harm or suicide, and an absence of positive thoughts or plans. The most widely used criteria for diagnosing depressive conditions are found in the American Psychiatric Association's revised fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), and the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) which uses different terminology, calling a similar condition "Recurrent depressive disorder". Major depressive disorder is classified as a mood disorder in DSM-IV-TR. The diagnosis hinges on the presence of a single or recurrent major depressive episode. Further qualifiers are used to classify both the episode itself and the course of the disorder (Sadock, & Sadock, 2007).

Subtypes

The DSM-IV-TR recognizes several subtypes, which are sometimes called "course specifiers":

- ***Atypical depression*** is characterized by mood reactivity (paradoxical anhedonia) and positivity, significant weight gain or increased appetite ("comfort eating"), excessive sleep or somnolence (hypersomnia), an sensation of heaviness in limbs known as leaden paralysis, and significant social impairment as a consequence of hypersensitivity to perceived interpersonal rejection. Difficulties in measuring this subtype have led to questions of its validity and prevalence.

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- ***Psychotic depression*** is the term for a major depressive episode, particularly of melancholic nature, where the patient experiences psychotic symptoms such as delusions or, less commonly, hallucinations. These are most commonly mood-congruent (content coincident with depressive themes).

- ***Catatonic depression*** is a rare and severe form of major depression involving disturbances of motor behavior and other symptoms. Here the person is mute and almost stuporose, and either immobile or exhibits purposeless or even bizarre movements. Catatonic symptoms also occur in schizophrenia, a manic episode, or be due to neuroleptic malignant syndrome.

- ***Postpartum depression*** is listed as a course specifier in DSM-IV-TR; it refers to the intense, sustained and sometimes disabling depression experienced by women after giving birth. Postpartum depression, which has incidence rate of 10–15%, typically sets in within three months of labor, and lasts as long as three months.

- ***Seasonal affective disorder*** is a specifier. Some people have a seasonal pattern, with depressive episodes coming on in the autumn or winter, and resolving in spring. The diagnosis is made if at least two episodes have occurred in colder months with none at other times over a two-year period or longer (American Psychiatric Association, 2000).

2.3.5.2 Dysthymia

Dysthymia is a mood disorder that falls within the depression spectrum. It is considered a chronic depression, but with less severity than a major depression. This disorder tends to be a chronic, long-lasting illness. Dysthymia can start early in life, even in childhood, and it is constant. Treatment can reduce how long it lasts and the intensity of the symptoms (Barlow, 2007).

Symptoms

The symptoms of dysthymia are similar to those of major depression, though they tend to be less intense. In both conditions, a person can have a low or irritable mood, lack of interest in things most people find enjoyable, and a loss of energy (not all patients feel this effect). Appetite and weight can be increased or decreased. The person may sleep too much

or have trouble sleeping. He or she may have difficulty concentrating. The person may be indecisive and pessimistic and have a negative self-image. The symptoms can grow into a full blown episode of major depression. This situation is sometimes called "double depression" because the intense episode exists with the usual feelings of low mood. People with dysthymia have a greater-than-average chance of developing major depression. While major depression often occurs in episodes, dysthymia is more constant, lasting for long periods, sometimes beginning in childhood, Dysthymia, like major depression, tends to run in families. It is two to three times more common in women than in men (Sadock, & Sadock, 2007).

Diagnoses

The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, characterizes Dysthymic disorder. The essential symptom involves the individual feeling depressed almost daily for at least two years, but without the criteria necessary for a major depression. Low energy, disturbances in sleep or in appetite, and low self-esteem typically contribute to the clinical picture as well. Sufferers have often experienced dysthymia for many years before it is diagnosed. People around them come to believe that the sufferer is 'just a moody person' (American Psychiatric Association, 2000).

2.3.5.3 Recurrent Brief Depression

Recurrent Brief Depression (RBD) defines a mental disorder characterized by intermittent depressive episodes, in women not related to menstrual cycles, occurring at least once a month over at least one year or more fulfilling the diagnostic criteria for major depressive episodes (DSM-IV and ICD-10) except for duration which in RBD is less than 14 days, typically 2-4 days. Despite the short duration of the depressive episodes, such episodes are severe and suicidal ideation and impaired function is rather common. The majority of patients with RBD also report symptoms of anxiety and increased irritability. Hypersomnia is also rather frequent. About 1/2 of patients fulfilling diagnostic criteria for RBD may have additional short episodes of brief hypomania which is a severity marker of RBD. RBD may be the only mental disorder present, but RBD may also occur as part of a history of recurrent major depressive episodes og bipolar disorders. RBD is also seen among some patients with personality disorders. The lifetime prevalence of RBD has been estimated at 2.6 to 10.0%, and the one-year prevalence at 5.0-8.2%) The World Health Organization

project on “Psychological problems in general health care”, which was based on primary care samples, reported a one-year prevalence of 3.7 – 9.9 %. However none of these studies differentiate between RBD with and without a history of other mood disorders (e.g. major depression). DSM-IV field trial estimated the life-time of RBD only to be about 2%. The cause (etiology) of RBD is unknown, but recent findings may suggest a link between RBD and bipolar disorders, pointing to the importance of genetic factors. A small sub-group of patients with RBD has temporal lobe epilepsy (Sadock, & Sadock, 2007).

2.4 Anxiety and Anxiety disorders

2.4.1 Overview and Definitions

Anxiety is a physiological and psychological state characterized by cognitive, somatic, emotional, and behavioral components. These components combine to create the painful feelings that are typically recognized as uneasiness, apprehension, or worry. Anxiety is a normal reaction to stress. It may help a person to deal with a difficult situation. Anxiety generally occurs without an identifiable triggering stimulus. As such, it is distinguished from fear, which occurs in the presence of an external threat. Additionally, fear is related to the specific behaviors of escape and avoidance, whereas anxiety is the result of threats that are perceived to be uncontrollable or unavoidable. When anxiety becomes excessive, it may fall under the classification of an *anxiety disorder*.
(Ohman, 2000).

Anxiety can be accompanied by physical effects such as heart palpitations, nausea, chest pain, fidgeting, shortness of breath, stomach aches, or headache. Physically, the body prepares the organism to deal with a threat. Blood pressure and heart rate are increased, sweating is increased, bloodflow to the major muscle groups is increased, and immune and digestive system functions are inhibited (the *fight or flight* response). External signs of anxiety may include pale skin, sweating, trembling, and pupillary dilation. Someone suffering from anxiety might also experience it as a sense of dread or panic. Although panic attacks are not experienced by every anxiety sufferer, they are a common symptom. Panic attacks usually come without warning, and although the fear is generally irrational, the perception of danger is very real. A person experiencing a panic attack will often feel as if he or she is about to die or pass out. Panic attacks may be confused with heart attacks (Seligman, et al. 2001).

Anxiety disorder is a blanket term covering several different forms of abnormal, pathological anxieties, fears, and phobias. In clinical usage, "fear", "anxiety" and "phobia" have distinct meanings, though the words are often used interchangeably in casual discourse to describe ubiquitous emotions. Clinically, a phobia is defined in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV-R) as a "persistent or irrational fear." Clinically, fear is defined as an emotional and physiological response to a recognized external threat. Anxiety is an unpleasant emotional state, the sources of which are less readily identified. Distinguishing among different anxiety disorders is important, since accurate diagnosis is more likely to result in effective treatment and a better prognosis. Surveys have shown as many as 18% of Americans may be affected by anxiety disorders. Anxiety disorders are frequently accompanied by physiological symptoms that may lead to fatigue or even exhaustion. Clinical depression is frequently co-morbid with anxiety disorders (American Psychiatric Association, 2000).

Anxiety disorders are often debilitating chronic conditions, which can be present from an early age or begin suddenly after a triggering event. They are prone to flare up at times of high stress. A good assessment is essential for the initial diagnosis of an anxiety disorder, preferably using a standardized interview or questionnaire procedure alongside expert evaluation and the views of the affected person. There should be a medical examination in order to identify possible medical conditions that can cause the symptoms of anxiety. A family history of anxiety disorders is often suggestive of the possibility of an anxiety disorder. It is important to note that a patient with an anxiety disorder will often exhibit symptoms of Clinical Depression and vice-versa. Rarely does a patient exhibit symptoms of only one or the other (Sadock, & Sadock, 2007).

2.4.2 Classification of Anxiety Disorders

Anxiety disorders can be viewed as a family of related but distinct mental disorders, which include the following as classified in the text revision of the fourth edition of *Diagnostic and statistical Manual Disorders* (DSM-IV-R). (1) panic disorder with or without agoraphobia; (2) agoraphobia with or without panic disorder; (3) specific phobia; (4) social phobia; (5) Obsessive-compulsive disorder (OCD); (6) Post-traumatic stress disorder (PTSD); (7) acute stress disorder; and (8) Generalized anxiety disorder (GAD) (Sadock, & Sadock, 2007).

Five major types of anxiety disorders are:

- Panic disorder
- Obsessive-compulsive disorder (OCD)
- Phobias
- Generalized anxiety disorder (GAD)
- Post-traumatic stress disorder (PTSD)

2.4.2.1 Panic disorder

Panic Disorder is a psychological condition characterized by recurring panic attacks in combination with significant behavioral change lasting at least a month, and of ongoing worry about the implications or concern about having other attacks. Panic Disorder sufferers usually have a series of intense episodes of extreme anxiety during panic attacks. These attacks typically last about ten minutes, but can be as short-lived as 1–5 minutes and last as long as twenty minutes or until medical intervention. However, attacks can wax and wane for a period of hours — panic attack rolling into another. They may vary in intensity and specific symptoms of panic over the duration (i.e. rapid heartbeat, perspiration, dizziness, dyspnea, trembling, psychological experience of uncontrollable fear, hyperventilation, etc.). Some individuals deal with these events on a regular basis; sometimes daily or weekly. The outward symptoms of a panic attack often cause negative social experiences (i.e. embarrassment, social stigma, social isolation, etc.). However, experienced sufferers can often have intense panic attacks with very little outward manifestations of the attack occurring. As many as 36% of all individuals with Panic Disorder also have agoraphobia. Panic Disorder is a serious health problem but can be successfully treated. It is estimated that up to 1.7 percent of the adult American population has Panic Disorder at some point in their lives. It typically strikes in early adulthood; roughly half of all people who have Panic Disorder develop the condition before age 24, especially if the person has been subjected to a traumatic experience. However, some sources say that the majority of young people affected for the first time are between the ages of 25 and 30. Women are twice as likely as men to develop Panic Disorder (Elkin, 1999).

Panic Disorder can continue for months or even years, depending on how and when treatment is sought. If left untreated, it may worsen to the point where the person's life is

seriously affected by panic attacks and by attempts to avoid or conceal the condition. In fact, many people have had problems with friends and family or employment while struggling to cope with Panic Disorder. Some people with Panic Disorder may begin to lie to conceal their condition. In some individuals symptoms may occur frequently for a period of months or years, then many years may pass symptom-free. In others, the symptoms persist at the same level indefinitely (Sadock, & Sadock, 2007).

2.4.2.2 Obsessive-compulsive disorder (OCD)

Obsessive-compulsive disorder (OCD) is a chronic anxiety disorder most commonly characterized by obsessive, distressing, intrusive thoughts and related compulsions. the individual often realizes are senseless. Compulsions are repetitive behaviors that the person feels forced or compelled into doing, sometimes, in order to relieve anxiety. Compulsions are tasks or "rituals" which attempt to neutralize the obsessions. OCD is distinguished from other types of anxiety, including the routine tension and stress that appear throughout life. Obsessive-compulsive disorder is very frustrating to the affected person and any friends and family. OCD manifests in a variety of forms. Studies have placed the prevalence between one and three percent, although the prevalence of clinically-recognized OCD is much lower, suggesting that many individuals with the disorder may not be diagnosed. The fact that many individuals do not seek treatment may be due in part to stigma associated with OCD. Another reason for not seeking treatment is because many sufferers of OCD do not realize that they have the condition. The typical OCD sufferer performs tasks (or compulsions) to seek relief from obsession-related anxiety. To others, these tasks may appear odd and unnecessary. But for the sufferer, such tasks can feel critically important, and must be performed in particular ways to ward off dire consequences and to stop the stress from building up. Physical symptoms may include those brought on from anxeties and unwanted thoughts, as well as tics or Parkinson's disease-like symptoms: rigidity, tremor, jerking arm movements, or involuntary movements of the limbs (Elkin, 1999).

Diagnoses

To be diagnosed with OCD, a person must have either obsessions or compulsions alone, or obsessions and compulsions, according to the DSM-IV-TR diagnostic criteria. The Quick Reference to the diagnostic criteria from DSM-IV-TR (2000) states six characteristics of obsessions and compulsions:

Obsessions

1. Recurrent and persistent thoughts, impulses, or images that are experienced as intrusive and that cause marked anxiety or distress.

2. The thoughts, impulses, or images are not simply excessive worries about real-life problems.

3. The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action.

4. The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind, and are not based in reality.

Compulsions

1. Repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly (American Psychiatric Association, 2000).

2. The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts are not actually connected to the issue, or they are excessive.

In addition to these criteria, at some point during the course of the disorder, the individual must realize that his/her obsessions or compulsions are unreasonable or excessive. Moreover, the obsessions or compulsions must be time-consuming (taking up more than one hour per day), cause distress, or cause impairment in social, occupational, or school functioning. OCD often causes feelings similar to those of depression (American Psychiatric Association, 2000).

2.4.2.3 Phobia

Phobias (in the clinical meaning of the term) are the most common form of anxiety disorders. An American study by the National Institute of Mental Health (NIMH) found that between 8.7% and 18.1% of Americans suffer from phobias. Broken down by age and gender, the study found that phobias were the most common mental illness among women

in all age groups and the second most common illness among men older than 25. It is generally accepted that phobias arise from a combination of external events and internal predispositions. Many specific phobias can be traced back to a specific triggering event, usually a traumatic experience at an early age. Social phobias and agoraphobia have more complex causes that are not entirely known at this time. It is believed that heredity, genetics, and brain chemistry combine with life-experiences to play a major role in the development of anxiety disorders, phobias and panic attacks (American Psychiatric Association, 2000).

Clinical Phobias

Most psychologists and psychiatrists classify most phobias into three categories:

- Social phobia, also known as social anxiety disorder - fears involving other people or social situations such as performance anxiety or fears of embarrassment by scrutiny of others, such as eating in public. Social phobia may be further subdivided into: generalized social phobia, and specific social phobia, which are cases of anxiety triggered only in specific situations. The symptoms may extend to psychosomatic manifestation of physical problems. For example, sufferers of paruresis find it difficult or impossible to urinate in reduced levels of privacy. That goes beyond mere preference. If the condition triggers, the person physically cannot empty their bladder.

- Specific phobias - fear of a single specific panic trigger such as spiders, snakes, dogs, elevators, water, waves, flying, balloons, catching a specific illness, etc.

- Agoraphobia - a generalized fear of leaving home or a small familiar 'safe' area, and of possible panic attacks that might follow (Kessler, et al. 2005)

According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), social phobia, specific phobia, and agoraphobia are sub-groups of anxiety disorder. Many of the specific phobias, such as fear of dogs, heights, spiders and so forth, are extensions of fears that a lot of people have. People with these phobias specifically avoid the entity they fear. Phobias vary in severity among individuals. Some individuals can simply avoid the subject of their fear and suffer only relatively mild anxiety over that fear. Others suffer fully-fledged panic attacks with all the associated disabling symptoms.

Most individuals understand that they are suffering from an irrational fear, but are powerless to override their initial panic reaction (American Psychiatric Association, 2000).

2.4.2.4 Post-traumatic Stress Disorder (PTSD)

Posttraumatic stress disorder (PTSD) is an anxiety disorder that can develop after exposure to one or more terrifying events that threatened or caused grave physical harm. It is a severe and ongoing emotional reaction to an extreme psychological trauma. This stressor may involve someone's actual death, a threat to the patient's or someone else's life, serious physical injury, or threat to physical or psychological integrity, overwhelming usual psychological defenses coping. In some cases it can also be from profound psychological and emotional trauma, apart from any actual physical harm. Often, however, the two are combined. PTSD is a condition distinct from traumatic stress, which has less intensity and duration, and combat stress reaction, which is transitory. PTSD has also been recognized in the past as railway spine, shell shock, traumatic war neurosis, or post-traumatic stress syndrome (PTSS) (Brunet , 2007).

PTSD is believed to be caused by psychological trauma. Possible sources of trauma includes encountering or witnessing childhood or adult physical, emotional or sexual abuse. In addition, encountering or witnessing an event perceived as life-threatening such as physical assault, adult experiences of sexual assault, accidents, drug addiction, illnesses, medical complications, or the experience of, or employment in occupations exposed to war (such as soldiers) or disaster (such as emergency service workers). Traumatic events that may cause PTSD symptoms to develop include violent assault, kidnapping, torture, being a hostage, prisoner of war or concentration camp victim, experiencing a disaster, violent automobile accidents or getting a diagnosis of a life-threatening illness. Children may develop PTSD symptoms by experiencing sexually traumatic events like age-inappropriate sexual experiences. Witnessing traumatic experiences or learning about these experiences may also cause the development of PTSD symptoms (American Psychiatric Association, 1994).

Although most people (50-90%) encounter trauma over a lifetime, only about 8% develop full PTSD. Vulnerability to PTSD presumably stems from an interaction of biological diathesis, early childhood developmental experiences, and trauma severity. Predictor models have consistently found that childhood trauma, chronic adversity, and familial stressors increase risk for PTSD as well as risk for biological markers of risk for PTSD

after a traumatic event in adulthood. This effect of childhood trauma, which is not well understood, may be a marker for both traumatic experiences and attachment problems. Proximity to, duration of, and severity of the trauma also make an impact; and interpersonal traumas cause more problems than impersonal ones (Barlow, 2007).

2.4.2.5 Generalized Anxiety Disorder (GAD)

Generalized anxiety disorder (GAD) is an anxiety disorder that is characterized by excessive, uncontrollable and often irrational worry about everyday things that is disproportionate to the actual source of worry. This excessive worry often interferes with daily functioning, as individuals suffering GAD typically catastrophes, anticipate disaster, and are overly concerned about everyday matters such as health issues, money, family problems, friend problems or work difficulties. They often exhibit a variety of physical symptoms, including fatigue, fidgeting, headaches, nausea, muscle tension, muscle aches, difficulty swallowing, trembling, twitching, irritability, sweating, insomnia, and hot flashes. These symptoms must be consistent and on-going, persisting at least 6 months, for a formal diagnosis of GAD to be introduced. Approximately 6.8 million American adults experience GAD. The usual age of onset is variable - from childhood to late adulthood. Women are two to three times more likely to suffer from generalized anxiety disorder than men. Some research suggests that GAD may run in families, and it may also grow worse during stress. GAD usually begins at an earlier age and symptoms may manifest themselves more slowly than in most other anxiety disorders. Some people with GAD report onset in early adulthood, usually in response to a life stressor. Once GAD develops, it can be chronic, but can be managed, if not all-but-alleviated, with proper treatment (Barlow, 2007).

2.5 Coping Strategies

2.5.1 Overview and Definition

Coping strategies refer to the specific efforts, both behavioral and psychological, that people employ to master, tolerate, reduce, or minimize stressful events. Two general coping strategies have been distinguished: problem-solving strategies are efforts to do something active to alleviate stressful circumstances, whereas emotion-focused coping strategies involve efforts to regulate the emotional consequences of stressful or potentially

stressful events. Research indicates that people use both types of strategies to combat most stressful events. The predominance of one type of strategy over another is determined, in part, by personal style (e.g., some people cope more actively than others) and also by the type of stressful event; for example, people typically employ problem-focused coping to deal with potential controllable problems such as work-related problems and family-related problems, whereas stressors perceived as less controllable, such as certain kinds of physical health problems, prompt more emotion-focused coping (Folkman & Lazarus, 1984).

An additional distinction that is often made in the coping literature is between active and avoidant coping strategies. Active coping strategies are either behavioral or psychological responses designed to change the nature of the stressor itself or how one thinks about it, whereas avoidant coping strategies lead people into activities (such as alcohol use) or mental states (such as withdrawal) that keep them from directly addressing stressful events. Generally speaking, active coping strategies, whether behavioral or emotional, are thought to be better ways to deal with stressful events, and avoidant coping strategies appear to be a psychological risk factor or marker for adverse responses to stressful life events (Holahan & Moos, 1987).

2.5.2 Dimensions of Coping

Different ways of coping have been found to be more or less adaptive, that *avoidant* coping strategies seem to be more adaptive in the short run whereas *attentive-confrontative* coping is more adaptive in the long run. Some researchers have come up with two basic dimensions-such as *instrumental, attentive, vigilant, or confrontative coping* on the one hand, in contrast to *avoidant, palliative, and emotional coping* on the other. A well-known approach has been put forward by Lazarus and Folkman (1984), who discriminate between *problem-focused* and *emotion-focused* coping. Another conceptual distinction has been suggested between *assimilative* and *accommodative* coping, the former aiming at an alteration of the environment to oneself, and the latter aiming at an alteration of oneself to the environment. (Brandtstädter, 1992).

Coping has also a temporal aspect. One can cope before a stressful event takes place, while it is happening (e.g., during the progress of a disease), or afterwards. Beehr and McGrath (1996) distinguish five situations that create a particular temporal context: (a) Preventive coping: Long before the stressful event occurs, or might occur; for example, a smoker

might quit well in time to avoid the risk of lung cancer; (b) Anticipatory coping: when the event is anticipated soon; for example, someone might take a tranquillizer while waiting for surgery; (c) Dynamic coping: while it is ongoing; for example, diverting attention to reduce chronic pain; (d) Reactive coping: after it has happened; for example, changing one's life after losing a limb; and (e) Residual coping: long afterward, by contending with long-run effects; for example, controlling one's intrusive thoughts years after a traumatic accident has happened.

Five coping strategies were identified Klauer and Filipp (1993) that turned up as dimensions in a factor analysis: (a) Seeking social integration, (b) rumination, (c) threat minimization, (d) turning to religion, and (e) seeking information (Aymanns, et al. 1995).

2.5.3 Coping Resources

Which of the dimensions is suitable for a valid description of an actual coping process depends on a number of factors, among them the particular stress situation, one's history of coping with similar situations, and one's personal and social coping resources, or the opposite, one's specific vulnerability (Schwarzer, 2001).

2.5.3.1 Personal Coping Resources

Individuals who are affluent, healthy, capable, and optimistic are seen as resourceful and, thus, are less vulnerable toward the stress of life. It is of most importance to be competent to handle a stressful situation. But actual competence is not a sufficient prerequisite. If the individual underestimates his potential for action, no adaptive strategies will be developed. Therefore, perceived competence is crucial. This has been labelled 'perceived self-efficacy' or 'optimistic self-beliefs. Actions are preshaped in thought, and people anticipate either optimistic or pessimistic scenarios in line with their level of self-efficacy. Once an action has been taken, high self-efficacious persons invest more effort and persist longer than those with low self-efficacy. When setbacks occur, the former recover more quickly and maintain the commitment to their goals. Self-efficacy also allows people to select challenging settings, explore their environments, or create new situations. A sense of competence can be acquired by mastery experience, vicarious experience, verbal persuasion, or physiological feedback (Bandura, 1992).

2.5.3.2 Social Coping Resources

Social support can assist coping and exert beneficial effects on various health outcomes. Social support has been defined in various ways, for example as "resources provided by others", as "coping assistance" or as an exchange of resources "perceived by the provider or the recipient to be intended to enhance the well-being of the recipient". Several types of social support have been investigated, such as instrumental support (e.g., assist with a problem), tangible support (e.g., donate goods), informational support (e.g., give advice), emotional support (e.g., give reassurance), among others. The definition and measurement problems involved in studying the social support construct, however, have remained an issue for debate (Dunkel-Schetter & Bennett, 1990).

2.6 Theories of violence and war

Theorists differ over whether aggression is based in biology or in cause by environment. Sociobiologists argue that aggression is a basic part of our biological makeup, and is elicited or repressed by various circumstances. Deviance studies have found violence associated with various physiological conditions. They have also found that aggression produces physiological changes. However, most violence is committed by physiologically (and otherwise mentally) normal individuals. In conclusion, Opotow calls for development of a culture of peace, which can "address the root causes of many kinds of aggression by emphasizing rights, law, and social justice. Cultures of peace work to implement their values and ideals for human rights, tolerance, democracy, free flow of information, sustainable development, peace education and gender equality." (Opotow, 2000).

2.6.1 Neurobiological studies

The neurobiology of aggression, studied in the lab, leads to little insight into the neurobiology of violence. The human brain mediates all human behavior — aggression, violence, fear, ideology — indeed, all human emotional, behavioral, cognitive and social functioning.

The brain's impulse-mediating capacity is related to the ratio between the excitatory activity of the lower, more-primitive portions of the brain and the modulating activity of higher, sub-cortical and cortical areas (Cortical Modulation Ratio). Any factors which increase the activity or reactivity of the brainstem (e.g., chronic traumatic stress, testosterone, dysregulated serotonin or norepinephrine systems) or decrease the moderating

capacity of the limbic or cortical areas (e.g., neglect) will increase an individual's aggressivity, impulsivity, and capacity to display violence.

As the brain develops and the sub-cortical and cortical areas organize, they begin to modulate and 'control' the more primitive and 'reactive' lower portions of the brain. With a set of sufficient motor, sensory, emotional, cognitive and social experiences during infancy and childhood, the mature brain develops — in a use-dependent fashion — a mature, humane capacity to tolerate frustration. A frustrated three year old will have a difficult time modulating the reactive, brainstem-mediated state of arousal — he will scream, kick, bite, throw and hit. However, the older child when frustrated may feel like kicking, biting and spitting, but has the capacity to modulate those urges. Loss of cortical function through any variety of pathological process (e.g., stroke, dementia, head injury, alcohol intoxication) results in *regression* — simply, a loss of cortical modulation of arousal, impulsivity, motor hyperactivity, and aggressivity — all mediated by lower portions of the central nervous system (brainstem, midbrain). Deprivation of key developmental experiences (which leads to underdevelopment of cortical, sub-cortical and limbic areas) will necessarily result in persistence of primitive, immature behavioral reactivity, and, thereby, predispose an individual to violent behavior (Robert, & David, 1996).

2.6.2 Social-Learning theory of violence

Behavioralists view aggression as a learned response. The legal system displays such an approach when it relies on punishment (negative reinforcement) to deter violence. However, punishment is only effective under very specific conditions; it must be swift, certain and severe. Social learning theorists see aggressions as leaned from personal experience and from role models. They emphasize environmental sources such as violent families and media portrayals of violence. Nonviolent behaviors will also be learned if they are effectively modeled. Social cognition approaches view aggression as the result of flawed or inadequate behavioral decision-making, and categorized aggression into two types:

* Reactive aggression occurs in response to perceived provocation. Reactively violent people may be overly sensitive to provocation or misinterpret situational cues.
* Proactive aggression occurs when violence is the preferred response to social challenge. Proactively violent people may lack knowledge of, or competency with, alternative responses, or may simply have an inappropriately positive evaluation of aggression (e.g. as

showing strength). Cultural and social context plays a significant role in determining what kinds and degrees of aggression are acceptable or even admirable.
Motivational theory sees blocked needs as the cause of aggression, drawing on Maslow's hierarchy of needs. Psychologists have explored the connection between goal frustration and aggression. They found that, while frustration can lead to aggression, it can also lead to more constructive behaviors, and that many cases of aggression do not involve frustration (Parens, 2007).

Moral norms can act as a powerful constraint on violence. At the same time, felt injustice can be a powerful incentive toward, and justification for, violence. Norms violations are least likely to spark destructive , escalating conflicts if the violation was unintentional and transient, and if there are norms in place for redressing the wrong. People's judgments of behavior will vary depending on which domain they associate the behavior with: moral, conventional, or personal. For example, corporal punishment could be judged as morally wrong, socially acceptable, or a matter of personal preference. Many types of violence are rationalized as being conventional or personal, rather than moral, matters.

Norms constraining violence can be disengaged by a variety of factors. They may be weakened by habituation and desensitization to violent acts. Opotow observes that "everyday structural violence flourishes when people preserve their self-esteem and sense of moral worthiness by keeping themselves uninformed and by avoiding questions that would reveal answers they do not want to know, such as the advantages that race confers on white people at the expense of people of color, or the advantages that gender confers on men at the expense of women."(p. 416) Norms constraining violence do not protect those who are excluded from the moral community, or the scope of justice. Those outside the moral community are seen as "expendable, undeserving, and eligible targets of exploitation, aggression, and violence (Opotow, 2000).

2.6.3 Psychoanalytic theory of violence

Sigmund Freud is well known as the father of psychoanalysis. In his early theory, Freud asserts that human behaviors are motivated by sexual and instinctive drives known as the libido, which is energy derived from the Eros, or life instinct . Thus, the repression of such libidinal urges is displayed as aggression. As an example of the expression of aggression as explained by Freud, let us consider his work on childhood aggression, and the Oedipus

Complex. A boy around age five begins to develop an intense sexual desire for his mother. He has come to regard her as the provider of food and love and thus wants to pursue an intimate, close relationship. The desire for his mother causes the boy to reject and display aggression toward his father. The father is viewed as a competitive rival and the goal they both try to attain is the mother's affection . Thus, an internal conflict arises in the young boy. On one hand, he loves his father, but on the other, he wants him to essentially "disappear", so that he can form an intimate relationship with his mother. A boy will develop an immense feeling of guilt over this tumultuous conflict and come to recognize the superiority of his father because of his size. This evokes fear in the boy and he will believe that by pursuing his mother's affection his father will want to hurt him, essentially castrate him . To resolve the conflict, the boy learns to reject his mother as a love object and will eventually identify with his father. Thus, he has come to understand that an intimate relationship with his mother is essentially inappropriate (Opotow, 2000).

Freud also developed the female Oedipal Complex, later named the Electra Complex, which is a similar theory for the childhood aggression of girls. In this theory, a girl around the age of five develops penis envy in attempts to relate to her father and rejects her mother . A similar internal conflict arises in the young girl, which is resolved after regarding her father as an inappropriate love object and ultimately identifying with her mother.

These examples of Freud's psychoanalytic theory demonstrate the idea that aggression is an innate personality characteristic common to all humans, and that behavior is motivated by sexual drives . According to Freud and demonstrated by the male and female Oedipal Complexes, aggression in children is instinctual and should be resolved by adulthood. Therefore, over the course of development, after the child has rejected the opposite sex parent, he or she will enter a period of latency in which they commonly reject all boys or all girls. Once puberty is reached, attention shifts to the genital region as an area of pleasure . Freud asserted that once this stage is reached, both men and women would search for an appropriate member of the opposite sex to fulfill sexual urges . Thus, Freud states that in individuals where the childhood conflicts have been successfully resolved, all aggression has been removed by adulthood in the pattern of development (Parens, 2007).

2.7 Theories of Depression

The researcher will view in this study 5 etiological theory for depression (psychoanalytic, cognitive, behavioral, interpersonal, and Biological theory).

2.7.1 Psychoanalytic theory of depression

The Concept of Depression in Freud and Jung Sigmund Freud argues that although there exist many different clinical forms of depression, or melancholia as he calls it, each form is characterized by an internal guilt caused by the loss or devaluation of a sexual object (Freud, 1966, 531). An understanding of several terms as Freud uses them is necessary for a complete understanding of his theory of depression. Basically, Freudian psychoanalytic theory argues that our psychological life is determined by our conscious and unconscious life (Freud, 1960, 3). Our conscious life, however, is transitory, in the sense that concepts or memories that are conscious or manifest at any given time may become preconscious or unconscious at a later time.

From the psychoanalytic perspective, depression may be intertwined with self-criticism. Sigmund Freud wrote that the "super-ego becomes over-severe, abuses the poor ego, humiliates it and ill-treats it, threatens it with the direst punishments". Freud argued that objective loss, as occurs through death or a romantic break-up, could result in subjective loss as well, when the depressed subject has identified with the object of its affection through an unconscious, narcissistic process called the *libidinal cathexis* of the ego. Such loss results in "a profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of self-regarding feelings" that is more severe than *mourning*. "In mourning 'it is the world that has become poor and empty; in [depression] it is the ego itself.'" (Barlow , 1999).

2.7.2 Cognitive theory of depression

One etiological theory of depression is the Aaron Beck cognitive theory of depression. His theory is regarded as the most verified psychological theory of depression. His theory states that depressed people think the way they do because their thinking is biased towards negative interpretations. According to this theory, depressed people acquire a negative schema of the world in childhood and adolescence. (Children and adolescents who suffer from depression acquire this negative schema earlier.) Depressed people acquire such

schemas through a loss of a parent, rejection of peers, criticism from teachers or parents, the depressive attitude of a parent and other negative events. When the person with such schemas encounters a situation that resembles in some way, even remotely, the conditions in which the original schema was learned, the negative schemas of the person are activated.

Beck also included a negative triad in his theory. A negative triad is made up of the negative schemas and cognitive biases of the person; Beck theorized that depressed individuals make negative evaluations of themselves, the world, and the future. Depressed people, according to this theory, have views such as “I never do a good job,” and "things will never get better." A negative schema helps give rise to the cognitive bias, and the cognitive bias helps fuel the negative schema. This is the negative triad. Also, Beck proposed that depressed people often have the following cognitive biases: arbitrary inference, selective abstraction, overgeneralization, magnification and minimization. These cognitive biases are quick to make negative, generalized, and personal inferences of the self, thus fueling the negative schema (Davison, 2001).

2.7.3 Behavioral theory of depression

In the mid 1970s Peter Lewinsohn developed the behavioral theory of depression. Lewinsohn argued that the essence of depression is a low rate of behavior, and this low rate of behavior causes all the other symptoms of depression. Lewinsohn also hypothesized that the low rate of behavior resulted from a lack of reinforcement from the environment. This was pure Skinnerian theory: teach the depressed patient to elicit higher rates of reinforcement, and the depressed patient’s rate of behavior will increase, causing the depression to lift (Grosscup, & Lewinsohn, 1980)

The predominant behavioral theory of depression postulates that major life stressors can result in a depressive episode because they disrupt normal behavior reinforcement patterns. Originating from an operant conditioning paradigm, this theory views depression as the consequence of a lack of or decrease in the efficiency of positively reinforced behavior and perhaps overt punishment for behavioral initiation. This may be a result of a decrease in the availability of reinforcing events, one’s personal skills to act on the environment, the impact of certain types of events, or a combination of these. In addition, the mobilization of support from family and other social networks may result in a negative feedback loop of social reinforcement for depressive behaviors (eg, social withdrawal, positive social

reinforcement for withdrawal, further withdrawal). In other words, in times of major stress from unexpected events, people may experience a low rate of positive reinforcement for mood-enhancing behavior and a higher rate of positive reinforcement for depressive behavior (Jacobson, et al. 1996).

2.7.4 Interpersonal theory of depression

The interpersonal theory of depression is based on theories emanating from the interpersonal school of psychiatry and empirical data related to attachment theory and social roles. Interpersonal psychotherapy, developed by Klerman et al. , is a focused, short-term, time-limited therapy that emphasizes the current interpersonal relations of the depressed patient.

A large body of research has documented the importance of interpersonal factors, including strained or critical personal relationships, in the onset of depressive symptoms and major depression in young and middle-aged adults. Vulnerability factors—such as early maternal loss, lack of a confiding relationship, responsibility for the care of several young children at home, and unemployment—can interact with life stressors to increase the risk of depression. For older adults, the factors are often health problems, changes in relationships with a spouse or adult children due to the transition to a care-giving or care-needing role, the death of a significant other, or a change in the availability or quality of social relationships with older friends because of their own health-related life changes (Miller, et al. 2001).

2.7.5 Biology of depression

Most antidepressants increase synaptic levels of the monoamine neurotransmitter serotonin. Some also enhance the levels of two other neurotransmitters, norepinephrine and dopamine. This observation gave rise to the monoamine theory of depression. In its contemporary formulation, the monoamine theory postulates that a deficiency of certain neurotransmitters is responsible for the corresponding features of depression: "Norepinephrine may be related to alertness and energy as well as anxiety, attention, and interest in life; [lack of] serotonin to anxiety, obsessions, and compulsions; and dopamine to attention, motivation, pleasure, and reward, as well as interest in life." The proponents of this theory recommend choosing the antidepressant with the mechanism of action impacting the most prominent symptoms. Anxious and irritable patients should be treated

with SSRIs or norepinephrine reuptake inhibitors, and those experiencing a loss of energy and enjoyment of life with norepinephrine and dopamine enhancing drugs (Nutt , 2008).

There may be a link between depression and neurogenesis of the hippocampus, a center for both mood and memory. Loss of hippocampal neurons is found in some depressed individuals and correlates with impaired memory and dysthymic mood. Drugs may increase serotonin levels in the brain, stimulating neurogenesis and thus increasing the total mass of the hippocampus. This increase may help to restore mood and memory. Similar relationships have been observed between depression and an area of the anterior cingulate cortex implicated in the modulation of emotional behavior. One of the neurotrophins responsible for neurogenesis is the brain-derived neurotrophic factor (BDNF). The level of BDNF in the blood plasma of depressed subjects is drastically reduced (more than threefold) as compared to the norm. Antidepressant treatment increases the blood level of BDNF. Although decreased plasma BDNF levels have been found in many other disorders, there is some evidence that BDNF is involved in the cause of depression and the mechanism of action of antidepressants.

Depression may also be caused in part by an overactive hypothalamic-pituitary-adrenal axis (HPA axis) that is similar to the neuro-endocrine response to stress. These HPA axis abnormalities participate in the development of depressive symptoms, and antidepressants serve to regulate HPA axis function (Duman , Heninger,& Nestler, 1997).

2.8 Theories of Anxiety

The researcher will view in this study 4 etiological theory for Anxiety (psychoanalytic, cognitive, behavioral, and Biological theory).

2.8.1 Psychoanalytic theory of anxiety

Anxiety is at the core of the psychoanalytic theory of *affects* (feelings), and from the beginning of psychoanalytic thought has been recognized as central to an understanding of mental conflict (for it is through bad feelings that conflicts are felt and known). In his early work, Freud, in keeping with his early discharge model of mental function, considered anxiety to be a "toxic transformation" of undischarged libido. This failure of discharge could either be physiological ("realistic"), as in *coitus interruptus* or other incomplete or

unsatisfactory sexual practices, resulting in "actual neuroses" or "anxiety neuroses"; or it could arise from repression (or its failure), as a symptom of the continued pressure of unacceptable desires, which led to the "psychoneuroses"—hysterias and obsessions.

In 1926 Freud radically revised his ideas about anxiety, abandoning the distinction between neurotic and realistic anxiety, and the claim that repression caused anxiety. In this new theory, Freud distinguished two types of anxiety, a traumatic, reality-oriented "automatic" anxiety in which the system was overwhelmed, and a secondary, "neurotic" anxiety in which reprisals of these situations were anticipated, thus setting in motion defensive processes. "Automatic anxiety" was an affective reaction to the helplessness experienced during a traumatic experience. The prototype for this experience lay in the helplessness of the infant during and after birth, in which the danger proceeded from outside, and flooded a psychic system essentially unmediated by the (as yet unformed) ego (Barlow, 1999).

The second form of anxiety originated within the psychical system and was mediated by the ego. This "signal anxiety" presaged the emergence of a new "danger situation" that would be a repetition of one of several earlier, "traumatic states." These states, whose prototype lay in birth, corresponded to the central preoccupations of different developmental levels, as the infant's needs become progressively abstracted from the original situation of immediate sensory overload to more sophisticated forms of need regulation capable of synthesizing the many elements facing it (from the reality and pleasure principles and the object world). These moments—*loss of the object, loss of the object's love, the threat of castration,* and *the fear of punishment by the internalized objects of the superego*—which were experienced serially during the developmental process, could reemerge at any time in a person's subsequent adult life, typically brought on by some conflation of reality and intrapsychic conflict, as a new edition of anxiety (Seligman, Walker, & Rosenhan, 2001).

Melanie Klein expanded on Freud's view by developing a theory of internal object relations linked to drives. She regarded fear of annihilation as the most fundamental anxiety and related it to Freud's death instinct. In her view, the ego engaged in a splitting process to deal with that fear of annihilation. All the derivatives of the death instinct, such as sadism, hatred, aggression, and any form of "badness," were evacuated from the infant

and projected into the mother. The infant then began to suffer persecutory anxiety from the death instinct derivatives projected into the mother. This form of anxiety, which Klein linked to the paranoid-schizoid position, involved a fear that the "bad" mother created by the infant's projections would invade the infant and destroy all the "good" aspects of the infant (Sadock, & Sadock, 2007).

2.8.2 Cognitive theory of anxiety

This theory describes the role of faulty thinking in making us anxious, and suggests a way to recover from it through cognitive restructuring. According to Beck and Emery, the way we process information is governed by structures called schemata. These schemata are made up of rules for explaining incoming information, and for retrieving what we have already learned. They are capable of exerting powerful effects on how we experience and relate to the world.

Schemata are an effective tool for understanding the world. Through the use of schemata, most everyday situations do not require effortful thought— automatic thought is all that is required. People can quickly organize new perceptions into schemata and act effectively without effort. For example, most people have a stairway schema and can apply it to climb staircases they've never seen before. However, schemata can influence and hamper the uptake of new information (proactive interference), such as when existing stereotypes, giving rise to limited or biased discourses and expectations (prejudices), may lead an individual to 'see' or 'remember' something that has not happened because it is more believable in terms of his/her schema. For example, the schemata of a person with a social phobia cause them to become anxious and avoidant by explaining incoming information and memories in terms of social threat. Treatment consists of correcting faulty or illogical thinking by repeatedly confronting cognitive schemata with discrepant information from role-playing and homework assignments (Ohman, 2000).

2.8.3 Behavioral theory of anxiety

holds that anxiety results from not knowing how to behave in a given situation. The possibility of suffering negative consequences because of inappropriate behavior may result in hesitation and inaction. The anxiety may be generalized to similar situations. For example, anxiety over taking a particular test may be generalized to taking all tests in the future. Test anxiety is the uneasiness, apprehension, or nervousness felt by students who

have a fear of failing an exam. Students suffering from test anxiety may experience any of the following: the association of grades with personal worth, fear of embarrassment by a teacher, fear of alienation from parents or friends, time pressures, or feeling a loss of control. Emotional, cognitive, behavioral, and physical components can all be present in test anxiety (Grosscup , & Lewinsohn, 1980).

2.8.4 Physiological theory of anxiety

The Autonomic Nervous System: (ANS). The nervous system of human beings is hard-wired to respond to dangers or threats. These responses are not subject to conscious control and are the same in humans as in lower animals. They represent an evolutionary adaptation to animal predators and other dangers that all animals—including primitive humans—had to cope with.

The most familiar reaction of this type is the fight-or-flight reaction to a life-threatening situation. When people have fight-or-flight reactions, the level of stress hormones in their blood rises. They become more alert and attentive, their eyes dilate, their heartbeats increase, their breathing rates increase, and their digestion slows down, making more energy available to the muscles (Sadock, & Sadock, 2007).

This emergency reaction is regulated by a part of the nervous system called the autonomic nervous system, or ANS. The ANS is controlled by the hypothalamus, a specialized part of the brainstem that is among a group of structures called the limbic system. The limbic system controls human emotions through its connections to glands and muscles; it also connects to the ANS and higher brain centers, such as parts of the cerebral cortex.

One problem with this arrangement is that the limbic system cannot tell the difference between a real physical threat and an anxiety-producing thought or idea. The hypothalamus may trigger the release of stress hormones from the pituitary gland even when there is no external danger (Sadock, & Sadock, 2007).

A second problem is caused by the biochemical side effects of too many false alarms in the ANS. When a person responds to a real danger, his or her body relieves itself of the stress hormones by facing up to the danger or fleeing from it. In modern life, however, people often have fight-or-flight reactions in situations where they can neither run away nor lash out physically. As a result, their bodies have to absorb all the biochemical changes of

hyperarousal rather than release them. These biochemical changes can produce anxious feelings as well as muscle tension and other physical symptoms of anxiety.

Diseases and Disorders: Anxiety can be a symptom of certain medical conditions. For example, anxiety is a symptom of certain endocrine disorders that are characterized by over activity or under activity of the thyroid gland. Cushing's syndrome, in which the adrenal cortex overproduces cortisol, is one such disorder. Other medical conditions that can produce anxiety include respiratory distress syndrome, mitral valve prolapse, porphyria, and chest pain caused by inadequate blood supply to the heart (angina pectoris).

Medications and Substance Use: Numerous medications may cause anxiety-like symptoms as a side effect. They include birth control pills, some thyroid or asthma drugs, some psychotropic agents, corticosteroids, antihypertensive drugs, nonsteroidal anti-inflammatory drugs (such as flurbiprofen and ibuprofen), and local anesthetics. Caffeine can also cause anxiety-like symptoms when consumed in sufficient quantity (Sadock, & Sadock, 2007).

2.9 Theories of coping

The effects of stress is directly linked to coping. The study of coping has evolved to encompass large variety of disciplines beginning with all areas of psychology such as health psychology, environmental psychology, neuropsychology and developmental psychology to areas of medicine spreading into the area of anthropology and sociology. Dissecting coping strategies into three broad components, (biological/physiological, cognitive, and learned) will provide a better understanding of what the seemingly immense area is about (Seyle, 1956).

2.9.1 Biological/physiological component

The body has its own way of coping with stress. Any threat or challenge that an individual perceives in the environment triggers a chain of neuroendocrine events. These events can be conceptualized as two separate responses, that being of sympathetic/adrenal response, with the secretion of catecholamines (epinephrine, norepinephrine) and the pituitary/adrenal response, with the secretion of corticosteroids (Frankanhauser, 1986).

The sympathetic/adrenal response takes the message from the brain to the adrenal medulla via the sympathetic nervous system, which secretes epinephrine and norepinephrine. This is the basic "fight or flight" response, where the heart rate quickens and the blood pressure rises. In the pituitary/adrenal response, the hypothalamus is stimulated and produces the corticotrophin releasing factor (CRF) to the pituitary gland through the blood veins, then the adrenal corticotropic hormone (ACTH) is released from the pituitary gland to the adrenal cortex. The adrenal cortex in turn secretes cortisol, a hormone that will report back to the original brain centers together with other body organs to tell it to stop the whole cycle. But since cortisol is a potent hormone, the prolonged secretion of it will lead to health problems such as the break down of cardiovascular system, digestive system, musculoskeletal system, and the recently established immune system. Also when the organism does not have a chance for recovery, it will lead to both catecholamine and corisol depletion and result in the third stage of the General Adaptation Syndrome of exhaustion (Seyle, 1956).

2.9.2 Cognitive component

The cognitive approach to coping is based on a mental process of how the individual appraises the situation. Where the level of appraisal determines the level of stress and the unique coping strategies that the individual partakes. There are two types of appraisals, the primary and the secondary. A primary appraisal is made when the individual makes a conscious evaluation of the matter at hand of whether it is either a harm or a loss, a threat or a challenge. Then secondary appraisal takes place when the individual asks him/herself "What can I do?" by evaluating the coping resources around him/her. These resources include, physical resources, such as how healthy one is, or how much energy one has, social resources, such as the family or friends one has to depend on for support in his/her immediate surroundings, psychological resources, such as self-esteem and self-efficacy, and also material resources such as how much money you have or what kind of equipment you might be able to use (Lazarus & Folkman, 1984).

2.9.3 Learned component

The learned component of coping includes everything from various social learning theories, which assume that much of human motivation and behavior is the result of what is learned through experiential reinforcement, learned helplessness phenomena which is

believed to have a relationship to depression, and even implications of the particular culture or society that the stress at hand is affected by can also be included in this component. Some of the examples for the social learning theories would be the wide range of stress management techniques that have been found to help ease stress. Changing how you cognitively process a particular situation, so called cognitive restructuring, changing how you behave in a particular situation, so called behavior modification, biofeedback which uses operant conditioning to alter involuntary responses mediated by the autonomic nervous system, and the numerous relaxation techniques such as meditation, breathing, and exercise are all part of what is learned through experiential reinforcement (Coyne, Aldwin, & Lazarus, 1981).

2.10 Studies Review

2.10.1 Political violence, War and Mental Health studies

In the study of Punamaki (1995) discussed the impact of political violence and personal factors on psychological stress responses. The sample consists of three groups of Palestinian women: (1) a West Bank/Gaza group of 174 women from the Israeli-occupied areas; (2) a Beirut group of 30 women from the refugee camps of Sabra and Shatila; and (3) a comparison group of 35 Palestinian women living in Israel proper who were not exposed to direct political violence. As the determinants of psychological stress responses, worries, appraisal of availability of resources to cope (helplessness-controllability), coping modes and mental health problems were assessed. The hypothesized determinants of the stress process are place of residence, personal exposure to political hardships, economic stand and the age of the woman. The results showed significant differences between the three groups in their stress responses. The women of the Beirut group were the most traumatized, but psychologically this was reflected only in their showing more helplessness and lack of control in their personal lives than the women of the other Palestinian groups. The Beirut group expressed the lowest and the comparison group the highest level of political and personal worries. Furthermore, the Beirut group suffered less from mental health problems than the West Bank/Gaza group. These results accord with observations that in war and conflict situations, mental health problems tend to be more common in threatened areas, where fighting is expected to occur, than in the actual fighting areas. They also refer to people's general tendency to delay or modify their psychological

symptoms in an extremely painful situation. In the West Bank/Gaza group, exposure to political hardships was related to a low level of passive and to a high level of socially-politically active coping modes. Yet, exposure to political hardships also increased mental health problems, which is a reminder of the price which people are forced to pay in order to cope with political violence.

In the study of baker (1990) examined the psychological symptoms of Palestinian children in order to test the hypothesis that their active support for the *Intifada* may have some bearing on their mental health, as it is affected by the military occupation. The data used for the study were collected nine months after the onset of the *Intifada*. Subjects were selected from city, village, and refugee camp dwellers. Using the subjects' mothers as informants, their individual environment was assessed for traumatizing events, and their psychological symptoms were noted. The most disturbing feature of the study is the intensity of certain psychological problems after such a relatively short period of environmental stress; however, it is hoped that the sense of self-reliance gained by their identification with the resistance, and the moral support they receive from the adult population, may help to keep the children's psychological problems within bounds.

Qouta et al (1995) in his study aimed to examine the impact of the Israeli-Palestinian peace treaty and Palestinian children's perception of it on their self-esteem and neuroticism. They also studied the relative importance of earlier exposure to traumatic experiences and psychosocial resources indicated by the children's creativity, intelligence and political activity in influencing their psychological well-being after the peace treaty. The sample used was a follow-up group of 64 Palestinian children of 11–12 years of age, living in the Gaza Strip. The results showed that the level of neuroticism was significantly lower after the peace treaty than before. The children's earlier exposure to traumatic experiences was still significantly related to high neuroticism and low self-esteem after the peace treaty. Acceptance of the treaty and participating in the subsequent festivities mitigated the negative impact of the traumatic experiences on their well-being. Increased neuroticism and decreased self-esteem were found only among children who refused to accept the peace treaty and did not participate in the festivities. Creativity and Intifada activity promoted their post-peace treaty well-being, in terms of psychosocial resources. The more creative the children were, the more their neurotic symptoms decreased because of the

treaty and the higher self-esteem they had after it. The more active the children were during the Intifada, the more their self-esteem increased because of the treaty.

In the study of Husain et al (1998) aimed to study of posttraumatic stress symptoms in children and adolescents during siege conditions in Sarajevo. A sample of Seven hundred ninety-one students aged 7–15 years were surveyed to assess symptoms of posttraumatic stress and level of deprivation. The finding were that girls reported more stress than boys. Loss of family members and deprivation of basic needs were associated with more symptoms reported avoidance behaviors and reexperiencing symptoms. However, the differences are small, even though significant, and should be interpreted with caution. Eighty-five percent of the sample had experienced sniper fire, but there was no significant relationship between experiencing sniper fire and the development of PTSD symptoms. The loss of a family member and deprivation of food, water, and shelter had a severe adverse impact on the children. They identified the needs for food and clothing more frequently than the needs for water and shelter. In general, deprivation was associated with significantly increased symptoms of avoidance and hypervigilance. These results imply that proximity to war atrocities and personal losses are highly correlated with the development of symptoms of PTSD.

In another study, Slone, and Gilat, (1999) in his study aimed to investigate the effect of three psychopolitical factors on children's psychological adjustment. The three factors are exposure to political life events, impact assigned to experienced events, and perception of threat. Subjects were 397 Israeli children aged 12-13 sampled from three residential areas, which differed along a religious-ideological axis—West Bank settlements, the Golan Heights, and greater Tel Aviv. All children responded to a political life events scale, a questionnaire battery assessing threat perception and ideological conviction, and the Brief Symptom Inventory. Results for two factors confirm the central hypothesis that the factors will be related linearly to distress, indicating increased distress levels with magnification of perceived impact of political events and perception of threat. A secondary hypothesis that ideology mediates the psychopolitical variables to distress relation was not confirmed. These results have implications for comprehension of political environmental dimensions impairing children's mental health.

Thabet & Vostanis (2000) in his study aimed to estimate the rate of post-traumatic stress reactions in Palestinian children who experienced war traumas, and to investigate the

relationship between trauma-related factors and PTSD reactions. The sample consisted of 239 children of 6 to 11 years of age. Measures included the Rutter A2 (parent) and B2 (teacher) scales, the Gaza Traumatic Event Checklist, and the Child Post-Traumatic Stress Reaction Index. Of the sample, 174 children (72.8%) reported PTSD reactions of at least mild intensity, while 98 (41%) reported moderate/severe PTSD reactions. Caseness on the Rutter A2 scale was detected in 64 children (26.8%), which correlated well with detection of PTSD reactions, but not with teacher-detected caseness. The total number of experienced traumas was the best predictor of presence and severity of PTSD. Intervention programmes for post-war children need to be evaluated, taking into account developmental and cultural aspects, as well as characteristics of the communities involved.

In the study of Dyregrov et al (2000) aimed to assess Trauma exposure and psychological reactions to genocide among Rwandan children. A total of 3030 children age 8-19 years from Rwanda was interviewed about their war experiences and reactions approximately 13 months after the genocide that started in April 1994. Rwandan children had been exposed to extreme levels of violence in the form of witnessing the death of close family members and others in massacres, as well as other violent acts. A majority of these children (90%) believed that they would die; most had to hide to surive, and 15% had to hide under dead bodies to surive. A shortened form of the Impact of Event Scale used in a group of 1830 of these children documented high levels of intrusion and avoidance. While children living in shelters were exposed to more trauma, they evidenced less posttraumatic reactions. Analyses showed that reactions were associated with loss, violence exposure, and, most importantly, feeling their life was in danger.

In the study of Barber (2001) to investigate the associations among involvement in political violence, family relations, and several measures of adolescent social and psychological functioning in a sample of 6,000 Palestinian families from the West Bank and the Gaza Strip. Structural equation analysis of youth self-reported survey data revealed that experience in the Intifada (as children) predicted increases in antisocial behavior (males and females) and depression (females) 1 to 2 years after the end of the Intifada (when adolescents), but was not related to family values, educational values, academic performance, or aggression. Intifada experience was related to increases in parental use of psychological control and conflict with daughters, but was unrelated to parental support, parental monitoring, or conflict with sons. The discussion centers on the role of cultural

forces and the psychological meaning of nationalistic conflict in the resilience of children and families to political violence. Intifada experience was positively associated with religiosity and unrelated to social integration in family, school, and peer relations; in some cases, social integration in family, education, religion, and peer relations significantly moderated the associations between Intifada experience and youth problems; integration in the several social contexts was directly related in predictable ways to youth problem behaviors, with neighborhood disorganization the most consistent and powerful predictor.

In the study of Smith (2002) aimed to explore War exposure among children from Bosnia-Hercegovina: Psychological adjustment in a community sample. Data were collected from a community sample of 2,976 children aged between 9 and 14 years. Children completed standardized self-report measures of posttraumatic stress symptoms, depression, anxiety, and grief, as well as a report of the amount of their own exposure to war-related violence. Results showed that children reported high levels of posttraumatic stress symptoms and grief reactions However, their self-reported levels of depression and anxiety were not raised. Levels of distress were related to children's amount and type of exposure. Girls reported more distress than boys, but there were few meaningful age effects within the age band studied.

In the of study of Kuterovac-Jagodic (2003) aimed to examine symptoms of posttraumatic stress in 252 school-aged children from Osijek, Croatia, which was subjected to massive military attacks from Yugoslavian forces. The children's symptoms were assessed in 1994 while the war was still going on and 30 months later when the war was over. In addition to changes in posttraumatic stress disorder symptoms over time, the study examined the predictive power of (a) different types and number of war traumata, (b) loss of social community, (c) the children's demographic characteristics (age and gender), (d) types of coping strategies and locus of control, and (e) the perceived availability of different kinds of social support. Although symptoms of posttraumatic stress declined over time, 10% of the children reported a severe level of symptomatology 30 months after the war. The results supported the hypothesized predictive power of all investigated factors for predicting short- and long-term posttraumatic stress reactions.

In another study in Palestine, (Qouta & EL-Sarrej, 2004) in his study aimed to get the prevalence of PTSD, and other psychological suffering among Palestinians children during the Al-Aqsa Intifada. In the study a sample of 944 children whom age ranged between 10-

19 years. The group excluded those with previous mental health problems, in this study, the result indicated that 32.7% of the children started to develop acute PTSD symptoms, that need psychological interventions, while 49.2% of them suffered from moderated level of PTSD symptoms. Also the result show that the most prevalence types of trauma exposure for children are for those who had witness funerals (94.6), witness shooting (83.2%), saw injured or dead who were not relatives (66.9%), and so family members injured or killed (61.6%).

In the study of Afana (2004) this was a quasi-experimental survey that looked at sex difference of mental disorders and the prevalence of mental health problems for people visiting primary health care clinics in the Gaza strip. A survey of 661 randomly selected primary heath care patients was completed using the HSCL-25. Results: about 73% of patients visiting primary care clinics in the Gaza strip had mental disorders. The prevalence among females was higher (76.8%) than males (67%); living in refugee camps was predictive of both anxiety and depression but, for depression, the difference comes from those living in the camps who also define themselves as refugees vs. those who are citizens. Low educational level is a predictor of anxiety and not being married is linked to depression. About 6% of the variance of anxiety can be accounted for in regression by sex, place of residence and education with gender being the most robust predictor. Only about 2.9% of depression can be accounted for sex, marital status, and education. Again gender is the important predictor.

In the study of Duncan et al (2005) aimed to investigate whether there is a relationship between the political violence that took place in Nepal and symptoms of posttraumatic stress disorder (PTSD) and physical symptoms. Eighty-five Nepali citizens completed brief questionnaires assessing background information, whether they were directly exposed to political violence, the presence of PTSD-like symptomatology as well as physical complaints. Participants also completed a measure of perceived psychological proximity to the political events using a novel application of the Pictorial Representation of Illness and Self-Measure (PRISM). Old-age, little education and residing in a rural village were associated with more PTSD-like symptomatology. Both direct exposure and perceived psychological proximity to the political violence were associated with more PTSD-like symptoms. Most parameters were unrelated to physical symptoms. Interestingly, PRISM-distance moderated the effects of exposure to violence on PTSD-like symptoms: in

participants exposed to violence, those with big PRISM-distances reported lower PTSD-like symptoms than those with little PRISM distances.

In the study of Polak (2005) war experiences, psychological symptoms, post traumatic stress disorder (PTSD) symptomatology, and the physical and sexual abuses of formerly abducted girls in Northern Uganda were assessed. In a cross-sectional self-report design, questionnaires were administered to 123 formerly abducted girls. Data originating from records at three rehabilitation centres were analysed. The girls had been exposed to horrific war events, participated in shocking atrocities, were physically and sexually abused, and diagnosed with diseases resulting from their abduction. As a result, many are psychologically distressed. There are child mothers and a few were pregnant at the time of the study.

In another study in Iraq, Al-Mashat et al, (2006) in his qualitative study investigated Iraqi children's experiences of "Operation Iraqi Freedom" and the meaning it had for them given their cultural context. Two focus groups were employed in Mosul, Iraq, to interview 12 children between the ages of 9 and 13. They elaborated on the drawings and letters that pertained to their war experiences. The Child's Reaction to Traumatic Events Scale (CRTES) was used for descriptive statistics. Results indicate a high level of distress amongst the majority of the children even seven months after the official end of the war in Iraq. A number of themes emerged that pertained to the children's war experiences, the meaning it had for them, how they coped, and their future hopes. Implications for counseling psychology are provided.

In the study of Al-Krenawi, Wiesel & Sehwail (2007) examined the impact of the level of exposure to political violence on the psychological symptomatology of Palestinian adolescents in the West Bank, an area affected by the ongoing political violence between Israel and the Palestinian Authority. A random sample of 1775 participants (54.1% males, 45.9% females) between the ages of 12–18 was administered a self-report questionnaire consisting of three measures: demographic variables, domestic violence, political violence events and psychological symptomatology (BSI). Results indicated that the average psychological symptomatology was higher among those who were exposed to political violence events compared to those who were not; the level of hostility was significantly higher in those who were exposed to each of the political violence events. However, the

factors that contributed most to psychological symptomatology were parental violence toward children and violence among siblings.

In the study of Thabet et al. (2007) determined the prevalence of PTSD, anxiety, behavioural, and emotional problems of Palestinian children in relation to traumatic events and other socioeconomic status. A sample of 409 children from the entire Gaza Strip aged 9-18 years was survey using self-report questionnaires. Children were interviewed using Gaza Trauma Checklist, Child Revised Impact of Event Scale-13, and Child Revised Manifest Anxiety Scale, and their parents reported about their children behavioural and emotional problems using Strength and Difficulties Questionnaire. The results estimated mean traumatic experiences were 7.7. There was significant relationship between number of traumatic events and PTSD of children, intrusion, avoidance, and arousal. No gender differences in PTSD symptom. Children coming from families with monthly income less than 271 $ reported more traumatic events. Total IES score of children was significantly associated with PTSD symptoms. No relationships between number of traumatic events and SDQ total or subscales. Prevalence of PTSD in children was 65.5%. The result showed that there were no sex differences in PTSD symptoms. Children coming from families with 4 and less children had more PTSD symptoms. Prevalence of anxiety disorder was (33.9%). No gender differences in anxiety disorder. General mental health problems rated by parents SDQ was (52.2%); conduct disorder (42.2%); hyperactivity (28.1%), emotional problems (32.8%), peers problems (69.9%), and prosocial problems (14%).

Thabet et al (2007) in his study aimed to establish the relationship between ongoing war traumatic experiences, PTSD and anxiety symptoms in children, accounting for their parents' equivalent mental health responses. Methods The study was conducted in the Gaza Strip, in areas under ongoing shelling and other acts of military violence. The sample included 100 families, with 200 parents and 197 children aged 9–18 years. Parents and children completed measures of experience of traumatic events (Gaza Traumatic Checklist), PTSD (Children's Revised Impact of Events Scale, PTSD Checklist for parents), and anxiety (Revised Children's Manifest Anxiety Scale, and Taylor Manifest Anxiety Scale for parents). The result showed that both children and parents reported a high number of experienced traumatic events, and high rates of PTSD and anxiety scores above previously established cut-offs. Among children, trauma exposure was significantly associated with total and subscales PTSD scores, and with anxiety scores. In contrast,

trauma exposure was significantly associated with PTSD intrusion symptoms in parents. Both war trauma and parents' emotional responses were significantly associated with children's PTSD and anxiety symptoms. Conclusions Exposure to war trauma impacts on both parents' and children's mental health, whose emotional responses are inter-related. Both universal and targeted interventions should preferably involve families.

In another study of Thabet et al (2008) aimed to investigate the effect of political violence on Palestinians in the Gaza Strip. A sample of 412 adult was selected randomly from three villages, three camp, and two cities. One street was selected in each area, and every other household that fulfilled the selection criteria (Male and female) was included. In larger buildings, one flat from each floor was selected.. Subjects were interviewed in their homes after being asked orally the possibility of participation in the study. The data was collected during August 2006, using The *Gaza Traumatic Events Checklist,* describing the most common traumatic experiences families could have faced in the Gaza Strip. The PCL is a 17-item self report questionnaire corresponding to the three *DSMIV* symptom clusters of reexperiencing, avoidance, and hyperarousal The *Posttraumatic Stress Disorder Checklist for adults and The Taylor's Manifest Anxiety Scale (MAS),* This measures symptoms of chronic anxiety. the Arabic version was used with 50 items rated as 'yes'/'no'. Scores can be classified as 0- 26 (no anxiety), 27-32 (mild anxiety), 33-40 (severe anxiety), and 41 and above (very severe anxiety). The result showed that Palestinians reported similar frequencies of traumatic events. The most common traumatic events were, watching mutilated bodies and wounded people on TV (97.1%), hearing the sonic sounds of the jetfighters (94.7%), and witnessing the signs of shelling on the ground (93.2%). Subjects reported a mean number of 7.7 traumatic events (SD = 2.21). Subjects ratings of exposure to trauma were significantly not correlated with PTSD (Spearman coefficient). Participants reported different reactions to traumatic events, the most common reactions being: upset by reminders (62.7%), distressing dreams (59.8%), and amnesia (50.2%).

Haj-Yahia (2008) in his study aimed to examine the effect of retrospective report of political violence during the first Intifada (1987—1993) on psychological adjustment of 1185 Palestinian adolescents (10^{th} to 12^{th} graders) seven years after the first Intifada had ended. Analysis of the inter-relations was conducted between self-reported measures of political violence, socio-demographic characteristics, perceived parents' psychological adjustment problems and internalizing (i.e., somatization, withdrawal, anxiety, and

depression) and externalizing (i.e., thought, attention and social problems, delinquent and aggressive behaviors) symptoms. It showed the significant net effect of retrospectively reported exposure to political violence on both internalizing symptoms and externalizing symptoms over and above the effect of socio-demographic characteristics and perceived parents' psychological adjustment problems.

Catani et al. (2008) in his study aimed to establish the prevalence and predictors of traumatic stress related to war, family violence and the recent Tsunami experience in children living in a region affected by a long-lasting violent conflict. In addition, the study looked at whether higher levels of war violence would be related to higher levels of violence within the family and whether this would result in higher rates of psychological problems in the affected children. 296 Tamil school children in Sri Lanka's North-Eastern provinces were randomly selected for the survey. Diagnostic interviews were carried out by extensively trained local Master level counselors. PTSD symptoms were established by means of a validated Tamil version of the UCLA PTSD Index. Additionally, participants completed a detailed checklist of event types related to organized and family violence. The result showed 82.4% of the children had experienced at least one war-related event. 95.6% reported at least one aversive experience out of the family violence spectrum. The consequences are reflected in a 30.4% PTSD and a 19.6% Major Depression prevalence. Linear regression analyses showed that fathers' alcohol intake and previous exposure to war were significantly linked to the amount of maltreatment reported by the child. A clear dose-effect relationship between exposure to various stressful experiences and PTSD was found in the examined children.

Thabet, Abu Tawahina, & El Sarraj (2008) in his study aimed to investigate the impact of siege of the Gaza Strip on Palestinians feelings of anger and anger state in relation psychological symptoms in relation to other socioeconomic variables. A random sample of 386 adults ' age range (18-64 years) selected from a community base. The subjects were interviewed using the following tools: Sociodemographic scale, Gaza Siege Checklist, Symptom Checklist (BSI-53), and State–Trait Anger Expression Inventory. The results showed that the most common impact of siege of Gaza items were: prices are sharply increased (97.67%), I feel I am in a big prison (92.23%), I can not find things I need in the market (91.70%), I quitted some purchased daily needs (88.30%), and social visits are less than before (85.23%). The main psychopathology showed that 75.91 % feel worthlessness,

56.5% blaming themselves for things, 55.7% feel that every thing in life is difficult, 54.4% had nervousness, 41.8% feel tense or keyed up, and 41.1% feel easily annoyed or irritated. The results showed that females reported more somatization, obsessive compulsive disorder, and phobic anxiety. Palestinians live in camps reported more general psychological problems, somatization, obsessive compulsive problems, interpersonal sensitivity, depression symptoms, anxiety, hostility, phobic anxiety, paranoid ideation than those in cities and village. However, psychosis symptoms were more common in people live in villages than in camps cities and. The results showed that there were statistically significant positive correlation between total siege scores and BSI in which people who scored more in siege items had more psychopathology, somatization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, panic (phobic anxiety), paranoid ideation, and psychosis. The results showed that the psychological problems were predicted by had suffering of not able to receive proper medical care, feel being in a big prison, sold some of furniture and gold, was not able to get specific medicine for themselves or for one of the family member, quitted purchasing daily needs. The study showed that the most common anger state were: I feel upset (18.4%) and I barely burned from the inside (10.4%). While trait of anger items were: I feel upset when my work is not appreciated (21.1%), I became angry when I did a good job and get the estimate is weak (19.9%), and I am angry when mistakes of others delayed my work (16.1%). The results showed that the total anger state was predicted by were not able to get specific medicine for me or for one of the family member, thought of Immigration, one of the family members died due to prevention of traveling for treatment, their work affected so much due to shortage of fuel, papers, medicine, and raw materials, feel they are in a big prison. While anger trait was predicted by having a quick-temper was predicting.

2.10.2 Coping Strategies and Mental Health Studies

In the study of Hill (1995) aimed to examine the relationship between coping strategies of 136 African-American mothers, their exposure to community violence, and their interpersonal victimization. It is suggested that the disproportionate victimization of African-American women produces a cumulative triple threat for those who live amidst conditions of community violence in the following manner: a) exposure through daily living in the midst of unpredictable community violence; b) exposure to violence from witnessing violence in the neighborhood; and c) exposure to violence from

disproportionately high rates of personal victimization. The findings suggest that coping strategies are used differentially as a function of the amount of violence within the social context, and the education and financial resources of the mothers. Mothers who live in lower-violence areas with college education preferred activism as a coping strategy, whereas those in high-violence areas with comparable incomes and education preferred reliance on prayer and instituting safety practices. Coping strategies differed based on whether mothers had been physical victims and witnesses to violence or had no personal experience with violence. This study lays the groundwork for a model of exploring the impact of the cumulative effects of violence on African-American mothers parenting in urban America.

In the study of Punamäki & Puhakka (1997) examined how age and gender, and the intensity of political violence and stressful events influence children's coping styles, and the effectiveness of coping. The participants were 185 Palestinian boys and girls of 10-13 years of age. Intensity of political violence was indicated by comparing a group tested before the Intifada (N = 89) and a group during the Intifada (N = 96). The results showed that older children used more emotional and cognitive coping, and a wider coping repertoire than younger ones. Boys used more Problem restructuring and behavioural coping than girls, who, for their part, used more emotional coping than boys. The more intensive the political violence was, the more Problem restructuring and the less Active fighting and Hostile confrontation children used. Further, during an intensively violent period of Intifada, children's coping repertoire was narrow and involved little emotional and cognitive coping modes. Personal exposure to stressful events increased behavioural coping, Active fighting and Problem restructuring, and decreased emotional modes of coping. The effectiveness of coping styles in alleviating psychosocial problems varied according to the intensity of political violence. Problem restructuring, Active fighting, and behavioural coping were effective only during the Intifada, but not before the Intifada.

In another study of Punamäki et al. (2001) aimed to explain the effects of cognitive capacity, perceived parenting, traumatic events, and activity, which were " measured in the midst of the political violence of the Intifada in 1993, were examined on post-traumatic stress disorder (PTSD), emotional disorders, school performance, and neuroticism three years later in more peaceful conditions among 86 Palestinian children of 14.04 ± 0.79 years of age. The results showed, that PTSD was high among the children who had been exposed

to a high level of traumatic events and had responded passively (not actively) to Intifada violence. Discrepant perceived parenting was also decisive for adjustment: Children who perceived their mothers as highly loving and caring but their fathers as not so showed a high level of PTSD. High intellectual but low creative performance was also characteristic of the children suffering from emotional disorders. Second, the hypothesis that cognitive capacity and activity serve a resiliency function if children feel loved and non rejected at home was confirmed. Third, neuroticism decreased significantly over the three years, especially among the children who had been exposed to a high number of traumatic events.

In the of study Hallis & Slone (1999) determined the relation between political life events and distress was examined with particular emphasis on coping strategies and locus of control as two possible mediators. Subjects were 88 Israeli children. Results partially supported a linear relation between reported impact of exposure and distress. Findings for coping strategies as a mediator suggested, counterintuitively, that greater use of coping strategies is related to more experienced distress. Findings for locus of control as a mediator suggested that subjects with external locus of control experience greater distress, other than in the case of depressive symptomatology. These results indicate that coping strategies and locus of control play a complex role in the stress-outcome relation, the precise nature of which remains to be resolved. Theoretical, clinical and political implications of the findings are discussed.

In the study of Barbarin et al. (2001) aimed to explore the effects of exposure to direct and vicarious political, family, and community violence on the adjustment of 625 six-year-old black South African children was examined. Children and their parents were recruited as part of the Birth to Ten (BTT) project, a longitudinal study of the effects of urbanization on physical and psychological development in South Africa. Although the larger study from which this sample was drawn consisted of both black and white children, the data reported here are from a subsample of 625 black children whose families were interviewed extensively when the sample children were five years old. The result showed that The principal effects of violence in these young children occurred in the domains of attention, aggression, and anxiety-depression. Community violence emerged as the most consistent predictor of adverse child outcomes (and was also predictive of maternal distress). The propinquity principal received modest support, in that family violence predicted child aggression, while victimization had an adverse effect on attention. Surprisingly, political

violence showed no relationship to children's psychological and academic functioning. It is important to note that these results confirm the significant role played by individual and family coping resources in mediating the problems of violence. Mothers themselves were not immune to the effects of violence. Community and family violence were associated with high levels of emotional distress in mothers. Resources in the form of individual child resilience, maternal coping, and positive family relationships were found to mitigate the adverse impact in all the assessed domains of children's functioning.

Punamäki et al. (2002) in his study examined the role of defenses in moderating and mediating between trauma and post-traumatic symptoms among Palestinian men. The sample considered of 128 Palestinian male political ex-prisoners who had reported various degrees of torture and ill-treatment. The first aim was to analyze the dimensionality and distribution of different defense mechanisms. The second was to examine which defenses would moderate the association between the reported torture and ill-treatment and the post-traumatic symptoms (PTSD). Third, the direct association between reported torture and ill-treatment and defenses and between the defenses and symptoms were explored. Defense mechanisms were assessed by a 40-item version of the Defense Style Questionnaire (DSQ), and Post-traumatic symptoms by the Harvard Trauma Questionnaire (HTQ), and experiences of torture and ill-treatment by a sale developed for that purpose. The results show, first, that men used predominantly mature defenses such as anticipation, sublimation, suppression, and rationalization, but also relatively frequently somatization and dissociation, which are characteristic responses among trauma victims. Second, the principal component analysis revealed four defense dimensions, differentiated by the level of maturity and the approach to reality: the mature reality-distorting consciousness-limiting, the immature reality-escaping, and the immature reality-distorting defense. Third, against our hypothesis, the moderating analyses indicated that the reported torture and ill-treatment were relatively more associated with vigilance, avoidance, and intrusion symptoms if men used consciousness-limiting defenses. Yet as expected, the mature reality-based defenses did not show a protective effect. Furthermore, a high level of reported torture and ill-treatment was associated with a low level of the mature reality-based defenses but not with a high level of immature defenses

Giacaman et al. (2007) in his study conducted a survey of Palestinian adolescents in school. We hypothesized that collective and individual exposures to violence would both

negatively affect adolescents' mental health. We also anticipated that the negative effect of collective exposures on mental health would be less than that of individual exposures. Analysis was designed to test these hypotheses. A representative sample of 3415 students of 10th and 11th grades from the Ramallah District of the West Bank participated in the survey. The primary independent variables were scales of individual and collective exposures to trauma/violence (ETV) by the Israeli military and settlers. Factor analysis revealed several sub-scales. Outcome measures were constructed and included: a binary measure of depressive-like states, and emotional, depressive-like state, and somatic scales. Several variables were identified as possible covariates: gender, age, school-type, residence, employment status of father, and identity documents held. Logistic and multiple regression analyses revealed a strong relationship between ETV and adolescents' mental health, with both individual and collective exposures having independent effects. There was a higher prevalence of depressive-like symptoms among girls compared with boys, and in adolescents living in Palestinian refugee camps compared with those living in cities, towns and villages.

Araya et al. (2007) in his study to evaluate trauma, coping, social support and sociodemographics among them particularly in relation to gender. From each randomly selected household in these shelters, a subject was interviewed, yielding 1200 subjects in all.: Men, compared to women, reported significantly higher physical abuse during childhood in the family, traumatic childhood life events, experience of most traumatic life events related to displacement, coping perceived social support. Women reported higher emotion-oriented coping whereas men reported higher task-oriented coping. Traumatic events were associated with higher emotion-oriented coping in both genders, and with higher task-oriented coping in women. Perceived social support was correlated positively with task-oriented coping in both genders, but was not associated with traumatic life events. Severe trauma is associated with coping perceived social support in part differently with regards to gender.

In the study of Gillham et al. (2008) this qualitative study explored the construct of resilience by Palestinian youth in the 10th to 12th grades at school living in and around Ramallah in the West Bank. We look at how adolescents themselves interpret and give meaning to the concept of resilience in de-humanising and abnormal conditions. The aim is to 'problematical' the construct to go beyond quantitative research and objective inquiry.

Focus groups were conducted with 321 male and female Palestinian students in 15 schools in Ramallah and the surrounding villages. This study presents findings that are consistent with previous research on the value of supportive relationships such as families and friends. Political participation and education are vital to a sense of identity and political resistance. However, a key finding reveals the normalization of everyday life in fostering resiliency within abnormal living conditions. Palestinian youth, nonetheless, paint a picture of resilience that reveals contradictions and tensions. This study underlines the fluid and dynamic nature of resilience. Despite the desire for order, Palestinian young people complain of emotional distress and boredom. Feelings of desperation are intermingled with optimism.

In the study of Thabet (2008) aimed to investigate the frequency and reactions to trauma such as PTSD and general mental health, then examining resilience from the perspective of decreased vulnerability to PTSD and mental health problems in reaction to trauma. The study sample consisted of 386 children from total of 400 children targeted as study population with respond rate of 96.5%, 201 of children were boys (52.07%) and 185 were girls (47.93%). Children age ranged from 7-18 years with a mean age of 13.44 years. Children were interviewed using Gaza Factional Fighting and Israelis Aggression Trauma Scales, Child Mental Health, UCLA-PTSD, and Resilience Scale. Palestinian children exposed to mean of 10.18 events due to Israeli aggression and 7.42 events due to factional fighting. No gender differences in reported traumatic events. Posttraumatic stress symptoms mean was 25.94, re-experiencing symptoms mean was 7.50, avoidance symptoms mean was 8.21, and arousal symptoms mean was 7.65. Forty eight 48 children reported probable PTSD (12.4%), 103 children were reported one Criteria (reexperiencing, or avoidance, or hyperarousal) (26.7%), 86 of children reported two criteria-Partial PTSD (22.3%), and 149 children had no PTSD symptoms (38.4%). No gender differences in PTSD. Younger age children was significantly reported total posttraumatic stress symptoms than older age children. The results showed that total scores of PTSD were correlated with traumatic events due to Israelis aggression PTSD, reexperiences, hyperarousal, and avoidance. No significant correlation between trauma due to factional violence.

Mean mental health symptoms mean was 9.05, somatic pains mean was 1.31, depression symptoms mean was 4.36, anxiety mean was 2.21, and fears mean was 1.14. There were no significant differences between boys and girls in total general mental health, somatic

pains, anxiety, depression, and fears. Fears were more in younger age children. Children reported mean resilience scores were 58.52, commitment subscale mean was 23.78, control subscale mean was 17.58, and challenging subscale mean was 17.60. There were no significant differences between boys and girls and age of children in total resilience, commitment, control, and challenging. The results showed that total scores of resilience were correlated negatively with total PTSD, arousal, and avoidance. Commitment was correlated negatively with arousal, children with better resilience had less PTSD, avoidance, and arousal symptoms and children with commitment had less arousal symptoms. Total scores of resilience were correlated negatively with total mental health, somatic pains, anxiety and fears. Commitment was correlated negatively with anxiety, control was negatively correlated with fears, and challenge was negatively correlated with fears.

2.11 Summary

The researcher will review the previous study, from the dimension of result of various studies and tools were used in the studies:-

Qouta et al. (1995) in the study showed that the level of neuroticism was significantly lower after the peace treaty than before. Thabet & Vostanis (2000) he found that from the sample 174 children (72.8%) reported PTSD reactions of at least mild intensity, while 98 (41%) reported moderate/severe PTSD reactions. Caseness on the Rutter A2 scale was detected in 64 children (26.8%), which correlated well with detection of PTSD reactions. Punamäki et al. (2002) The results of the study show, first, that men used predominantly mature defenses such as anticipation, sublimation, suppression, and rationalization, Second, the principal component analysis revealed four defense dimensions, differentiated by the level of maturity and the approach to reality: the mature reality-distorting consciousness-limiting, the immature reality-escaping, and the immature reality-distorting defense. Qouta & EL-Sarrej (2004) the result of the study indicated that 32.7% of the children started to develop acute PTSD symptoms, that need psychological interventions, while 49.2% of them suffered from moderated level of PTSD symptoms. Also the result show that the most prevalence types of trauma exposure for children are for those who had witness funerals (94.6), witness shooting (83.2%), saw injured or dead who were not relatives (66.9%), and so family members injured or killed (61.6%). Al-Mashat, K. et al.

(2006) Results of the study indicate a high level of distress amongst the majority of the children even seven months after the official end of the war in Iraq.

Al-Krenawi, Wiesel & Sehwail (2007) study's results indicated that the average psychological symptomatology was higher among those who were exposed to political violence events compared to those who were not; the level of hostility was significantly higher in those who were exposed to each of the political violence events. Thabet et al. (2007) The result of study showed that both children and parents reported a high number of experienced traumatic events, and high rates of PTSD and anxiety scores above previously established cut-offs. Among children, trauma exposure was significantly associated with total and subscales PTSD scores, and with anxiety scores. Catani et al. (2008) The result of study showed 82.4% of the children had experienced at least one war-related event. 95.6% reported at least one aversive experience out of the family violence spectrum. The consequences are reflected in a 30.4% PTSD and a 19.6% Major Depression prevalence. Thabet, Abu Tawahina, & El Sarraj (2008) The study results showed that the most common impact of siege of Gaza items were: prices are sharply increased (97.67%), I feel I am in a big prison (92.23%), I can not find things I need in the market (91.70%), I quitted some purchased daily needs (88.30%), and social visits are less than before (85.23%). The main psychopathology showed that 75.91 % feel worthlessness, 56.5% blaming themselves for things, 55.7% feel that every thing in life is difficult, 54.4% had nervousness, 41.8% feel tense or keyed up, and 41.1% feel easily annoyed or irritated. Thabet (2008) the result of the study shows Forty eight 48 children reported probable PTSD (12.4%), 103 children were reported one Criteria (reexperiencing, or avoidance, or hyperarousal) (26.7%), 86 of children reported two criteria-Partial PTSD (22.3%), and 149 chidren had no PTSD symptoms (38.4%). No gender differences in PTSD. Younger age children was significantly reported total posttraumatic stress symptoms than older age children. The results showed that total scores of PTSD were correlated with traumatic events due to Israelis aggression PTSD, reexperiences, hyperarousal, and avoidance.

Tools of previous studies: Thabet & Vostanis (2000) Measures included the Rutter A2 (parent) and B2 (teacher) scales, the Gaza Traumatic Event Checklist, and the Child Post-Traumatic Stress Reaction Index. Of the sample, Al-Mashat, K. et al. (2006) use in his study The Child's Reaction to Traumatic Events Scale (CRTES). Al-Krenawi, Wiesel & Sehwail (2007) use in his study a self-report questionnaire consisting of three measures: demographic variables, domestic violence, political violence events and psychological

symptomatology Thabet et al. (2007) in his study children were interviewed using Gaza Trauma Checklist, Child Revised Impact of Event Scale-13, and Child Revised Manifest Anxiety Scale. Thabet, Abu Tawahina, & El Sarraj (2008) in their study the subjects were interviewed using the following tools: Sociodemographic scale, Gaza Siege Checklist, Symptom Checklist (BSI-53), and State–Trait Anger Expression Inventory.

Chapter 3

*M*ethodology

Chapter 4
Methodology

3.1 Introduction

The researcher present in this chapter description of study design, population, sample, instrument that used in data collection, ethical consideration and limitation of the study.

3.2 Study Design

The current study is a descriptive-analytical study, which tries to answer the study questions about examining the psychological impact of political violence on Palestinian adolescents living in Gaza Strip and coping strategies as a mediating factors. It has been selected because this method would be useful for descriptive and analysis of study variables. This type of study measures the level and the prevalence of the phenomena, which applied on the sample in particular time and place.

3.3 The Study Population

The study population includes all the students in the secondary schools (10th class, 11th class, and 12th class) between the ages of 15-18 years old that equal (57 205) adolescents; males 44.1 % (27396), females 55.9 % (29 809). By using Epi. Info. program the researcher calculate the sample size. (Figure 2)

3.4 Study Sample

The researcher selected the study sample by using stratified cluster random sample, 358 adolescents; 158 (44.1%) males and 200 (55.9%) females aged 15-18 years. The researcher selected randomly by using sampling frame two schools from each governorate; (one males schools and one female schools) and three classes (10th , 11th, 12th) from each school. (Figure 3,4)

Figure 2: Distribution of the study population according to place of resident and gender

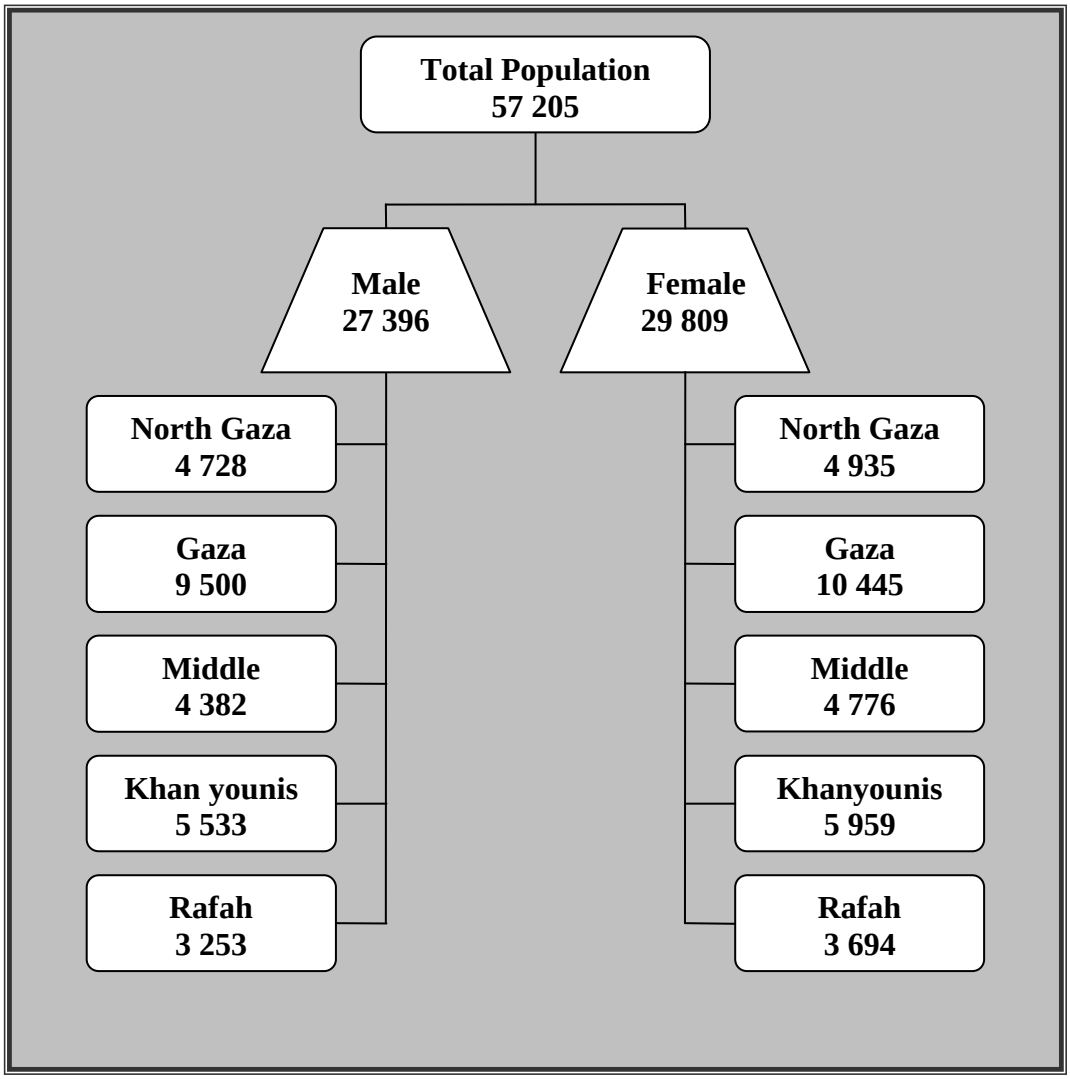


Figure 3: Distribution of the sample according to place of resident and gender

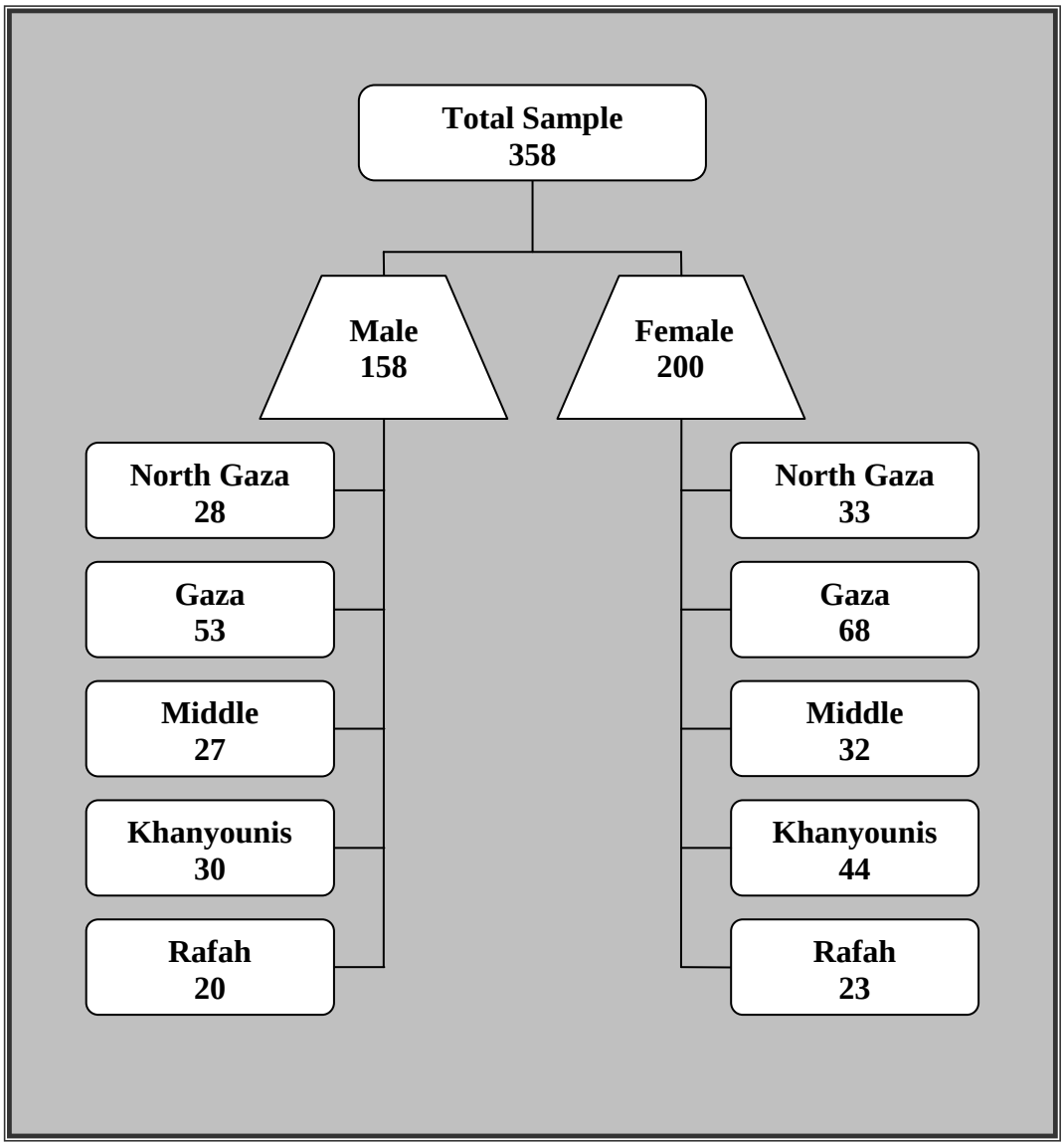
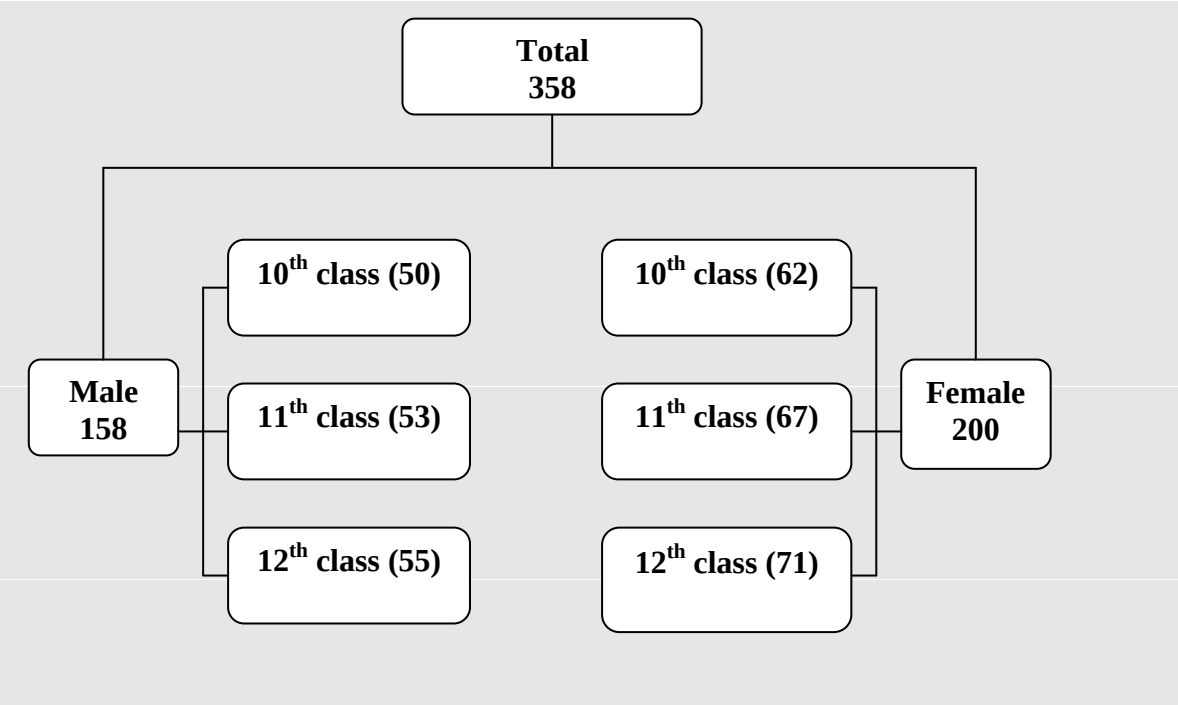


Figure 4: Distribution of the sample according to gender and educational class



3.5 Period of the Study

The study carried out in the second semester of the scholastic year 2008/2009. The duration of the study approximately 3 months in the period from 23/3/2009 to 13/4/2009.

3.6 Place of the Study

The study conducted on adolescents at randomly selected secondary school that belong to ministry of education. The schools distributed in all areas of Gaza Strip governorates. (North Gaza, Gaza, Middle zone, Khan younis, and Rafah).

3.7 Instruments of the study

The researcher used Sociodemographic status questionnaire, War on Gaza Traumatic Events Checklist (Thabet et al. 2009)), Spence Children's Anxiety Scale -(SCAS) (Spence, 1998) (Arabic version, Thabet 2008), Dépression Self- Rating Scale for Children (DSRS) (Birleson et al, 1987) (Arabic version, Thabet 2008), UCLA PTSD Index for DSM-IV: Adolescent Version (Rodriguez, Steinberg, & Pynoos, 1999) (Arabic version, Thabet 2008), and A-Cope Adolescent -Coping Orientation for Problem experiences (Patterson and McCubbin, 1987), that described in detail in the following section:

3.7.1 Sociodemographic status (developed by the researcher)

This was gathered from adolescents by questionnaire includes sex, age, place of residence, type of housing, number of sibling and rooms, father education and mother education, father work, mother work, and family income etc. (Annex 4)

3.7.2 War on Gaza Traumatic Events Checklist (Thabet et al. 2009)

Traumatic events were assessed by checklists that reflected the nature of violence, trauma and losses during the war on Gaza. Israeli military violence was assessed by the Gaza Traumatic Events Checklist for Israeli Violence (Thabet, Abdulla, El Helou, & Vostanis, 2006). This checklist consist of 30 items covering different types of traumatic events that child and adolescence may have been exposed to in the particular circumstances of the regional conflict and Israeli violence in the last year. This checklist cover three domains of trauma. The first domain cover witness acts of violence such as the killing of relatives, home demolition, bombardment, and injury of others. The second domain covers hearing experiences such as hearing o the killing or injury of friends or relatives. The third domain covers personal traumatic events such as being shot, or beaten. The checklist can be completed by children and adolescents aged 6-16 ('yes' or 'no'). In this study the reliability of the scale using Cronbach’s alpha was 0.92 and split half was 0.86 (Annex 5)

3.7.3 Spence Children's Anxiety Scale (SCAS) (Spence, 1998) (Arabic version, Thabet 2007)

This measure consists of 44 items, of which 38 reflect specific symptoms of anxiety and 6 relate to positive, filler items to reduce negative response bias. Of the 38 anxiety items, 6 reflect separation anxiety, 6 social phobia, 6 obsessive compulsive problems, 6 panic/3 agoraphobia, 6 generalized anxiety/overanxious symptoms and 5 items concern fears of

physical injury. Items are randomly allocated within the questionnaire. Children are asked to rate on a 4 point scale involving never (0), sometimes (1), often (2), and always (3), the frequency with which they experience each symptom. The instructions state " Please put a circle around the word that shows how often each of these things happens to you. There are no right and wrong answers". There are six, positively worded filler items. This scale was used previously in labour children in the Gaza Strip and showed that the internal consistency calculated using Cronbach's alpha, was α=0.85. The split half reliability of the scale was = 0.86 (Mater, Thabet, Vostanis, In press 2007). In this study the reliability of the scale using Cronbach's alpha was 0.88 and split half was 0.83 (Annex 6)

3.7.4 Dépression Self- Rating Scale for Children (DSRS) (Birleson et al ,1987) (Arabic version, Thabet 2008)

The Depression Self-Rating Scale for Children was developed in 1978 as part of a Masters of Philosophy Thesis at the University of Edinburgh. The scale emerged from a longer inventory of 37 items that had been described in the literature as associated with major depressive syndromes in childhood. These items were put into positive and negative statements, the order was randomized and the final inventory was given to four groups of children aged between 7 and 13 years. The test-retest reliability of the Scale on an independent sample showed satisfactory stability (0.80). Individual items had a reliability coefficient of 0.65-0.95. The Scale's corrected split-half reliability was 0.86. This scale has developed to measure depression among children and adolescent and it cover most of depression symptoms and it consists of 18 items and the Subjects reported on a 3-point scale (1 = No; 2=sometimes;3= Most of the time)**,** Responses to items are simply scored in the direction of disturbance, i.e. depressive items score 2, "sometimes" items score 1, and non-depressive items score 0. The scores are summed to give the total score. In this study the reliability of the scale using Cronbach's alpha was 0.80 and split half was 0.83. (Annex 7)

3.7.5 UCLA PTSD Index for DSM-IV: Adolescent Version (Rodriguez, Steinberg, & Pynoos, 1999) (Arabic version, Thabet 2008)

UCLA PTSD index for DSM-IV is a series of self- and parent- report instruments to screen both for exposure to traumatic events and for all DSM-IV PTSD symptoms in school-age children and adolescents who report traumatic stress experiences. These instruments are meant to serve as brief screening tools to provide information regarding trauma exposure

and PTSD symptoms. The items of the UCLA PTSD indices are keyed to DSM-IV criteria and can provide preliminary PTSD diagnostic information. Self-reports for children and adolescents exist, as well as a parent report of PTSD symptoms. The adolescent Version (for adolescent aged 13 years and older) contain a total of 22 questions , have also been administered in school classroom settings. A 5-point Likert scale from 0 (none of the time) to 4 (most all the time) is used to rate PTSD symptoms. The structure of the measure facilitates scoring. The first 18 questions on the child and adolescent version, and the first 19 questions on the parent version, assess for DSM-IV PTSD Criterion B, C, and D symptoms, three separate scores were computed from these 20 items for intrusive symptoms (Criterion B), avoidance symptoms (Criterion C), and hyperarousal symptoms (Criterion D). Questions 13-19 assess Criterion A1, and 20-22 assess for Criterion A2. The internal consistency of the Arabic version of the PTSD Adolescent Reaction Index was highly satisfactory (Cronbach's alpha = 0.88) and split half was 0.82. In this study the reliability of the scale using Cronbach's alpha was 0.85 and split half was 0.82. (Annex 8)

3.7.6 A-Cope Adolescent-Coping Orientation For Problem experiences (Patterson and McCubbin, 1987) (Arabic version, Thabet et al, 2004)

The Adolescents Coping Orientation for Problem Experiences (A-COPE Questionnaire, Patterson and McCubbin, 1987) is a self-report questionnaire consisting of 54 specific coping behaviour which adolescents may use to manage and adapt to stressful situations. Subjects reported on a 5-point scale (1 = Never; 5= Most of the time) to indicate how often they use each coping strategy when feeling tense or facing a problem or difficulty. Patterson and McCubbin (1987) used the factor analyses for the A-cope questionnaire and reported 12 subscales. This scale was translated to Arabic language and validated in this culture (Thabet et al, 2004). In this research, the split half reliability technique of the scale was high (r =.80). Internal consistency of the scale, calculated using Chronbach's alpha was (α= .84) (Annex 9)

3.8 Data collection

The researcher collected data through the distribution of questionnaires on governmental secondary schools in all areas of Gaza Strip governorates. (North Gaza, Gaza, Middle zone, Khan younis, and Rafah), y help of some teachers in those schools and trained psychologists in the period from 23/3/2009 to 12/4/2009.

3.9 Data entry and analysis

The collected data is processed and analyzed under the supervision of the academic supervisor and the statisticians. Data was entered by the statistical Package for Social Sciences (SPSS) software version 13 computer program for the data entry and analysis . This statistical program has a variety of options that is optimal for use in thus studies. Were data can be entered, labeled, coded and recorded as different variables, while the researcher used other statistical analysis that clarifying the differences between the groups such as frequencies, t- independent test, comparing means, one way A NOVA, and chi-square that also denoted the differences between the groups and within the groups of the study variables.

3.10 Eligibility criteria

3.10.1 Inclusion criteria

The inclusion criteria of the study were adolescents between 15-18 years old who reside of Gaza Strip and study in governmental secondary schools at (10^{th} class, 11^{th} class, and 12^{th} class) at the time of the study were eligible for the study.

3.10.2 Exclusion criteria

Adolescents younger than (15 years) and older than (18 years) of age were excluded from the study. In addition to adolescents who not learned in the secondary schools that belong to Palestinians ministry of education (private schools) were excluded from the study.

3.11 Ethical consideration

1- An approval letter was obtained from Helsinki Committee (Annex 2).

2- And an official letter was obtained from the General Director of Ministry of Education in order to conduct the study in governmental secondary schools and facilitate the process of data collection (Annex 3).

3- Every subject in the study had an explanatory letter about the study, this form includes the purpose of the research, confidentiality of information, the researcher explained to all adolescents that, participation is optional and emphasis confidentiality, ethical concept, respect for trust, and respect for people have been considered.

3.12 Limitation of the study

There are a number of limitations are predicted to apply the study

1. Possible mediating family and social factors were not examined.
2. Cultural factors may have affect the validity of the instruments.
3. Recent political violence and traumatic events due to factional fighting that might affect the adolescents psychological condition.

Chapter 4
*R*esults

Chapter 4
Results

4.1 Introduction

In this chapter the researcher clarified the main results of the study after data collection and analysis by using statistical tools of sample of 358 adolescents. The researcher used SPSS program for data entry and analysis. The researcher used many statistical test like descriptive statistics, frequencies, percentage, mean, standard deviation. In addition to differences between study variables using t- independent test and one- way ANOVA test.

4.2 Demographic characteristics of the study sample

The following table shows the demographic results of the study, which described the study sample according to sex, place of residence, type of residence, number of sibling, mother & father educational level, mother & father job, and monthly income.

The sample consist of 358 adolescents, 158 males (44.1%) and 200 females (55.9%), aged between 15-18 years (Mean = 16.7; SD =0.82). Adolescents coming from North Gaza were (19.6%), from Gaza (29.4%), from middle area (17.3%), from Khan younis (18.9%), and from Rafah (14.9%). According to number of siblings were (19%) of adolescents had 4 and less sibling, (48.3%) of adolescents had 5-7 siblings, and (32.7%) of adolescents had more than 8 siblings. According to place of residence, (66.2%) of the study sample live in cities, (26.0%) live in camps, and (7.8%) live in villages. According to family monthly income were (21.8%) of adolescents had family income less than 600 NIS, (28.5%) of adolescents had family income from 601-1200 NIS, (17.2%) were from 1201-2000 NIS, (10.9%) were from 2001-3000 NIS, and (19.6%) were from more than 3000 NIS

Table 1: Demographic characteristics of the study sample (N = 358)

Gender	**N**	**%**
Male	158	44.1
Female	200	55.9
Total	358	100.0
Place of residence		
North Gaza	70	19.6
Gaza	123	29.4
Middle zone	69	17.3
Khan younis	75	18.9
Rafah	21	14.9
Total	358	100.0

Type of residence	**N**	**%**
City	237	66.2
Camp	94	26.0
Village	27	7.8
Total	358	100.0
Number of Siblings		
4 and less	68	19
5-7 siblings	172	48.3
8 and above	118	32.7
Total	358	100.0
Mother Education		
illiterate	15	4.2
Primary	16	4.5
Preparatory	53	14.8
Secondary	154	43.0
Diploma	31	8.7
University	81	22.6
Higher education	8	2.2
Total	358	100.0
Father Education		
illiterate	18	5.0
Primary	27	7.5
Preparatory	53	14.8
Secondary	92	25.7
Diploma	27	7.5
University and higher	141	39.4
Total	358	100.0
Mother Job	**N**	**%**
House wife	295	82.4
Employee	61	17.0
Others	3	.9
Total	358	100.0
Father Job		
Unemployed	98	27.4
Employee	143	39.8
Worker	42	11.8
Maker	6	1.7
Farmer	8	2.5
Business	38	10.6
Others	23	6.4
Total	358	100.0
Family income by 'NIS'		
600 and less	109	30.4
601 - 1200	78	21.8
1201 - 2000	62	17.3
2001 – 3000	39	10.9
More than 3000 NIS	70	19.6
Total	358	100.0

4.3 Frequencies of traumatic events

4.3.1 Frequencies of traumatic events of the study sample

The following table describe the most traumatic events due to political violence and its frequency among study sample. The researcher found that mean total traumatic events was 13.34 (SD =7.37). while the highest traumatic event 90.8% of study sample watching mutilated bodies on TV, 88.5% hearing shelling of the area by artillery, 86.6% witnessing the signs of shelling on the ground, and 86.0% hearing the sonic sounds of the jetfighters. While, the least percent of traumatic events were physical injury due to bombardment of your home 21.8%, 22.9 being arrested during the last incursion, 24.0% shooting by bullets, rocket, or bombs, and 24.3% threatened to death by being used as human shield to arrest your neighbors by the army. While, 9.2% among study sample able to protect themselves and only 13.4 % feel save at home.

Table 2: Frequency of traumatic events of the study sample (N=358)

No	Traumatic events	Yes	%
14.	Watching mutilated bodies on TV	325	90.8
3.	Hearing shelling of the area by artillery	317	88.5
16.	Witnessing the signs of shelling on the ground	310	86.6
4.	Hearing the sonic sounds of the jetfighters	308	86.0
15.	Witnessing assassination of people by rockets	240	67.0
21.	Deprivation from water or electricity during detention at home	226	63.1
2.	Hearing killing of a close relative	217	60.6
1.	Hearing killing of a friend	215	60.1
5.	Hearing of arrest of someone or a friend	199	55.6
12.	Witnessing firing by tanks and heavy artillery at neighbors homes	187	52.2
19.	Being detained at home during incursion	180	50.3
30.	Forced to leave your home during the war	175	48.9
22.	Threaten by shooting	165	46.1
11.	Witnessing of a friend home demolition	158	44.1
23	Destroying of your personal belongings during incursion	117	32.7
8.	Witnessing shooting of a friend	113	31.6
25.	Threaten of family member of being killed	108	30.2
28.	Exposure to burn by bombs and phosphorous bombs	108	30.2
6.	Witnessing killing of a friend	107	29.9
27.	Deprivation from going to toilet and leave the room at home where you was detained	102	28.5
13.	Witnessing firing by tanks and heavy artillery at own home	99	27.7
9.	Witnessing shooting of a close relative	98	27.4
7.	Witnessing killing of a close relative	95	26.5
10.	Witnessing of own home demolition	93	26.0

20.	Beating and humiliation by the army	93	26.0
24.	Threaten of being killed	87	24.9
26.	Threatened to death by being used as human shield to arrest your neighbors by the army	89	24.3
17.	Shooting by bullets, rocket, or bombs	86	24.0
29.	Being arrested during the last incursion	82	22.9
18.	Physical injury due to bombardment of your home	78	21.8

4.3.2 Means and Standard deviation of traumatic events of the study sample

The following table shows means and standard deviation of traumatic events that adolescents expose, mean total 13.34 (SD =7.37).

Table 3: Means and standard deviation of traumatic events of the study sample (N=358)

Variables	Mean	Std. Deviation
Traumatic events	13.34	7.37

4.3.3 Frequencies of feeling of safety toward traumatic events of the study sample

The following table describe the feeling of safety and protection among adolescent toward traumatic events. The researcher found that 86.6% of study sample didn't feel save at home, while 90.8**%** were unable to protect themselves, 81.8% of study sample were unable to protect their families during the war, and 79.6% don't think that others were able to protect them.

Table 4:

Frequency of feeling of safety toward traumatic events of the study sample (N=358)

No	Items	Freq.	Percent	Freq.	Percent
		No	%	Yes	%
1.	Feel save at home	310	86.6	48	13.4
2.	Able to protect self	325	90.8	33	9.2
3.	Able to protect your family	293	81.8	65	18.2
4.	Others were able to protect them	285	79.6	73	20.4

4.3.4 Gaza War experiencing according to sex of the study sample

In order to investigate the sex differences in traumatic events due to Gaza War among study sample. T independent test was performed. As shown in the following table: The results showed that there were significant differences in traumatic events due to Gaza War according to sex with actual probability (t =3.48; df =356; P =0.001) in favor to males, this means that males expose to traumatic events more than females.

Table 5:

T-independent test comparing mean of Gaza War experiencing according to sex of the study sample (N=358)

Variables	Males N = 158		Females N =200		t – value df = 356	Significant level
	Mean	*SD*	*Mean*	*SD*		
Political violence	14.85	7.47	12.16	7.09	3.48	**0.001

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

4.3.5 Gaza War experiencing according to educational class

In order to investigate the differences in traumatic events due to Gaza War according to educational class of the study sample (10^{th}, 11^{th}, 12^{th}). One-way ANOVA was performed. As shown in the following table: The results showed that there were significant difference in traumatic events (f=6.88; p=0.001) according to educational class of the study sample.

Table 6:

One-way ANOVA comparing of Gaza War experiencing according to educational class of the study sample (N=358)

Variable	Source of variables	Sum of Squares	df	Mean Square	F– value	Significant level
Traumatic events	Between Groups	725.327	2	362.664	6.886	**.001
	Within Groups	18695.413	355	52.663		
	Total	19420.740	357			

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

As shown in the following table: The results showed that there were significant difference in traumatic events according to educational class of the study sample (mean=14.17; SD= 7.50) in favor to 11^{th} educational class.

Table 7:

Mean and standard deviation of Gaza War experiencing according to educational class of the study sample (N=358)

Variable		N	Mean	Std. Deviation
Traumatic events	10th	84	10.77	6.22539
	11th	159	14.17	7.50207
	12th	115	14.08	7.60096
	Total	358	13.34	7.37562

4.3.6 Gaza War experiencing according to type of residence of the study sample

In order to investigate the differences in traumatic events due to Gaza War according to type of residence of the study sample (city, village, camp). One-way ANOVA was performed. As shown in the following table: The results showed that there were significant difference in traumatic events (f=7.411; p=0.001) according to type of residence of the study sample.

Table 8:

One-way ANOVA comparing of Gaza War experiencing according to type of residence of the study sample (N=358)

Variable	Source of variables	Sum of Squares	df	Mean Square	F– value	Significant level
Traumatic events	Between Groups	778.389	2	389.194	7.411	**.001
	Within Groups	18642.351	355	52.514		
	Total	19420.740	357			

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

As shown in the following table: The results showed that there were significant difference in traumatic events according to type of residence of the study sample (mean=15.07; SD= 6.82) in favor to village.

Table 9:

Mean and standard deviation of Gaza War experiencing according to type of residence of the study sample (N=358)

Variable		N	Mean	Std. Deviation
Traumatic events	City	237	14.10	7.74804
	Camp	93	10.89	5.91325
	Village	28	15.07	6.82549
	Total	358	13.34	7.37562

4.3.7 Gaza War experiencing according to family income of the study sample

In order to investigate the differences in traumatic events due to Gaza War according to family income of the study sample (600 NIS and less, 601 – 1200, 1201 – 2000, 2001 – 3000, More than 3000 NIS). One-way ANOVA was performed. As shown in the following table: The results showed that there were significant difference in traumatic events (f=3.073; p=0.006) according to family income of the study sample.

Table 10:
One-way ANOVA comparing of Gaza War experiencing according to family income of the study sample (N=358)

Variable	Source of variables	Sum of Squares	df	Mean Square	F– value	Significant level
Traumatic events	Between Groups	969.232	6	161.539	3.073	*.006
	Within Groups	18451.508	351	52.568		
	Total	19420.740	357			

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

As shown in the following table: The results showed that there were significant difference in traumatic events according to family income of the study sample (mean=15.49; SD= 9.060) in favor to family income (2001 – 3000 NIS).

Table 11:

Mean and standard deviation of Gaza War experiencing according to family income of the study sample (N=358)

Variable		N	Mean	Std. Deviation
Traumatic events	600 and less	102	15.00	7.56752
	601 - 1200	78	11.52	6.99856
	1201 - 2000	62	13.45	6.96991
	2001 – 3000	40	15.49	9.06082
	More than 3000 NIS	76	11.49	5.89522
	Total	358	13.34	7.37562

4.4 Frequencies and prevalence of mental health problems

4.4.1 Frequency of Anxiety scale items of the study sample

The following table describe the most Anxiety items and its frequency among study sample. The researcher found that the highest Anxiety item was 60.9% of study sample" I am liked between my peers in the same age", 53.4% "I had good character" and 48.3% "I have to do some things over and over again (like washing my hands, cleaning or putting together)". While, the lowest Anxiety item was "I feel scared if I have to travel in the car, or on a bus or at rain", 2.5%, 3.4% "I feel afraid if I have to talk in front of my class", and "My heart suddenly starts to beat too quickly for no reason" 4.5%. While 32.1% among study sample had scared from other things.

Table 12: Frequency of Anxiety items of the study sample (N=358)

No	Items	Never	Sometimes	Often	Always
		%	%	%	%
11.	I am liked between my peers in the same age	5.0	10.3	23.7	60.9
26.	I had good character	3.4	14.2	29.1	53.4
40.	I have to do some things over and over again (like washing my hands, cleaning or putting	13.1	20.7	17.6	48.3
20.	When I have a problem, my heart beats really fast	7.5	30.4	16.2	45.8
43.	I am proud of my school work	9.2	21.8	24.9	43.9
33.	I am scared of insects or spiders	35.5	16.2	10.6	37.7
18.	I am scared of dogs	34.6	19.6	9.2	36.6
42.	I have to do some things in just the right way	10.3	29.9	23.2	36.3
14.	I have to keep checking that I have done things right	21.5	28.8	14.8	34.9
6.	I feel scared when 1 have to take a test	13.4	36.3	17.0	33.2
38.	I like my self	15.9	33.0	18.7	32.4
17.	I am good in sport	22.6	32.1	14.5	30.7
12.	I worry that something awful will happen to.	18.7	39.4	12.3	29.6
10.	l worry that I will d o badly at my school work	21.2	33.8	15.9	29.1
44.	I would feel scared if I had to stay away from	40.2	26.5	7.5	25.7
8.	I worry a bout being away from my parents	36.0	31.3	7.3	25.4
9.	I feel a afraid that I will make a fool of myself in	36.0	26.8	12.6	24.6
1.	I worry about things	6.1	55.0	14.5	24.3
41.	I get bothered by bad or silly thoughts or pictures in my mind	23.7	39.7	15.9	20.4
2.	I am scared of the dark	24.3	27.1	7.3	20.1
5.	I would feel afraid o f being on my own at home. .	44.9	25.3	9.8	19.9
22.	I worry that something bad will happen to me	20.1	43.3	17.3	19.3
31.	I feel happy	15.1	41.1	24.9	19.0
24.	When I have a problem, I feel shaky	30.7	36.0	14.2	19.0
29.	I worry what other people think of me	31.0	39.7	11.7	17.3
7.	I feel a afraid if I have to use public toilets	50.0	23.7	10.1	16.2
4.	I feel afraid	23.8	48.7	11.5	16.0
19.	I can't seem to get bad or silly thoughts out of my head	25.1	47.5	14.0	13.4
15.	I feel scared if I have to sleep on my own	56.0	24.4	6.7	12.9
23	I am scared of going to the doctors or dentists	55.9	21.5	9.8	12.8
39.	I am afraid o f being in small closed places, like tunnels or small rooms	56.9	22.7	8.7	11.8
3.	When I have a problem, I get a funny	40.3	38.4	10.4	10.9

34.	I suddenly become dizzy or faint	48.9	34.1	6.7	10.3
25.	I am scared o f being in high places o r lifts (elevators)	58.7	24.9	6.4	10.1
27.	I have to think of special thoughts to stop bad	41.9	35.5	14.0	8.7
30.	I am a afraid of being in crowded places (like shopping centers, the movies, buses)	59.5	24.0	8.9	7.5
13.	I suddenly feel as if can 't breath e when there is no reason for this	64.8	19.8	7.8	7.5
21.	I suddenly start to tremble or shake when there is no reason for this	55.6	29.9	7.0	7.5
32.	All o f a sudden I feel really scared form of me	57.5	31.6	4.2	6.7
37.	I worry that I will suddenly get a scared feeling when there is no thing to be a afraid of	56.0	32.5	5.9	5.6
16.	I have trouble going to school in the mornings because ! feel nervous or afraid	73.5	16.8	4.2	5.6
36.	My heart suddenly starts to be at too quickly f o r no reason	64.2	25.1	6.1	4.5
35.	I feel afraid if I have to talk in front of my class	68.4	24.9	3.4	3.4
28.	I feel scared if I have to travel in the car, or on a bus or at rain	84.1	9.2	4.2	2.5

4.4.2 Prevalence of Anxiety among the study sample

The following table shows that the total weight mean for Anxiety (37.0%), and the highest score for obsessive compulsive subscale (49.4%), then (45.8%) for Generalized Anxiety subscale, social phobia subscale (38.8%), physical injury fears subscale (36.5%), and then separation Anxiety subscale (34.2%), and the least score for panic/Agoraphobia subscale (20.0%).

Table 13: Mean, standard deviation and weight mean of Anxiety subscale. (N=358)

No	Anxiety Subscale	items	Mean	SD	Weight mean %
1.	Obsessive Compulsive	6	8.9	3.4	49.4
2.	Generalized Anxiety	6	8.3	3.8	45.8
3.	Social Phobia	6	7.0	3.7	38.8
4.	Physical Injury Fears	5	5.5	4.0	36.5
5.	Separation Anxiety	6	6.2	4.3	34.2

6.	Panic/Agoraphobia	9	5.4	6.6	20.0
Total score		**38**	**41.1**	**18.3**	**36.0**

4.4.3 Anxiety according to sex of the study sample

In order to investigate the sex differences in Anxiety and its dimensions, among study sample, T independent test was performed. As shown in the following table: The results showed that there were significant differences in Anxiety and its subscales according to sex actual probability ((t = -12.43; df =352; P =0.001) in favor to females**,** this means that girls suffer from Anxiety subscales (panic/Agoraphobia, separation Anxiety, physical Injury Fears, social Phobia, obsessive compulsive, Generalized Anxiety) more than boys.

Table 14: T-independent test comparing mean of Anxiety according to sex (N=358)

Variables	Sex	No	Mean	SD	t –value	Significant level
Panic/Agoraphobia	Male	158	3.93	3.64	-5.66	**0.001
	Female	198	6.58	4.91		
Separation Anxiety	Male	158	3.58	3.13	-11.70	**0.001
	Female	198	8.20	4.09		
Physical Injury Fears	Male	158	3.44	2.42	-15.10	**0.001
	Female	200	8.07	3.19		
Social Phobia	Male	158	5.25	3.31	-8.65	**0.001
	Female	200	8.35	3.39		
Obsessive Compulsive	Male	158	7.99	3.15	-4.63	**0.001
	Female	200	9.62	3.41		
Generalized Anxiety	Male	158	6.14	2.91	-10.76	**0.001
	Female	198	9.93	3.58		
Total Anxiety	Male	158	41.31	13.76	-12.43	**0.001
	Female	196	61.53	16.29		

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

4.4.4 Anxiety according to educational class of the study sample

In order to investigate the differences in Anxiety according to educational class of the study sample (10^{th}, 11^{th}, 12^{th}). One-way ANOVA was performed. As shown in the following table: The results showed that there were no significant difference in Anxiety (f=1.114; p=.329) and its dimensions (panic/agoraphobia, separation anxiety, physical injury fears, social phobia, obsessive compulsive disorder, Generalized anxiety) according to educational class of the study sample.

Table 15:

One-way ANOVA comparing Anxiety according to educational class (N=358)

Variable	Source of variables	Sum of Squares	df	Mean Square	F– value	Significant level
Panic/agoraphobia	Between Groups	172.716	2	86.358	4.183	.016
	Within Groups	7287.225	353	20.644		
	Total	7459.941	355			
Separation anxiety	Between Groups	85.271	2	42.635	2.269	.105
	Within Groups	6633.920	353	18.793		
	Total	6719.191	355			
Physical injury fears	Between Groups	122.124	2	61.062	4.595	.011
	Within Groups	4717.597	355	13.289		
	Total	4839.721	357			
Social phobia	Between Groups	8.296	2	4.148	.303	.739
	Within Groups	4857.659	355	13.684		
	Total	4865.955	357			
Obsessive compulsive disorder	Between Groups	54.154	2	27.077	2.369	.095
	Within Groups	4057.424	355	11.429		
	Total	4111.578	357			
Generalized anxiety	Between Groups	25.489	2	35.761	2.492	.084
	Within Groups	31289.373	2	14.349		
	Total	31314.862	353			
Total anxiety	Between Groups	740.227	2	370.114	1.114	.329
	Within Groups	116578.24	351	332.132		
	Total	117318.47	353			

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

4.4.5 Anxiety according to type of residence of the study sample

In order to investigate the differences in Anxiety according to type of residence of the study sample (city, village, camp). One-way ANOVA was performed. As shown in the following table: The results showed that there were no significant difference in Anxiety (f=3.071; p=.048) and its dimensions (panic/agoraphobia, separation anxiety, physical injury fears, social phobia, obsessive compulsive disorder, Generalized anxiety) according to type of residence of the study sample.

Table 16 :

One-way ANOVA comparing Anxiety according to type of residence (N=358)

Variable	Source of variables	Sum of Squares	df	Mean Square	F– value	Significant level
Panic/agoraphobia	Between Groups	4.599	2	2.300	.109	.897
	Within Groups	7455.342	353	21.120		
	Total	7459.941	355			
Separation anxiety	Between Groups	126.334	2	63.167	3.382	.035
	Within Groups	6592.857	353	18.677		
	Total	6719.191	355			
Physical injury fears	Between Groups	135.019	2	67.509	5.094	.007
	Within Groups	4704.702	355	13.253		
	Total	4839.721	357			
Social phobia	Between Groups	8.424	2	4.212	.308	.735
	Within Groups	4857.532	355	13.683		
	Total	4865.955	357			
Obsessive compulsive disorder	Between Groups	9.161	2	4.580	.396	.673
	Within Groups	4102.417	355	11.556		
	Total	4111.578	357			
Generalized anxiety	Between Groups	66.699	2	33.350	2.322	.100
	Within Groups	5070.051	353	14.363		
	Total	5136.750	355			
Total anxiety	Between Groups	2017.826	2	1008.91	3.071	.048
	Within Groups	115300.64	351	328.492		
	Total	117318.47	353			

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

4.4.6 Anxiety according to family income of the study sample

In order to investigate the differences in Anxiety according to family income of the study sample (600 NIS and less, 601 – 1200, 1201 – 2000, 2001 – 3000, More than 3000 NIS). One-way ANOVA was performed. As shown in the following table: The results showed that there were no significant difference in Anxiety (f=.617; p=.717) and its dimensions (panic/agoraphobia, separation anxiety, physical injury fears, social phobia, obsessive compulsive disorder, Generalized anxiety) according to family income of the study sample.

Table 17 :

One-way ANOVA comparing Anxiety according to family income (N=358)

Variable	Source of variables	Sum of Squares	df	Mean Square	F– value	Significant level
Panic/agoraphobia	Between Groups	93.537	6	15.590	.739	.619
	Within Groups	7366.404	349	21.107		
	Total	7459.941	355			
Separation anxiety	Between Groups	135.177	6	22.529	1.194	.309
	Within Groups	6584.014	349	18.865		
	Total	6719.191	355			
Physical injury fears	Between Groups	87.366	6	14.561	1.075	.377
	Within Groups	4752.355	351	13.539		
	Total	4839.721	357			
Social phobia	Between Groups	52.265	6	8.711	.635	.702
	Within Groups	4813.691	351	13.714		
	Total	4865.955	357			
Obsessive compulsive disorder	Between Groups	31.340	6	5.223	.449	.845
	Within Groups	4080.239	351	11.625		
	Total	4111.578	357			
Generalized anxiety	Between Groups	59.920	6	9.987	.687	.661
	Within Groups	5076.830	349	14.547		
	Total	5136.750	355			
Total anxiety	Between Groups	1238.706	6	206.451	.617	.717
	Within Groups	116079.76	347	334.524		
	Total	117318.47	353			

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

4.4.7 Frequency of depression scale items

The following table describe the most depression items and its frequency among study sample. The researcher found that 65.6% "I like talking with my family", 56.4% "I can stick up for myself", and "I think life isn't worth living" 36.0%. While the least frequent items were "I have lots of energy" 7.8% , 12.3% "I feel so sad I can hardly stand it" and "I feel very lonely" 14.5%.

Table 18: Frequency of depression items of the study sample (N=358)

No	Items	Never	Sometime	Always
		%	%	%
13.	I like talking with my family	10.1	24.3	65.6
9.	I can stick up for myself	5.3	38.3	56.4
10.	I think life isn't worth living	12.6	51.4	36.0
8.	I enjoy my food	12.6	52.8	34.6
11.	I am good at the things I do	7.0	61.7	31.3

16.	I am easily cheered up	20.1	49.4	30.2
6.	I get tummy aches	14.8	56.1	29.1
18.	I feel very bored	15.4	55.6	29.1
2.	I sleep very well	18.4	53.9	27.7
1.	I look forward to things as much as I used to..	17.6	57.0	25.4
4.	I like to go out to play	41.9	32.7	25.4
12.	I enjoy the things I do as much as I used to	27.4	47.5	25.1
5.	I feel like running away	43.0	32.1	24.9
3.	I feel like crying	24.3	52.0	23.7
14.	I have bad dreams	29.3	54.5	16.2
15.	I feel very lonely	47.8	37.7	14.5
17.	I feel so sad I can hardly stand it	46.1	41.6	12.3
7.	I have lots of energy	51.1	41.1	7.8

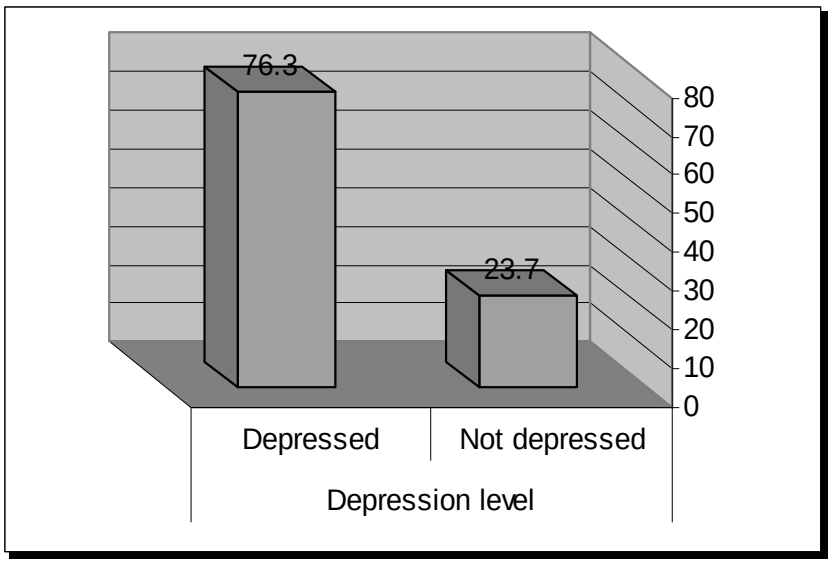
4.4.8 Prevalence of depression among of the study sample

The following table shows that 76.3% of study sample are depressed manifestations (cutoff point >=17) while 23.7% of study sample are not depress (cutoff point <17)**,** (mean =19.6; SD = 4.5). (Table 8), (Figure 5).

Table 19: The prevalence of depression manifestations levels (N=358)

Variables		**Freq. N**	**Percent %**
Depression level	No depression manifestations	85	23.7
	Depression manifestations	273	76.3
Total		**358**	**100.0**

Figure 5: The prevalence of depression manifestations levels (N=358)



4.4.9 Depression manifestations according to sex of the study sample

In order to investigate the sex differences in depression, among study sample, T independent test was performed. As shown in the following table: The results showed that there were significant differences in depression according to sex actual probability (t = 2.94; df =356; P =0.003) in favor to boys**,** this means that males suffer from depression more than girls.

Table 20:

T-independent test comparing mean of depression manifestations according to sex

Variables	Sex	No	Mean	SD	t –value	Significant level
depression	Male	158	20.98	3.24	2.94	**0.003
	Female	200	19.90	3.58		

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

4.4.10 Depression manifestations according to educational class of the study sample

In order to investigate the differences in Depression according to educational class of the study sample (10^{th}, 11^{th}, 12^{th}). One-way ANOVA was performed. As shown in the following table: The results showed that there were no significant difference in depression (f=.326; p=.722) according to educational class of the study sample.

Table 21:

One-way ANOVA comparing depression according to educational class (N=358)

Variable	Source of variables	Sum of Squares	df	Mean Square	F– value	Significant level
Depression	Between Groups	7.875	2	3.937	.326	.722
	Within Groups	4288.461	355	12.080		
	Total	4296.335	357			

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

4.4.11 Depression manifestations according to type of residence of the study sample

In order to investigate the differences in Depression according to type of residence of the study sample (city, village, camp). One-way ANOVA was performed. As shown in the following table: The results showed that there were no significant difference in depression (f=2.090; p=.125) according to type of residence of the study sample.

Table 22 :

One-way ANOVA comparing depression manifestations according to type of residence (N=358)

Variable	Source of variables	Sum of Squares	df	Mean Square	F– value	Significant level
Depression	Between Groups	50.000	2	25.000	2.090	.125
	Within Groups	4246.335	355	11.962		
	Total	4296.335	357			

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

4.4.12 Depression according to family income of the study sample

In order to investigate the differences in Depression according to family income of the study sample (600 NIS and less, 601 – 1200, 1201 – 2000, 2001 – 3000, More than 3000 NIS). One-way ANOVA was performed. As shown in the following table: The results showed that there were no significant difference in depression (f=.520; p=.793) according to family income of the study sample.

Table 23 :

One-way ANOVA comparing depression manifestations according to family income (N=358)

Variable	Source of variables	Sum of Squares	df	Mean Square	F– value	Significant level
Depression	Between Groups	37.831	6	6.305	.520	.793
	Within Groups	4258.505	351	12.132		
	Total	4296.335	357			

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

4.4.13 Frequency of PTSD scale items

The following table describe the most PTSD items and its frequency among study sample. The table shows that the item " I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me" is the most frequent one (14.8%), then the item "I think that I will not live a long life (14.5%) , then the item " I try not to talk about, think about, or have feelings about what happened (14.2%). While the least frequent items were "I feel like staying by myself and not being with my friends" (3.1%), then "I feel alone inside and not close to other people "(3.6%), and then " I have trouble remembering important parts of what happened" (4.5%).

Table 24: Frequency of PTSD items of the study sample (N=358)

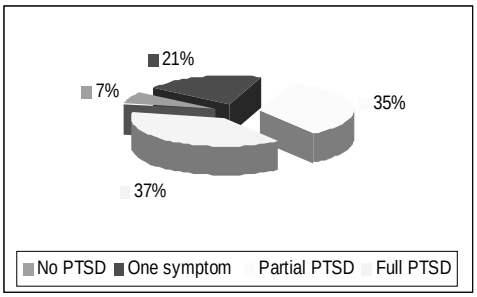
No	Items	None	Little	Some	Much	Most
		%	%	%	%	%
12.	I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me.	21.8	18.4	22.6	22.3	14.8
19.	I think that I will not live a long life.	30.2	13.1	23.5	18.7	14.5
9.	I try not to talk about, think about, or have feelings about what happened.	29.1	22.1	24.0	14.2	14.2
2.	When something reminds me of what happened, I get very upset, afraid.	15.1	17.9	30.7	22.6	13.7
17.	I try to stay away from people, places, or things that make me remember what happened.	24.9	20.7	21.5	19.8	13.1
22.	I am afraid that the bad thing will happen again.	19.0	22.1	23.2	22.6	13.1
6.	I feel like I am back at the time when the bad thing happened, living through it again.	26.5	20.1	25.4	16.2	11.7
3.	I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I do not want them to.	22.1	22.3	27.9	16.2	11.5
1.	I watch out for danger or things that I am afraid of.	13.7	33.2	22.3	20.1	10.6
18.	When something reminds me of what happened, I have strong feelings in my body, like my heart beat, my headache, or my stomach aches.	31.6	20.9	19.8	18.4	9.2
14.	I think that some part of what happened is my fault.	29.7	20.4	28.9	12.9	8.1
13.	I have trouble going to sleep or I wake up often during the night	42.6	18.5	17.1	14.6	7.3
5.	I have dreams about what happened or other bad dreams.	36.6	26.5	20.1	9.8	7.0
20.	I have arguments or physical fights.	46.4	22.9	15.1	9.5	6.1
21.	I feel pessimistic or negative about my future.	36.6	22.3	18.2	17.0	5.9
16.	I have trouble concentrating or paying attention.	28.2	28.5	22.9	14.8	5.6
4.	I feel grouchy, angry or mad.	19.3	27.1	32.4	15.9	5.3
10.	I have trouble feeling happiness or love.	43.7	21.3	20.7	9.5	4.8
15.	I have trouble remembering important parts of what happened	43.6	20.4	22.9	8.7	4.5
11.	I have trouble feeling sadness or anger.	36.9	29.3	19.0	10.9	3.9
8.	I feel alone inside and not close to other people.	52.2	17.9	18.7	7.5	3.6
7.	I feel like staying by myself and not being with my friends	60.6	16.8	14.0	5.6	3.1

4.4.14 Prevalence of PTSD among the study sample

The following table shows that 25 of study sample have no PTSD (6.7%), 74 of study sample have Two symptoms & less (20.5%), 125 of study sample have partial PTSD (35.1%), while 134 of study sample have full PTSD (37.6%) according to DSM-VI.

Table 25: The prevalence of PTSD level of the study sample (N=358)

Variables		Frequency N	Percent %
PTSD level	No PTSD	25	6.7
	One symptom	74	20.5
	Two symptoms	125	35.1
	Full PTSD	134	37.6
Total		**358**	**100.0**



4.4.15 Prevalence of PTSD subscales among the study sample

The following table shows that 34 of study sample fulfill criterion (B) (re-experiencing) 9.5% (mean = 8.2; SD = 4.2) while 120 of study sample fulfill criterion (C**)** (avoidance) 33.3% (mean = 8.5; SD = 4.8), and 191 of study sample fulfill criterion (D) (Increase arousal) 53.2% (mean = 8.0; SD = 3.7).

Table 26: Means and Standard deviation of PTSD subscales of the study sample (N=358)

PTSD subscale	Frequency N	Percent %	Mean	Std. Deviation
Criterion (D) Increase arousal	191	53.2	8.0	3.7
Criterion (C**)** Avoidance	120	33.3	8.5	4.8
Criterion (B) Re-experiencing	34	9.5	8.2	4.2

4.4.16 PTSD according to sex of the study sample

In order to investigate the sex differences in mental health (PTSD and its subscales), among study sample, T independent test was performed. As shown in the following table: The results showed that there are significant differences in PTSD according to sex actual probability (t = -4.14; df =356; P =0.001) in favor to females**,** this means that girls suffer from PTSD more than boys. As well as the results showed that there are significant differences in PTSD subscales (Re-experiencing, Increase arousal) in favor to females, while there were no significant differences in PTSD subscale (avoidance) according to sex actual probability (t = -1.83; df =358; P =0.067).

Table 27: T-independent test comparing mean of PTSD according to sex (N=358)

Variables	Sex	No	Mean	SD	t –value	Significant level
Re-experiencing	Male	158	6.86	3.78	-5.44	***0.001
	Female	200	9.20	4.16		
Avoidance	Male	158	7.99	4.31	-1.83	//0.067
	Female	199	8.92	5.11		
Increase arousal	Male	158	7.19	3.43	-3.61	***0.001
	Female	199	8.59	3.75		
Total PTSD	Male	158	19.22	8.49	-4.14	***0.001
	Female	198	23.28	9.69		

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

4.4.17 PTSD according to educational class of the study sample

In order to investigate the differences in mental health problems according to educational class of the study sample (10^{th}, 11^{th}, 12^{th}). One-way ANOVA was performed. As shown in the following table: The results showed that there were no significant difference in PTSD (f=.144; p=.866) and its dimensions (re-experiencing, avoidance, hyperarousal) according to educational class of the study sample.

Table 28: One-way ANOVA comparing PTSD according to educational class (N=358)

Variable	Source of variables	Sum of Squares	df	Mean Square	F– value	Significant level
Re-experiencing	Between Groups	38.447	2	19.224	1.117	.329
	Within Groups	6112.111	355	17.217		
	Total	6150.559	357			
Avoidance	Between Groups	69.588	2	34.794	1.523	.219
	Within Groups	8085.645	354	22.841		
	Total	8155.232	356			
Hyper-arousal	Between Groups	24.976	2	12.488	.924	.398
	Within Groups	4784.744	354	13.516		
	Total	4809.720	356			
Total PTSD	Between Groups	25.489	2	12.744	.144	.866
	Within Groups	31289.373	353	88.638		
	Total	31314.862	355			

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

4.4.18 PTSD according to type of residence of the study sample

In order to investigate the differences in PTSD according to type of residence of the study sample (city, village, camp). One-way ANOVA was performed. As shown in the following table: The results showed that there were no significant difference in PTSD (f=.472;

p=.624) and its dimensions (re-experiencing, avoidance, hyperarousal) according to type of residence of the study sample.

Table 29: One-way ANOVA comparing PTSD according to type of residence

Variable	Source of variables	Sum of Squares	df	Mean Square	F– value	Significant level
Re-experiencing	Between Groups	4.334	2	2.167	.125	.882
	Within Groups	6146.225	355	17.313		
	Total	6150.559	357			
Avoidance	Between Groups	52.517	2	26.258	1.147	.319
	Within Groups	8102.716	354	22.889		
	Total	8155.232	356			
Hyperarousal	Between Groups	21.905	2	10.952	.810	.446
	Within Groups	4787.815	354	13.525		
	Total	4809.720	356			
Total PTSD	Between Groups	83.473	2	41.736	.472	.624
	Within Groups	31231.390	353	88.474		
	Total	31314.862	355			

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

4.4.19 PTSD according to family income of the study sample

In order to investigate the differences in PTSD according to family income of the study sample (600 NIS and less, 601 – 1200, 1201 – 2000, 2001 – 3000, More than 3000 NIS). One-way ANOVA was performed. As shown in the following table: The results showed that there were no significant difference in PTSD (f=.737; p=.620) and its dimensions (re-experiencing, avoidance, hyper-arousal) according to family income of the study sample.

Table 30: One-way ANOVA comparing PTSD according to family income (N=358)

Variable	Source of variables	Sum of Squares	df	Mean Square	F– value	Significant level
Re-experiencing	Between Groups	51.693	6	8.615	.496	.811
	Within Groups	6098.866	351	17.376		
	Total	6150.559	357			
Avoidance	Between Groups	122.197	6	20.366	.887	.504
	Within Groups	8033.036	350	22.952		
	Total	8155.232	356			
Hyper-arousal	Between Groups	91.946	6	15.324	1.137	.340
	Within Groups	4717.774	350	13.479		
	Total	4809.720	356			
Total PTSD	Between Groups	392.002	6	65.334	.737	.620
	Within Groups	30922.860	349	88.604		
	Total	31314.862	355			

4.5 The frequencies and prevalence of coping strategies

4.5.1 Frequencies of Coping scale items

The following table describe the most coping items and its frequency among study sample. The table shows that the item " try to improve yourself (get body in shape, get better grades, etc.) 58.9%, then the item "try to keep up friendships or make new friends" 45.5%, and then " go a long with parents and rules 40.2%. While, the least frequent items were " try to see the good things in a difficult situation 0.6%, then " get professional counseling (not from a school teacher or school counselor) 1.4%, and then " use drugs (not prescribed by doctor) 2.5%.

Table 31: The Frequencies of Coping items (N=358)

No	Items	None	Little	Sometimes	Usually	Always
		%	%	%	%	%
13.	Try to improve yourself (get body in shape, get better grades, etc.)	4.5	7.3	13.7	15.6	58.9
35.	Try to keep up friendships or make new friends	8.1	9.8	20.7	15.9	45.5
1.	Go a long with parents and rules	4.7	8.4	19.8	26.8	40.2
7.	Eat food	13.1	14.5	15.4	17.0	39.9
41.	Do things with your family	10.6	14.5	22.1	20.1	32.7
15.	Try to think of the good things in your life	5.6	10.6	29.1	22.9	31.8
30.	Try to help other people solve their problems	7.5	9.2	27.9	23.7	31.6
29.	Be close with someone you care about	10.3	13.7	25.1	19.6	31.3
33.	Work on a hobby you have (sewing, model building, etc.)	17.6	13.7	27.7	11.7	29.3
18.	Say nice things to others	6.7	9.2	32.1	23.5	28.5
48.	Sleep	11.7	16.8	23.7	20.9	26.8
16.	Be with a boyfriend or girlfriend	19.3	12.0	27.7	15.9	25.1
5.	Listen to music – stereo, radio, etc.	27.7	14.8	18.7	14.2	24.6
32.	Try, on your own, to figure out how to deal with your problems or tension	9.8	12.0	33.2	20.4	24.6
51.	Let off steam by complaining to your friends	12.3	16.8	31.3	15.4	24.3
27.	Work hard on schoolwork or other school projects	10.1	16.0	30.5	19.3	24.1
49.	Say mean things to people, be sarcastic	8.4	12.8	32.1	22.9	23.7
47.	Try to make your own decision	7.0	16.5	30.3	22.7	23.5
23.	Go to mosque	33.0	15.4	20.4	9.2	22.1
38.	Daydream about how you would like things to be	19.6	13.7	27.7	17.3	21.8
4.	Apologize to people	13.1	12.6	29.3	23.7	21.2

37.	Go to a movie	21.2	14.0	26.5	17.9	20.4
11.	Go shopping ; buy things you like	20.7	14.2	30.4	15.1	19.6
52.	Talk to a friend about how you feel	18.4	19.0	31.6	12.3	18.7
12.	Try to reason with parents and talk things out ; compromise	20.9	18.2	31.0	12.3	17.6
44.	Pray	22.1	15.6	28.2	16.5	17.6
20.	Joke and keep a sense of humor	16.2	20.1	32.7	14.0	17.0
25.	Organize your life and what you have to do	12.0	15.9	35.5	19.6	17.0
9.	Use drugs prescribed by a doctor	43.9	10.9	15.6	13.1	16.5
14.	Cry	20.7	19.0	33.5	10.6	16.2
39.	Talk to a brother or sister about how you feel	31.0	16.8	25.1	11.5	15.6
45.	Try to see the good things in a difficult situation	13.7	21.8	36.3	14.0	14.2
31.	Talk to your mother about what bothers you	32.7	17.0	27.9	8.7	13.7
43.	Watch T.V	22.7	20.2	33.1	10.6	13.4
22.	Let off steam by complaining to family members	30.2	20.9	26.5	9.2	13.1
2.	Read	16.8	29.1	33.8	9.2	11.2
21.	Talk to a Sheikh/religious person	34.6	15.1	28.2	10.9	11.2
50.	Talk to your father about what bothers you	36.9	19.3	23.7	9.2	10.9
54.	Do a strenuous physical activity (jogging, biking, etc.)	36.6	21.2	22.3	9.2	10.6
10.	Get more involved in activities at school	26.0	19.3	34.4	10.3	10.1
40.	Get a job or work harder at one	30.4	23.2	29.9	7.0	9.5
3.	Try to be funny and make light of it all	28.8	22.1	26.5	13.7	8.9
17.	Ride around in the car	36.9	15.4	25.1	13.7	8.9
28.	Blame other for what going wrong	25.4	23.2	31.8	10.9	8.7
53.	Play video games (Space Invaders, Pat-Man) pool, pinball, etc.	53.4	14.0	18.7	7.0	7.0
19.	Get angry and yell at people	21.2	30.2	29.9	12.0	6.7
36.	Tell yourself the problem is not important	28.8	22.1	36.0	6.7	6.4
42.	Smoke	79.3	5.9	6.7	2.5	5.6
26.	Swear	49.7	29.3	12.6	3.4	5.0
8.	Try to stay away from home as much as possible	44.4	20.7	21.8	8.7	4.5
6.	Talk to a teacher or counselor at school about what bothers you	62.6	14.2	15.6	3.4	4.2
24.	Use drugs (not prescribed by doctor)	70.4	13.1	12.3	1.7	2.5
34.	Get professional counseling (not from a school teacher or school counselor)	74.0	11.5	10.1	3.1	1.4
46.	Drink beer, wine, liquor	89.7	3.1	4.7	2.0	0.6

4.5.2 The prevalence of Coping subscales

The following table shows the 12 coping subscale, the researcher found that adolescents used a group of coping strategies to overcome trauma and stress, The total Weight mean of ACOPE subscale was (56.5%)**,** (mean = 152.6; SD= 22.4), while, the highest subscale of coping was "developing social support" (66.8%) among study sample, then " investing in close friend" score (66.3%), and then " engaging in demanding activities" score (62.2%).

Table 32: Means, Standard deviation and weight mean of ACOPE subscales (N=358)

No	Coping subscales	N	Mean	Std. Deviation	Weight mean %
4.	Developing social support	358	20.05	4.23	66.8
8.	Investing in close friend	358	6.63	2.09	66.3
3.	Developing self-reliance	357	18.92	4.16	63.0
10.	Engaging in demanding activities	357	12.43	3.04	62.2
11.	Being humorous	358	5.47	2.08	61.5
12.	Relaxing	358	12.00	3.18	60.0
5.	Solving family problems	358	17.82	5.01	59.4
2.	Seeking diversion	357	22.45	5.47	56.1
7.	Seeking spiritual support	358	8.13	2.94	54.2
1.	Ventilating feelings	358	15.25	3.63	53.6
6.	Avoiding problems	358	10.12	2.58	34.8
9.	Seeking professionals support	358	3.19	1.61	31.9
Total		**358**	**152.6**	**22.4**	**56.5**

4.5.3 Coping strategies according to sex of the study sample

In order to investigate the sex differences in coping strategies among study sample, T independent test was performed. As shown in the following table: The results showed that there are no significant differences in coping strategies among males and females, that's means both boys and girls use coping strategies equally (t = -0.04; P =0.97). While the results showed that there are significant differences in coping strategies subscales (developing social support, solving family problems, being humorous) in favor to females, that's means girls use these strategies more than boys. As well as the results showed that there are significant differences in coping strategies subscales (avoiding problems, developing social support, investing in close friend, seeking professionals support) in favor to male, that's means boys use these strategies more than girls. While the results showed that there were no significant differences in coping strategies subscales (ventilating feelings, seeking diversion, engaging in demanding activities, relaxing).

Table 33:

T-independent test comparing mean of ACOPE and subscales according to sex

Variables	Sex	No	Mean	SD	t –value	Significant level
Ventilating feelings	Male	158	16.08	3.84	-0.08	//0.94
	Female	200	16.11	3.40		
Seeking diversion	Male	158	22.64	5.50	0.57	//0.57
	Female	200	22.31	5.44		
Developing self reliance	Male	158	18.59	4.50	-1.25	//0.21
	Female	200	19.15	3.87		
Developing social support	Male	158	18.87	4.58	-4.84	**0.001
	Female	200	20.99	3.68		
Solving family problems	Male	158	17.09	5.24	-2.45	**0.001
	Female	200	18.40	4.76		
Avoiding problems	Male	158	9.59	3.06	5.59	**0.001
	Female	200	8.01	2.28		
Seeking spiritual support	Male	158	9.12	2.95	5.94	**0.001
	Female	200	7.35	2.69		
Investing in close friend	Male	158	7.03	2.19	3.24	**0.001
	Female	200	6.32	1.96		
Seeking professionals support	Male	158	3.70	1.85	5.52	**0.001
	Female	200	2.79	1.27		
Engaging in demanding activities	Male	158	12.16	3.40	-1.54	//0.13
	Female	200	12.66	2.70		
Being humorous	Male	158	5.81	1.92	-3.11	**0.001
	Female	200	6.41	1.73		
Relaxing	Male	158	11.82	3.30	-0.94	//0.35
	Female	200	12.14	3.08		
Total ACOPE	Male	158	152.51	27.37	-0.06	//0.95
	Female	200	152.62	17.62		

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

4.5.4 Coping strategies according to educational class of the study sample

In order to investigate the differences in coping strategies according to educational class of the study sample (10^{th}, 11^{th}, 12^{th}). One-way ANOVA was performed. As shown in the following table: The results showed that there were no significant difference in coping strategies (f=.99; p=.37) and its dimensions according to educational class of the study sample.

Table 34:

One-way ANOVA comparing coping strategies according to educational class

Variable	Source of variables	Sum of Squares	df	Mean Square	F– value	Significant level
Ventilating feelings	Between Groups	22.012	2	11.006	.834	.435
	Within Groups	4686.357	355	13.201		
	Total	4708.369	357			
Seeking diversion	Between Groups	10.243	2	5.122	.170	.843
	Within Groups	10634.149	354	30.040		
	Total	10644.392	356			
Developing self-reliance	Between Groups	67.331	2	33.665	2.841	.060
	Within Groups	4195.409	354	11.851		
	Total	4262.739	356			
Developing social support	Between Groups	2.890	2	1.445	.080	.923
	Within Groups	6381.102	355	17.975		
	Total	6383.992	357			
Solving family problems	Between Groups	44.960	2	22.480	.894	.410
	Within Groups	8931.599	355	25.159		
	Total	8976.559	357			
Avoiding problems	Between Groups	28.833	2	14.417	1.896	.152
	Within Groups	2699.371	355	7.604		
	Total	2728.204	357			
Seeking spiritual support	Between Groups	35.553	2	17.777	2.069	.128
	Within Groups	3050.536	355	8.593		
	Total	3086.089	357			
Investing in close friend	Between Groups	4.785188	2	2.392594	0.545	0.58
	Within Groups	1558.279	355	4.389518		
	Total	1563.064	357			
Seeking professionals support	Between Groups	24.59614	2	12.29807	4.819	0.009
	Within Groups	905.8648	355	2.551732		
	Total	930.4609	357			
Engaging in demanding activities	Between Groups	6.028	2	3.014	.325	.722
	Within Groups	3279.675	354	9.265		
	Total	3285.703	356			
Being humorous	Between Groups	2.905	2	1.452	.334	.716
	Within Groups	1542.369	355	4.345		
	Total	1545.274	357			
Relaxing	Between Groups	73.645	2	36.823	2.467	.086
	Within Groups	5297.944	355	14.924		
	Total	5371.589	357			
Total ACOPE	Between Groups	1002.906	2	501.453	.99	.37
	Within Groups	178352.43	355	502.401		
	Total	179355.34	357			

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

4.5.5 Coping strategies according to type of residence of the study sample

In order to investigate the differences in coping strategies according to type of residence of the study sample (city, village, camp). One-way ANOVA was performed. As shown in the following table: The results showed that there were no significant difference in coping strategies (f=.90; p=.40) and its dimensions according to type of residence of the study sample.

Table 35:

One-way ANOVA comparing coping strategies subscales according to type of residence

Variable	Source of variables	Sum of Squares	df	Mean Square	F– value	Significant level
Ventilating feelings	Between Groups	10.578	2	5.289	.400	.671
	Within Groups	4697.791	355	13.233		
	Total	4708.369	357			
Seeking diversion	Between Groups	94.228	2	47.114	1.581	.207
	Within Groups	10550.16	354	29.803		
	Total	10644.39	356			
Developing self-reliance	Between Groups	38.968	2	19.484	1.633	.197
	Within Groups	4223.772	354	11.932		
	Total	4262.739	356			
Developing social support	Between Groups	60.792	2	30.396	1.707	.183
	Within Groups	6323.199	355	17.812		
	Total	6383.992	357			
Solving family problems	Between Groups	53.677	2	26.839	1.068	.345
	Within Groups	8922.881	355	25.135		
	Total	8976.559	357			
Avoiding problems	Between Groups	5.786	2	2.893	.377	.686
	Within Groups	2722.418	355	7.669		
	Total	2728.204	357			
Seeking spiritual support	Between Groups	98.456	2	49.228	5.849	.003
	Within Groups	2987.634	355	8.416		
	Total	3086.089	357			
Investing in close friend	Between Groups	1.465299	2	0.732649	0.1665	0.847
	Within Groups	1561.599	355	4.39887		
	Total	1563.064	357			
Seeking professionals support	Between Groups	11.97969	2	5.989843	2.31512	0.100
	Within Groups	918.4812	355	2.587271		
	Total	930.4609	357			
Engaging in demanding activities	Between Groups	31.313	2	15.657	1.703	.184
	Within Groups	3254.390	354	9.193		
	Total	3285.703	356			
Being humorous	Between Groups	4.210	2	2.105	.485	.616
	Within Groups	1541.063	355	4.341		
	Total	1545.274	357			

Relaxing	Between Groups	18.301	2	9.150	.607	.546
	Within Groups	5353.289	355	15.080		
	Total	5371.589	357			
Total ACOPE	Between Groups	907.111	2	453.555	.90	.40
	Within Groups	178448.23	355	502.671		
	Total	179355.34	357			

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

4.5.6 Coping strategies according to family income of the study sample

In order to investigate the differences in coping strategies according to family income of the study sample (600 NIS and less, 601–1200, 1201–2000, 2001–3000, More than 3000 NIS). One-way ANOVA was performed. As shown in the following table: The results showed that there were no significant difference in coping strategies (f=1.10; p=.36) and its dimensions according to family income of the study sample.

Table 36: One-way ANOVA comparing coping strategies according to family income

Variable	Source of variables	Sum of Squares	df	Mean Square	F–value	Significant level
Ventilating feelings	Between Groups	85.930	6	14.322	1.087	.369
	Within Groups	4622.439	351	13.169		
	Total	4708.369	357			
Seeking diversion	Between Groups	219.458	6	36.576	1.228	.291
	Within Groups	10424.934	350	29.786		
	Total	10644.392	356			
Developing self-reliance	Between Groups	79.826	6	13.304	1.113	.354
	Within Groups	4182.914	350	11.951		
	Total	4262.739	356			
Developing social support	Between Groups	131.812	6	21.969	1.233	.288
	Within Groups	6252.179	351	17.812		
	Total	6383.992	357			
Solving family problems	Between Groups	202.623	6	33.771	1.351	.234
	Within Groups	8773.935	351	24.997		
	Total	8976.559	357			
Avoiding problems	Between Groups	26.869	6	4.478	.582	.745
	Within Groups	2701.335	351	7.696		
	Total	2728.204	357			
Seeking spiritual support	Between Groups	47.995	6	7.999	.924	.477
	Within Groups	3038.095	351	8.656		
	Total	3086.089	357			
Investing in close friend	Between Groups	17.612	6	2.935	.667	.677
	Within Groups	1545.452	351	4.403		
	Total	1563.064	357			

Seeking professionals support	Between Groups	18.417	6	3.070	1.181	.316
	Within Groups	912.044	351	2.598		
	Total	930.461	357			
Engaging in demanding activities	Between Groups	23.212	6	3.869	1.415	.869
	Within Groups	3262.492	350	9.321		
	Total	3285.703	356			
Being humorous	Between Groups	30.659	6	5.110	1.184	.314
	Within Groups	1514.614	351	4.315		
	Total	1545.274	357			
Relaxing	Between Groups	267.807	6	44.635	3.070	.006
	Within Groups	5103.782	351	14.541		
	Total	5371.589	357			
Total ACOPE	Between Groups	3316.039	6	552.673	1.102	.36
	Within Groups	176039.304	351	501.536		
	Total	179355.344	357			

*p<0.05, ** p<0.01 *** p<0.001 //p>0.05

4.6 The relation between experiencing of Gaza War and mental Health

4.6.1 The relation between experiencing of Gaza War and Anxiety

In order to study the relation between traumatic events due to Gaza War and Anxiety among study sample as well as to test the relative significant of independent Variable (traumatic events due to political violence) on Anxiety among adolescents. The researcher used linear regression analysis. As shown in the following table; F value is statistically significant ((F=11.2; P<0.001) this shown that there were significant effect for independent variable (traumatic events due to political violence) on Anxiety, which means that independent variables (hearing the sonic sounds of the jetfighters, hearing shelling of the area by artillery, hearing of arrest of someone or a friend, witnessing assassination of people by rockets, Forced to leave your home during the war) have significant effect on Anxiety, this model shows that 37% of Anxiety scores among adolescents due to the previous traumatic events items, while 63% of Anxiety scores due to others factors.(R^2 =0.37)

Table 37: Linear regression analysis

The relation between the next traumatic events items and Anxiety (N=358)

No	Independent Variable	B	Std. Error	Beta	t	P
3	Hearing shelling of the area by artillery	9.54	3.47	0.17	2.75	0.001**

4	Hearing the sonic sounds of the jetfighters	7.79	3.24	0.15	2.40	0.001**
5	Hearing of arrest of someone or a friend	4.69	1.88	0.13	2.50	0.001**
15	Witnessing assassination of people by rockets	-6.06	1.96	-0.16	-3.1	0.001**
30	Forced to leave your home during the war	5.74	1.84	0.16	3.12	0.001**
constant		24.45	3.31		7.38	0.001**
R^2		0.37				
F-test (5,348)		**11.2				

** P<0.01 *P<0.05 // P>0.05

4.6.2 The relation between experiencing of Gaza War and depression

In order to study the relation between traumatic events due to Gaza War and depression among study sample as well as to test the relative significant of independent Variable (traumatic events due to political violence) on depression among adolescents. The researcher used linear regression analysis. As shown in the following table; F value is statistically significant (F=6.66; P<0.001) this shown that there were significant effect for independent variable (traumatic events due to political violence) on depression, which means that independent variables (Hearing of arrest of someone or a friend, Witnessing killing of a friend, Witnessing assassination of people by rockets, Forced to leave your home during the war) have significant effect on depression, this model shows that 27% of depression scores among adolescents due to the previous traumatic events items, while 73% of depression scores due to others factors.(R^2 =0.27)

Table 38: Linear regression analysis

The relation between traumatic events items (30 items) and depression (N=358)

No	Independent Variable	B	Std. Error	Beta	t	P
5	Hearing of arrest of someone or a friend	-1.37	0.47	-0.15	-2.9	0.001**
6	Witnessing killing of a friend	1.60	0.55	0.16	2.90	0.001**
15	Witnessing assassination of people by rockets	1.13	0.50	0.12	2.24	0.03*

30	Forced to leave your home during the war	-1.75	0.50	-0.19	-3.4	0.001**
constant		20.08	0.50		39.9	0.001**
R^2		0.27				
F-test (4,352)		**6.66				

** P<0.01 *P<0.05 // P>0.05

4.6.3 The relation between experiencing of Gaza War and PTSD

In order to study the relation between traumatic events due to Gaza War and PTSD among study sample as well as to test the relative significant of independent Variable (traumatic events due to political violence) on PTSD among adolescents. The researcher used linear regression analysis. As shown in the following table; F value is statistically significant (F=7.1; P<0.001) this shown that there were significant effect for independent variable (traumatic events due to political violence) on PTSD, which means that independent variables (hearing the sonic sounds of the jetfighters, hearing the sonic sounds of the jetfighters, hearing of arrest of someone or a friend, witnessing the signs of shelling on the ground, forced to leave your home during the war) have significant effect on PTSD, this model shows that 37% of PTSD scores among adolescents due to the previous traumatic events items, while 73% of PTSD scores due to others factors.(R^2 =0.37)

Table 39: Linear regression analysis

The relation between traumatic events items (30 items) and PTSD (N=358)

No	Independent Variable	B	Std. Error	Beta	t	P
4	Hearing the sonic sounds of the jetfighters	4.7	1.7	0.2	2.8	0.01**
5	Hearing of arrest of someone or a friend	3.1	1.1	0.1	2.8	0.001**
16	Witnessing the signs of shelling on the ground	-3.8	1.7	-0.1	-2.3	0.03*
30	Forced to leave your home during the war	3.5	1.1	0.2	3.33.3	0.03*
constant		20.4	1.8		11.1	0.001**
R^2		0.37				
F-test (4,351)		**7.1				

** P<0.01 *P<0.05 // P>0.05

4.7 The relation between coping strategies and mental health problems

4.7.1 The relation between coping strategies and Anxiety

In order to test the hypothesis of relationship between Anxiety and coping strategies used by adolescents to overcome the violence and consequences. The researcher used ,correlation coefficient test by Pearson correlation. As shown in the following table; there were no significant correlation between Anxiety and total coping strategies (r=0.07; p >0.05), while there were positive significant correlation between Anxiety and coping strategies subscales; ventilating feelings (r=0.11; p=0.03), developing social support (r =0.24; p=0.001), engaging in demanding activities (r=0.11; p =0.03), this mean increase of Anxiety among adolescents will lead to increase of using of these coping strategies. Also the result shown that there were negative significant correlation between Anxiety and coping strategies subscale; seeking spiritual support (r= -0.11; p=0.04), which mean the increase of Anxiety among adolescents will lead to decreasing the use of this strategy and vice versa. While there were no significant correlation between Anxiety and the remain subscales.

Table 40: Correlation coefficients between coping strategies subscales and Anxiety

Coping strategies	**R**	**P**
Ventilating feelings	*0.11	0.03
Seeking diversion	0.01	0.81
Developing self-reliance	-0.02	0.72
Developing social support	**0.24	0.001
Solving family problems	0.06	0.26
Avoiding problems	-0.05	0.36
Seeking spiritual support	*-0.11	0.04
Investing in close friend	-0.10	0.07
Seeking professionals support	-0.09	0.10
Engaging in demanding activities	*0.11	0.03
Being humorous	0.09	0.11
Relaxing	0.05	0.33
Total ACOPE	0.07	0.19

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

* Correlation is significant at the 0.05 level (2-tailed).

4.7.2 The relation between coping strategies and depression

In order to test the hypothesis of relationship between depression and coping strategies used by adolescents to overcome the violence and consequences. The researcher used , correlation coefficient test by Pearson correlation. As shown in the following table; there were positive significant correlation between depression and total coping strategies (r =0.21; p<0.05), this mean increase of depression among adolescents will lead to increase of using of coping strategies and vice versa. And also it found positive significant correlation between depression and coping strategies subscales; seeking diversion (r=0.15; p=0.01), developing self-reliance (r=0.14; p=0.01), solving family problems (r 0.25; p =0.001), seeking spiritual support (r=0.22; p=0.001), investing in close friend (r=0.19; p=0.001), seeking professionals support (r=0.19; p=0.001), and engaging in demanding activities (r=0.11; p =0.01), while the results shown there were no significant correlation between depression and the remain subscales.

Table 41: Correlation coefficients between coping strategies subscales and depression

Coping strategies	**R**	**p**
Ventilating feelings	0.08	0.13
Seeking diversion	*0.15	0.01
Developing self-reliance	**0.14	0.01
Developing social support	0.01	0.83
Solving family problems	**0.25	0.001
Avoiding problems	-0.02	0.78
Seeking spiritual support	**0.22	0.001
Investing in close friend	**0.19	0.001
Seeking professionals support	**0.19	0.001
Engaging in demanding activities	**0.11	0.04
Being humorous	0.01	0.82
Relaxing	0.001	0.93
Total ACOPE	**0.21	0.001

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

* Correlation is significant at the 0.05 level (2-tailed).

4.7.3 The relation between coping strategies subscales and PTSD

In order to test the hypothesis of relationship between PTSD and coping strategies used by adolescents to overcome the violence and consequences. The researcher used , correlation coefficient test by Pearson correlation. As shown in the following table; there were no significant correlation between PTSD and total coping strategies (r=0.04; p>0.05), while there were positive significant correlation between PTSD and coping strategies subscale;

ventilating feelings (r=0.16; p=0.001), developing social support (r=0.12; p=0.03), and avoiding problems (r=0.12; p=0.02), this mean increase of PTSD among adolescents will lead to increase of using of these coping strategies and vice versa. While the results shown there were negative significant correlation between Anxiety and solving family problems subscale (r= -0.13;p=0.01). While the results shown there were no significant correlation between PTSD and the remain subscales.

Table 42: Correlation coefficients between coping strategies subscales and PTSD

Coping strategies	**R**	**p**
Ventilating feelings	**0.16	0.001
Seeking diversion	0.01	0.91
Developing self-reliance	-0.04	0.49
Developing social support	**0.12	0.03
Solving family problems	**-0.13	0.01
Avoiding problems	**0.12	0.02
Seeking spiritual support	0.02	0.64
Investing in close friend	-0.07	0.20
Seeking professionals support	0.06	0.29
Engaging in demanding activities	0.001	1.00
Being humorous	0.06	0.25
Relaxing	0.07	0.16
Total ACOPE	0.04	0.40

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

* Correlation is significant at the 0.05 level (2-tailed).

Chapter 5

*I*mplications & *R*ecommendations

Chapter 5
Implications & Recommendations

5.1 Introduction

This chapter introduced the main results that achieved in the previous one and its discussion on the light of the previous studies. Furthermore, its important here to clarify the results and its relation with other studies that may be helpful in supporting our finding. However , the researcher will put on the hand some of implications and recommendations regarding to political violence, mental health and coping strategies among adolescents that are likely to be in consideration in the application of the future planning. Also, recommendation for further research will be provided on the basis of the results of the current study.

5.2 Main results

- The researcher found that the total mean of traumatic events was 13.34. while The most traumatic events due Gaza War was 90.8% of study sample 'Watching mutilated bodies in TV, 88.5% "Hearing shelling of the area by artillery", 86.6% "Witnessing the signs of shelling on the ground", and 86.0% "Hearing the sonic sounds of the jetfighters". While the least percent of traumatic events were "Physical injury due to bombardment of your home" 21.8%, 22.9 "Being arrested during the last incursion, 24.0% Shooting by bullets, rocket, or bombs", and 24.3% "Threatened to death by being used as human shield to arrest your neighbors by the army". While 86.6% of study sample didn't feel save at home, 90.8**%** were unable to protect self, 81.8% of study sample were unable to protect their families during the war, and 79.6% don't think that others were able to protect them.

  The study found that there were significant differences in traumatic events due to political violence according to sex in favor to males, this means that males expose to traumatic events more than females and there were significant difference in traumatic events (f=6.88; p=0.001) according to educational class of the study sample in favor to 11^{th} educational class (mean=14.17; SD= 7.50), and there were significant difference in traumatic events (f=7.411; p=0.001) according to type of residence of the study sample in favor to village (mean=15.07; SD= 6.82), and the study found that there were significant difference in traumatic events (f=3.073; p=0.006) according to family income of the study sample in favor to family income (2001 – 3000 NIS) (mean=15.49; SD= 9.060).

- The researcher found that the total weight mean for Anxiety (37.0%), and the highest score for obsessive compulsive subscale (49.4%), then (45.8%) for Generalized Anxiety subscale, social phobia subscale (38.8%), physical injury fears subscale (36.5%), and then separation Anxiety subscale (34.2%), and the least score for panic/Agoraphobia subscale (20.0%). And there were significant differences in Anxiety and its subscales according to sex actual probability ((t = -12.43; df =352; P =0.001) in favor to females**,** this means that girls suffer from Anxiety and its subscales (panic/Agoraphobia, separation Anxiety, physical Injury Fears, social Phobia, obsessive compulsive, Generalized Anxiety) more than boys but there were no significant difference in Anxiety and its dimensions (panic/agoraphobia, separation anxiety, physical injury fears, social phobia, obsessive compulsive disorder, Generalized anxiety) according to educational class, type of residence and family income of the study sample.
- The researcher found that 65.6% "I like talking with my family", 56.4% "I can stick up for myself", and "I think life isn't worth living" 36.0%. While the least frequent items were "I have lots of energy" 7.8% , 12.3% "I feel so sad I can hardly stand it" and "I feel very lonely" 14.5% and the prevalence of depression among study sample was: (76.3%) of study sample are depressed, while 23.7% of study sample are not depress. And the study found that there were significant differences in depression according to sex actual probability (t = 2.94; df =356; P =0.003) in favor to boys**,** this means that males suffer from depression more than girls but there were no significant difference in depression according to educational class, type of residence and family income of the study sample.
- The study found that the most PTSD items and its frequency among study sample the item " I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me" is the most frequent one (14.8%), then the item "I think that I will not live a long life (14.5%) , then the item " I try not to talk about, think about, or have feelings about what happened (14.2%). While the least frequent items were "I feel like staying by myself and not being with my friends" (3.1%), then "I feel alone inside and not close to other people " (3.6%), and then " I have trouble remembering important parts of what happened" (4.5%).

  The prevalence of PTSD among study sample was: 25 of study sample have no PTSD (6.7%), 74 of study sample have Two symptoms & less (20.5%), 125 of study sample have partial PTSD (35.1%), while 134 of study sample have full PTSD (37.6%) according to DSM-VI and the prevalence of PTSD subscale was: 34 of study sample fulfill criterion (B) (re-experiencing) 9.5% (mean = 8.2; SD = 4.2) while 120 of study sample fulfill criterion (C**)** (avoidance) 33.3% (mean = 8.5; SD = 4.8), and 191 of study sample fulfill criterion

(D) (Increase arousal) 53.2% (mean = 8.0; SD = 3.7). And the study found showed that there are significant differences in PTSD according to sex actual probability (t = -4.14; df =356; P =0.001) in favor to females**,** this means that girls suffer from PTSD more than boys. As well as the results showed that there are significant differences in PTSD subscales (Re-experiencing, Increase arousal) in favor to females, while there were no significant differences in PTSD subscale (avoidance) according to sex actual probability (t = -1.83; df =358; P =0.067). But there were no significant difference in PTSD and its dimensions (re-experiencing, avoidance, hyperarousal) according to educational class, type of residence and family income of the study sample

- The researcher found that the most common coping items and its frequency among study sample, the item " try to improve yourself (get body in shape, get better grades, etc.) 58.9%, then the item "try to keep up friendships or make new friends" 45.5%, and then " go a long with parents and rules 40.2%. While, the least frequent items were " try to see the good things in a difficult situation 0.6%, then " get professional counseling (not from a school teacher or school counselor) 1.4%, and then " use drugs (not prescribed by doctor) 2.5%, and the researcher found that adolescents used a group of coping strategies to overcome trauma and stress, The total Weight mean of ACOPE subscale was (56.5%)**,** (mean = 152.6; SD= 22.4), while, the highest subscale of coping was "developing social support" (66.8%) among study sample, then " investing in close friend" score (66.3%), and then " engaging in demanding activities" score (62.2%), and the study found that that there are no significant differences in coping strategies among males and females, that's means both boys and girls use coping strategies equally (t = -0.04; P =0.97). While the results showed that there are significant differences in coping strategies subscales (developing social support, solving family problems, being humorous) in favor to females, that's means girls use these strategies more than boys. As well as the results showed that there are significant differences in coping strategies subscales (avoiding problems, developing social support, investing in close friend, seeking professionals support) in favor to male, that's means boys use these strategies more than girls. While the results showed that there were no significant differences in coping strategies subscales (ventilating feelings, seeking diversion, engaging in demanding activities, relaxing), but there were no significant difference in coping strategies and its dimensions according to educational class, type of residence and family income of the study sample.
- The study found that there were significant effect for independent variable (traumatic events due to political violence) on Anxiety, which means that independent variables

(Hearing the sonic sounds of the jetfighters, Hearing shelling of the area by artillery, Hearing of arrest of someone or a friend, Witnessing assassination of people by rockets, Forced to leave your home during the war) have significant effect on Anxiety, this model shows that 37% of Anxiety scores among adolescents due to the previous traumatic events items, while 63% of Anxiety scores due to others factors.

- There were significant effect for independent variable (traumatic events due to political violence) on depression, which means that independent variables (Hearing of arrest of someone or a friend, Witnessing killing of a friend, Witnessing assassination of people by rockets, Forced to leave your home during the war) have significant effect on depression, this model shows that 27% of depression scores among adolescents due to the previous traumatic events items, while 73% of depression scores due to others factors.
- There were significant effect for independent variable (traumatic events due to political violence) on PTSD, which means that independent variables (Hearing the sonic sounds of the jetfighters Hearing the sonic sounds of the jetfighters, Hearing of arrest of someone or a friend, Witnessing the signs of shelling on the ground, Forced to leave your home during the war) have significant effect on PTSD, this model shows that 37% of PTSD scores among adolescents due to the previous traumatic events items, while 73% of PTSD scores due to others factors.
- There were no significant correlation between Anxiety and total coping strategies ($r=0.07$; $p>0.05$), while there were positive significant correlation between Anxiety and coping strategies subscales; ventilating feelings ($r=0.11$; $p=0.03$), developing social support ($r=0.24$; $p=0.001$), engaging in demanding activities ($r=0.11$; $p=0.03$), this mean increase of Anxiety among adolescents will lead to increase of using of these coping strategies. Also the result shown that there were negative significant correlation between Anxiety and coping strategies subscale; Seeking spiritual support ($r= -0.11$; $p=0.04$), which mean the increase of Anxiety among adolescents will lead to decreasing the use of this strategy and vice versa. While there were no significant correlation between Anxiety and the remain subscales.
- There were positive significant correlation between depression and total coping strategies ($r=0.21$; $p<0.05$), this mean increase of depression among adolescents will lead to increase of using of coping strategies and vice versa. And also it found positive significant correlation between depression and coping strategies subscales; seeking diversion ($r=0.15$; $p=0.01$), developing self-reliance ($r=0.14$; $p=0.01$), solving family problems (r 0.25; $p=0.001$), seeking spiritual support ($r=0.22$; $p=0.001$), investing in close friend ($r=0.19$;

p=0.001), seeking professionals support (r=0.19; p=0.001), and engaging in demanding activities (r=0.11; p =0.01), while the results shown there were no significant correlation between depression and the remain subscales.

- There were no significant correlation between PTSD and total coping strategies (r=0.04; p>0.05), while there were positive significant correlation between PTSD and coping strategies subscale; ventilating feelings (r=0.16; p=0.001), developing social support (r=0.12; p=0.03), and avoiding problems (r=0.12; p=0.02), this mean increase of PTSD among adolescents will lead to increase of using of these coping strategies and vice versa. While the results shown there were negative significant correlation between Anxiety and solving family problems subscale (r= -0.13;p=0.01). While the results shown there were no significant correlation between PTSD and the remain subscales.

5.3 Discussion

The most prevalent traumatic events due to Gaza War that effect study sample was 'Watching mutilated bodies in TV" 90.8%. The researcher hypothesized that these finding related to continuous browsing of martyrs and injured in TV by the media that attracted all ages to follow these events. Furthermore, the daily news exhibit different media that presented to audience without monitoring. Also this reflect the importance of media and its effect on our community. The second most traumatic events due political violence that effect study sample was " Hearing shelling of the area by artillery" 88.5%. The researcher hypothesized that these finding related to that artillery occurred suddenly, randomly, and widespread places in Gaza Strip.

The study of Thabet et, al (2007) found that the most common traumatic events were, watching mutilated bodies and wounded people on TV (97.1%), hearing the sonic sounds of the jetfighters (94.7%), that appeared to be consistent with our current results.

Subjects reported a mean number of 13.3 traumatic events (SD = 7.37). The researcher hypothesized that these finding related to the last war on Gaza, while in the study of Thabet et, al (2008) found that Subjects reported a mean number of 7.7 traumatic events (SD = 2.21), the increase in a mean in our current results may related to increase of violence in the last war in Gaza.

The total weight mean for Anxiety (37.0%), and the highest score for obsessive compulsive subscale (49.4%), then (45.8%) for Generalized Anxiety subscale, social phobia subscale (38.8%), Physical injury fears subscale (36.5%), and then separation Anxiety subscale (34.2%), and the least score for Panic/Agoraphobia subscale (20.0%).

In another study of Thabet et, al (2007) found that prevalence of anxiety disorder was (33.9%), which is less than our study result.

The study found that 76.3% of study sample are depressed (cutoff point >=17) while 23.7% of study sample are not depress (cutoff point <17)**,** (mean =19.6; SD = 4), this result doesn't mean they are suffer from depressive disorder but 76.3% of study samle suffer from depression symptoms.

The study found that 25 of study sample have no PTSD (6.7%), 74 of study sample have Two symptoms & less (20.5%), 125 of study sample have partial PTSD (35.1%), while 134 of study sample have full PTSD (37.6%) according to DSM-VI. And the study found that 34 of study sample fulfill Criterion (B) (re-experiencing) 9.5% (mean = 8.2; SD = 4.2) while 120 of study sample fulfill Criterion (C**)** (avoidance) 33.3% (mean = 8.5; SD = 4.8),

and 191 of study sample fulfill Criterion (D) (Increase arousal) 53.2% (mean = 8.0; SD = 3.7).

The study of Catani et al. (2008) found that The consequences are reflected in a 30.4% PTSD and in another study of the study of Thabet (2008) found that Posttraumatic stress symptoms mean was 25.94, re-experiencing symptoms mean was 7.50, avoidance symptoms mean was 8.21, and arousal symptoms mean was 7.65. Forty eight 48 children reported probable PTSD (12.4%), 103 children were reported one Criteria (reexperiencing, or avoidance, or hyperarousal) (26.7%), 86 of children reported two criteria-Partial PTSD (22.3%), and 149 children had no PTSD symptoms (38.4%). The researcher hypothesized that the increase in our current results may related to increase of violence in the last war in Gaza.

The study found that adolescents used a group of coping strategies to overcome trauma and stress, The total Weight mean of ACOPE subscale was (56.5%)**,** (mean = 152.6; SD= 22.4), while the highest subscale of coping was "Developing social support" (66.8%) among study sample, then " Investing in close friend" score (66.3%), and then " Engaging in demanding activities" score (62.2%). While the total score for coping among study sample (56.5%). The total Weight mean of study sample was (56.5%)**.** The highest score of coping subscale "Developing social support" (66.8%) reflect the importance of social support in our community, and second subscale in coping " Investing in close friend" score (66.3%) reflect the importance of friendship among adolescents.

The study found that there were significant effect for independent variable (traumatic events due to political violence) on Anxiety, which means that independent variables (Hearing the sonic sounds of the jetfighters, Hearing shelling of the area by artillery, Hearing of arrest of someone or a friend, Witnessing assassination of people by rockets, Forced to leave your home during the war) have significant effect on Anxiety, this model shows that 37% of Anxiety scores among adolescents due to the previous traumatic events items, while 63% of Anxiety scores due to others factors. The researcher hypothesized that other factors which significant on effect Anxiety may factional violence, siege, economic conditions, and social problems**.**

The study found that there were significant effect for independent variable (traumatic events due to political violence) on depression, which means that independent variables (Hearing of arrest of someone or a friend, Witnessing killing of a friend, Witnessing assassination of people by rockets, Forced to leave your home during the war) have

significant effect on depression, this model shows that 27% of significant on depression scores among adolescents due to the previous traumatic events items, while 73% of depression scores due to others factors. The researcher hypothesized that other factors which effect depression may factional violence, siege, economic conditions, and social problems**.**

The study found that there were significant effect for independent variable (traumatic events due to political violence) on PTSD, which means that independent variables (Hearing the sonic sounds of the jetfighters Hearing the sonic sounds of the jetfighters, Hearing of arrest of someone or a friend, Witnessing the signs of shelling on the ground, Forced to leave your home during the war) have significant effect on PTSD, this model shows that 37% of PTSD scores among adolescents due to the previous traumatic events items, while 73% of PTSD scores due to others factors. The researcher hypothesized that other factors which effect depression may factional violence, siege, economic conditions, and social problems**.**

The study found that there were no significant correlation between Anxiety and total coping strategies ($r=0.07$; $p>0.05$), while there were positive significant correlation between Anxiety and coping strategies subscales; ventilating feelings ($r=0.11$; $p=0.03$), developing social support ($r=0.24$; $p=0.001$), engaging in demanding activities ($r=0.11$; $p=0.03$), this mean increase of Anxiety among adolescents will lead to increase of using of these coping strategies. Also the result shown that there were negative significant correlation between Anxiety and coping strategies subscale; Seeking spiritual support ($r= -0.11$; $p=0.04$), which mean the increase of Anxiety among adolescents will lead to decreasing the use of this strategy and vice versa. While there were no significant correlation between Anxiety and the remain subscales. And found that there were positive significant correlation between depression and total coping strategies ($r=0.21$; $p<0.05$), this mean increase of depression among adolescents will lead to increase of using of coping strategies and vice versa. And also it found positive significant correlation between depression and coping strategies subscales; seeking diversion ($r=0.15$; $p=0.01$), developing self-reliance ($r=0.14$; $p=0.01$), solving family problems (r 0.25; $p=0.001$), seeking spiritual support ($r=0.22$; $p=0.001$), investing in close friend ($r=0.19$; $p=0.001$), seeking professionals support ($r=0.19$; $p=0.001$), and engaging in demanding activities ($r=0.11$; $p=0.01$), while the results shown there were no significant correlation between depression and the remain subscales. And also the researcher found that there were no

significant correlation between PTSD and total coping strategies (r=0.04; p>0.05), while there were positive significant correlation between PTSD and coping strategies subscale; ventilating feelings (r=0.16; p=0.001), developing social support (r=0.12; p=0.03), and avoiding problems (r=0.12; p=0.02), this mean increase of PTSD among adolescents will lead to increase of using of these coping strategies and vice versa. While the results shown there were negative significant correlation between Anxiety and solving family problems subscale (r= -0.13;p=0.01). While the results shown there were no significant correlation between PTSD and the remain subscales. That's mean no correlation between and total coping strategies and (Anxiety ,PTSD), but there is positive correlation between and total coping strategies and depression. Which mean increase of depression among adolescents will lead to increase of using of coping strategies and vice versa.

The researcher investigate the sex differences in traumatic events due to political violence among study sample and mental health. The result of investigation found that there are significant differences in traumatic events due to political violence according to sex with actual probability (t =3.48; df =356; P =0.001) in favor to males, this means that males expose to traumatic events more than females. The researcher hypothesized that these finding related to nature of male character in our community that's they are stay out of their home more than female and also may because they more engage in different activities which make them more exposing to risk and dangers.

The study found that there are significant differences in Anxiety and its subscales according to sex actual probability ((t = -12.43; df =352; P =0.001) in favor to females**,** this means that girls suffer from Anxiety and its subscales (Panic/Agoraphobia, Separation Anxiety, Physical Injury Fears, Social Phobia, Obsessive Compulsive, Generalized Anxiety) more than boys.

The study found that there are significant differences in depression according to sex actual probability ((t = 2.94; df =356; P =0.003) in favor to boys**,** this means that males suffer from depression more than girls.

The study found that there are significant differences in PTSD according to sex actual probability (t = -4.14; df =356; P =0.001) in favor to females**,** this means that girls suffer from PTSD more than boys. As well as the results showed that there are significant differences in PTSD subscales (Re-experiencing, Increase arousal) in favor to females, while there were no significant differences in PTSD subscale (Avoidance) according to sex actual probability (t = -1.83; df =358; P =0.067).

The study found that there are significant differences in depression according to sex in favor to males, but there are significant differences in Anxiety, and PTSD according to sex in favor to females. The researcher hypothesized that these finding related to the nature of females and their personality, they are more sensitive and emotionally than males.

This result was inconsistence with the study of Thabet (2008) that found that mean mental health symptoms mean was 9.05, somatic pains mean was 1.31, depression symptoms mean was 4.36, anxiety mean was 2.21, and fears mean was 1.14. There were no significant differences between boys and girls in total general mental health, somatic pains, anxiety, depression, and fears. Mean mental health symptoms mean was 9.05, somatic pains mean was 1.31, depression symptoms mean was 4.36, anxiety mean was 2.21, and fears mean was 1.14. There were no significant differences between boys and girls in total general mental health, somatic pains, anxiety, depression, and fears.

The study found that there are no significant differences in coping strategies among males and females, that's means both boys and girls use coping strategies equally ($t = -0.04$; $P = 0.97$). While the results showed that there are significant differences in coping strategies subscales (Developing social support, Solving family problems, Being humorous) in favor to females, that's means girls use these strategies more than boys. As well as the results showed that there are significant differences in coping strategies subscales (Avoiding problems, Developing social support, Investing in close friend, Seeking professionals support) in favor to male, that's means boys use these strategies more than girls. While the results showed that there were no significant differences in coping strategies subscales (Ventilating feelings, Seeking diversion, Engaging in demanding activities, Relaxing).

In the study of Thabet (2008) found that There were no significant differences between boys and girls and age of children in total resilience, commitment, control, and challenging. The results showed that total scores of resilience were correlated negatively with total PTSD, arousal, and avoidance. Commitment was correlated negatively with arousal, children with better resilience had less PTSD, avoidance, and arousal symptoms and children with commitment had less arousal symptoms. Total scores of resilience were correlated negatively with total mental health, somatic pains, anxiety and fears. Commitment was correlated negatively with anxiety, control was negatively correlated with fears, and challenge was negatively correlated with fears.

5.4 Recommendations

- Therapeutic programs: including crisis intervention and counseling for victims of violence or for those at risk, support group, and behavioral therapy for those who are mentally ill as sequences of violence.
- Family therapy programs and home visits: these programs aimed to improving communications and interactions among family members, as well as teaching problem – solving skills to assist parents and children in facing various traumatic events. And performing regular visits to home of families at risk by trained mental health professionals. Intervention includes counseling, and therapy.
- Public education campaign: using public meetings, workshops and media to target entire communities or for specific settings such as schools, civil institutions, and other health agencies.
- Create community policies to provide partnerships and coordination among various social institutions and governmental and nongovernmental organizations.
- Extracurricular activities for children and adolescents for those at risk such as drama, sport, art, and music etc.
- Specialized training programs for mental health professionals, parents, and teachers to make them better able to identify and deal with type of violence and its sequences.
- Organize specialized trained team for crisis intervention, which able to work during crisis and disasters and provide help for those who are need. As well as supported community groups to provide support for their community during crisis.

5.5 Suggested research studies

- Effect of collective violence on mental health.
- Effect of siege on mental health.
- Effect of self- directed and interpersonal violence on mental health.
- Identified the risk and protective factors that link with violence exposure.
- Identified the factors that promote coping resources & promote positive outcome.

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Annexes

Annexes

Annex 1

Location Map of the Gaza

Annex 2
Helsinki Committee Approval Letter

Palestinian National Authority
Ministry of Health
Helsinki Committee

السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

التاريخ2009/6/3

Name:

الاسم: **عمر حمدان البحيصي**

I would like to inform you that the committee has discussed your application about:

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

The influence of political violence on mental health and coping strategies of Palestinian Adolescents in Gaza strip

In its meeting on June 2009
and decided the Following:-
To approve the above mention research study.

و ذلك في جلستها المنعقدة لشهر 6 2009
و قد قررت ما يلي:-
الموافقة على البحث المذكور عاليه.

Signature
توقيع

Member
عضو

Member
عضو

Chairperson
Ministry of Health Helsinki Committee

Conditions:-

- Valid for 2 years from the date of approval to start.
- It is necessary to notify the committee in any change in the admitted study protocol.
- The committee appreciate receiving one copy of your final research when it is completed.

Annex 3
Ministry of Education & Higher Education Approval Letter

بسم الله الرحمن الرحيم

Palestinian National Authority
Ministry of Education & Higher Education

السلطة الوطنية الفلسطينية
وزارة التربية والتعليم العالي
الإدارة العامة للتخطيط التربوي

الرقم : و ت غ / مذكرة داخلية ٥٣٠ .
التاريخ :1 /2/ 2009

السادة / مديرو التربية والتعليم – محافظات غزة حفظهم الله،،،

والسلام عليكم ورحمة الله وبركاته،،،

الموضوع : تسهيل مهمة بحث

يقوم الطالب : **عمر البحيصي**، والمسجل لدرجة الماجستير في الصحة النفسية المجتمعية، كلية الصحة العامة في جامعة القدس، بعمل بحث بعنوان " **The Influence Of Political Violence On Mental Health and Coping Strategies of Palestinian Adolescents in Gaza Strip**"

لا مانع من قيام الباحث من تطبيق أداة بحثه وهي عبارة عن استبانة على طلبة الصف العاشر، والحادي عشر، والثاني عشر، وذلك حسب الأصول.

وتفضلوا بقبول فائق الاحترام،،،

د. زياد ثابت
وكيل الوزارة المساعد للشئون التعليمية

السلطة الوطنية الفلسطينية * وزارة التربية والتعليم العالي *

نسخة : وزير التربية والتعليم العالي
/ وكيل الوزارة
/ وكيل الوزارة المساعد لشئون التطوير والادارة
/ الملف

غزة. هاتف(08-2861409- 2849311) فاكس(08-2865909) (08-2865909) Fax:(08-2865909) Gaza (08-2861409-2849311)
E-MAIL: MOEHE@GOV.PS

Annex 4
Socio-demographic status Questionnaire

عزيزي الطالب/ عزيزتي الطالبة:

يقوم الباحث بإعداد رسالة ماجستير في الصحة النفسية المجتمعية بعنوان "العنف السياسي و تأثيره على الصحة النفسية، و آليات المواجهة لدى المراهقين في قطاع غزة" و يرجو منك الباحث أن تجيب على فقرات الاستبانة التالية بالكامل علما بان جميع الإجابات صحيحة ما دامت تعبر عن وضعك و رأيك الشخصي، و أن البيانات التي سيتم جمعها لن تستخدم إلا لأغراض البحث العلمي فقط:

الباحث

أولا: استبيان الحالة الاجتماعية و الاقتصادية:

1. **العمر:** .....
2. **الصف:** ❐ العاشر ❐ الحادي عشر ❐ الثاني عشر
3. **الجنس:** ❐ ذكر ❐ أنثى
4. **مكان السكن:** ❐ شمال غزة ❐ غزة ❐ الوسطى
   ❐ خان يونس ❐ رفح
5. **نوع السكن:** ❐ مدينة ❐ مخيم ❐ قرية
6. **عدد الإخوة:** .....
7. **سنوات تعليم الأم:** .....
8. **سنوات تعليم الأب:** .....
9. **عمل الأم:** ❐ ربة بيت ❐ موظفة ❐ عاملة
   ❐ أخرى حدد .....
10. **عمل الأب:** ❐ لا يعمل ❐ موظف ❐ عامل
    ❐ صانع ❐ مزارع ❐ تاجر
    ❐ أخرى حدد .....
11. **دخل الأسرة الشهري:** ❐ اقل من 600 شيكل ❐ من 601-1200 شيكل
    ❐ من 1201-2000 شيكل ❐ من 2001-3000 شيكل ❐ أكثر من 3000 شيكل

Annex 5
War on Gaza Traumatic Events Checklist

ثانيا: مقياس الخبرات الصادمة الناجمة عن الحرب على غزة

أمامك مجموعة من البنود التي توضح الخبرات الصادمة (الأحداث المؤلمة) التي يتعرض لها أي إنسان في الظروف الصعبة مثل الاحتلال و الحروب و التي قد تشمل بعض ما تعرضت له خلال فترة الحرب الأخيرة على غزة، نرجو أن تضع علامة (**x**) في الخانة الموجودة أمام السؤال بما يتفق مع رأيك:

	الحدث أو الخبرة الصادمة	نعم	لا
1	سماعك لاستشهاد صديق لك		
2	سماعك لاستشهاد أب أو أخ أو أخت أو قريب لك		
3	سماعك للقصف المدفعي للمناطق المختلفة من قطاع غزة		
4	سماعك لأصوات الطائرات الحربية عند اختراقها لحاجز الصوت		
5	سماعك لاعتقال أو خطف أحد الأشخاص		
6	مشاهدة استشهاد صديق لك أمامك		
7	مشاهدة استشهاد أب أو أخ أو أخت أو قريب لك أمامك		
8	مشاهدة إصابة صديق لك أمامك بالرصاص		
9	مشاهدة إصابة أب أو أخ أو أخت أو قريب لك أمامك بالرصاص		
10	مشاهدة بيتكم و هو يهدم ، و يدمر من القصف أو الجرافات		
11	مشاهدة بيت جيرانكم و هو يهدم ، و يدمر من القصف أو الجرافات		
12	مشاهدة بيوت الجيران و هي تقصف بالمدفعية الثقيلة والرشاشات، و الطائرات.		
13	مشاهدة بيتكم وهو يقصف بالمدفعية الثقيلة، والرشاشات، والرشاشات، و الطائرات		
14	مشاهدة صور الجرحى و الأشلاء والشهداء في التلفزيون		
15	مشاهدة عمليات الاغتيالات لرجال المقاومة من قبل الطائرات أو القصف المدفعي		
16	مشاهدة الآثار الناتجة عن القصف المدفعي على قطاع غزة		
17	تعرضك للإصابة بشظية قنبلة أو صاروخ أو الرصاص		
18	تعرضك للإصابة الجسدية نتيجة لقصف منزلك		
19	تعرضك للاحتجاز في البيت		
20	تعرضك للضرب والإهابة		
21	تعرضك للحرمان من الماء و الأكل و الكهرباء		
22	تعرضك لإطلاق النار بقصد التخويف		
23	تعرض إغراضك الشخصية للتدمير و التكسير والنهب		
24	تعرضك للتهديد شخصياً بالقتل		
25	تعرضك للتهديد بقتل أحد أفراد الأسرة		

	الحدث أو الخبرة الصادمة	نعم	لا
26	تعرضك للخطر الشديد باستخدامك كدرع بشري للقبض على جار لكم		
27	تعرضك للحرمان من استخدام دورة المياه ومنعك من الخروج من الغرفة التي حجزت فيها		
28	تعرضك للحرق بالقنابل العادية و الفسفورية		
29	تعرضك للاعتقال من الجيش أثناء الاجتياح		
30	تعرضك للتهجير مع عائلتك وأقاربك		

هل تعرضت لخبرات أخرى _____

1. هل شعرت بأنك آمن في البيت ❑ نعم ❑لا
2- هل كنت قادرا على حماية نفسك ❑ نعم ❑لا
3- هل كنت قادرا على حماية أهلك ❑ نعم ❑لا
4- هل تعتقد بأن الآخرين كانوا قادرين على حمايتك ❑ نعم ❑لا

Annex 6
SPENCE CHILDREN'S ANXIETY SCALE-(SCAS)

مقياس القلق

ثالثا: هذه قائمه ببعض الأشياء التي قد تحدث لك ،ضع علامة (x) أمام كل عبارة بما يتفق مع رأيك:

البند	لا	أحيانا	عادة	دائما
1. أصاب بالقلق على بعض الأشياء				
2. أخاف من العتمة في الليل				
3. عندما أكون في مشكلة يصيبني شعور غريب في معدتي				
4. اشعر بالخوف				
5. اشعر بالخوف عندما أكون لوحدي في البيت				
6. اشعر بالخوف عندما اذهب للامتحان				
7. اشعر بالخوف عند استخدامي للحمام خارج البيت				
8. اشعر بالقلق عندما أكن بعيدا عن والدي				
9. اشعر بالخوف من أن أبدو غبيا أمام الآخرين				
10. أقلق من أنني لن أقوم بواجبي المدرسي على أكمل وجه				
11. أنا محبوب بين زملائي في نفس عمري				
12. اشعر بالقلق بأن شيء سيئ سوف يحدث في عائلتي				
13. أصاب بنوبات من ضيق التنفس بدون سبب واضح				
14. استمر في تفقد الأشياء التي اعملها عدة مرات (مثل التأكد من أن النور مطفى، باب البيت مقفول)				
15. اشعر بالخوف عندما أنام لوحدي				
16. أجد صعوبة في الذهاب للمدرسة في الصباح لأنني أشعر بالخوف و التوتر				
17. أنا كويس في الرياضة				
18. أخاف من الكلاب				
19. لا أستطيع التغلب على بعض الأفكار السخيفة أو السيئة من رأسي				
20. عندا أقع في مشكلة يدق قلبي بشدة				
21. أصاب فجأة بالرعشة في كل جسمي بدون سبب لذلك				
22. اقلق بأن أشياء سيئة سوف تحدث لي				
23. أخاف جدا من الذهاب لطبيب الأسنان أو الطبيب العام				

البند	لا	أحيانا	عادة	دائما
24. أشعر بالرعشة عندما أقع في مشكلة				
25. أخاف من الأماكن العالية ومن ركوب المصعد				
26. أنا شخص كويس				
27. لإيقاف أشياء سيئة قد تحدث لي أفكر في أشياء مثل بعض الأرقام و الكلمات				
28. أخاف من السفر في السيارة أو الأتوبيس				
29. أشعر بالقلق لما يعتقده الناس عني				
30. أخاف من الأماكن المزدحمة				
31. اشعر بالسعادة				
32. أشعر فجأة بالخوف الشديد بدون سبب				
33. أخاف من الحشرات و العقارب				
34. أصاب فجأة بالدوار و الدوخة بدون سبب				
35. أخاف الوقوف في الفصل و التحدث أمام زملائي				
36. يبدأ قلبي بالدق بسرعة بدون سبب				
37. أقلق من أنني سوف أصاب بالخوف الشديد من شيء غير موجود				
38. أحب نفسي				
39. أخاف من الأماكن الضيقة مثل الغرف الصغيرة				
40. أقوم بعمل أشياء مرات عدة (مثل غسيل اليدين، التنظيف، ترتيب أشياء بطريقة معينة)				
41. أصاب بالقلق من الأفكار و الصور السخيفة و السيئة التي تكون في رأسي				
42. افعل أشياء صحيحة لإيقاف أشياء سيئة قد تحدث لي				
43. أفخر بعملي المدرسي				
44. اشعر بالخوف عندما أكون خارج البيت في الليل				

45. هل هناك أشياء أخري تخاف منها؟	نعم	لا
إذا كانت الإجابة بنعم فما هي	_____	

Annex 7
Dépression Self- Rating Scale for Children (DSRS)

رابعا: أمامك مجموعة من الأسئلة تتعلق بما تشعر/ي به في خلال الأسبوع، من فضلك ضع علامة (**x**) أمام كل عبارة بما يتفق مع رأيك:

البند	دائما	بعض الأحيان	لا
1- ما زلت أنظر للأشياء في حياتي كما تعودت عليها			
2- أنام جيداً .			
3- أشعر بأنني سوف أبكي .			
4- أحب أن أخرج في الشارع للعب .			
5- أرغب في الهروب بعيداً .			
6- أتمتع بطاقة كبيرة .			
7- تصيبني آلام في المعدة .			
8- استمتع بالأكل.			
9- أستطيع القيام بخدمة نفسي .			
10- أشعر بأن الحياة لا تساوي شيئاً .			
11- أفعل الأشياء بشكل جيد .			
12- استمتع بعمل الأشياء كما كنت في السابق .			
13- أحب التحدث مع أهلي ومع الآخرين .			
14- أحلم أحلام مزعجة .			
15- أشعر بالوحدة الشديدة .			
16- من السهولة أن أبتهج			
17- أشعر بالتعاسة لدرجة لا تطاق			
18- أشعر بالملل .			

Annex 8
UCLA PTSD Index for DSM IV

خامسا: الأسئلة التالية تتعلق بالخبرة الصادمة التي تعرضت لها خلال الفترة الماضية. كل سؤال يصف التغيرات التي حدثت في مشاعرك خلال الفترة السابقة، من فضلك أجب علي كل الأسئلة .

هذه قائمه ببعض الأشياء التي قد تحدث لك ،ضع علامة (X) أمام كل عبارة بما يتفق مع رأيك:

	البند	لا	قليلا	أحيانا	كثيرا	غالبا
1	أترقب دائما شيء خطير يمكن أن يحدث أو أشياء آخري أخاف منها.					
2	عندما يذكرني احد بالحدث الذي واجهته، أصاب بالقلق، والتوتر، والحزن.					
3	تنتابني أفكار، أصوات، صور، لما حدث لي بدون رغبة مني في استرجاعها.					
4	أشعر بالغضب الشديد، التهيج.					
5	أعاني من أحلام مزعجة تتعلق بما تعرضت له.					
6	أشعر بأن ما حدث لي سيحدث مرة أخري الآن كما لو أنني أعيش بنفس الحدث مرة أخري الآن.					
7	أحب أن أكون لوحدي وليس مع أصدقائي.					
8	أحس بأنني وحيد ولست قريبا من أحد.					
9	أحاول بألا أتحدث، أفكر، أشعر بما حدث.					
10	أعاني من صعوبات في الشعور بالسعادة أو حب الآخرين.					
11	أعاني من صعوبات في الشعور بالحزن والغضب.					
12	أشعر بأني أتهيج بسرعة، أو أتفزز بمجرد سماع صوت عالي، أو أحد يفاجئني بسرعة.					
13	لدي صعوبة في الذهاب للنوم. وأصحو كثيرا في الليل.					
14	اشعر بأن ما حدث لي هو غلطتي أنا.					
15	لدي صعوبات في تذكر الأحداث التي تعرضت لها.					
16	عندي صعوبة في التركيز والانتباه.					
17	أتجنب الأشخاص، الأماكن، الأشياء التي تذكرني بالحدث الصادم.					
18	عندما يذكرني أحدهم بما حدث أشعر بقشعريرة في جسمي، وسرعة في ضربات قلبي، ووجع في المعدة، وصداع.					
19	أعتقد بأنني لن أعيش لفترة طويلة سيكون عمري قصير					
20	أجادل كثيرا أو أتعارك جسديا مع الآخرين.					
21	أشعر بالتشاؤم والسلبية تجاه مستقبلي.					
22	أخاف من أن أشياء سيئة سوف تحدث لي.					

Annex 9

مقياس التكيف والتأقلم للمراهقين

A-Cope Adolescent -Coping Orientation for Problem experiences

سادسا: من فضلك أقرأ الأسئلة التالية والتي تصف تصرفك للتأقلم مع المشاكل التي تواجهها في حياتك اليومية. ما هو التصرف الذي تقوم به عندما تواجه الصعوبات أو عند شعورك بالقلق . يمكن أن تفعل بعض التصرفات المذكورة أدناه ولو على سبيل المزاح. من فضلك صف فقط كل تصرف عند تعاملك مع كل مشكله ضع دائرة حول الإجابة الصحيحة على الإجابات التالية:

ا – لا 2– قليلا 3 – بعض الأحيان 4– عادة 5 – دائماً

عندما تواجه مشاكل أو تشعر بالقلق ماذا تفعل	لا	قليلا	بعض الأحيان	عادة	دائما
1–تطيع ما يطلبه منك والديك					
2– تقرأ في كتاب أو مجلة					
3–تحاول أن تمزح ولاتهتم بما حدث					
4–تعتذر للآخرين عما حدث					
5–تستمع إلى الأغاني والموسيقى والراديو					
6– تتحدث إلى مدرسك في المدرسة أو المرشد المدرسي الاجتماعي الموجود في المدرسة مشاكلك					
7– تأكل					
8– تخرج و تبقى بعيدا عن البيت أكبر فتره ممكنة					
9– تستعمل دواء برشته موصوفة من الطبيب					
10–تشغل نفسك بنشاطات تتعلق بالدراسة.					
11– تذهب للسوق لشراء أغراض تحبها.					
12–تحاول أن تكون منطقي و معقول وتتكلم عن الأشياء التي تضايقك مع والديك.					
13– تحاول أن تحسن من وضعك الدراسي (تحصل على درجات أعلى في المدرسة).					
14– تبكي					
15– تحاول أن تفكر في الحاجات الجيدة في حياتك.					
16– تذهب مع صديق					
17– تذهب في جولة في السيارة					
18– تقول أشياء جيدة للآخرين .					

عندما تواجه مشاكل أو تشعر بالقلق ماذا تفعل	لا	قليلا	بعض الأحيان	عادة	دائما
19- تغضب وتصيح على الآخرين.					
20- تنكت وتعطى روح من المرح.					
21- تتكلم مع شخص ملتزم ومتدين(شيخ، أمام مسجد، أو فتاح)					
22-تشكو مشاكلك لأفراد عائلتك					
23- تذهب للمسجد للصلاة					
24- تتناول أدوية (لم توصف من الطبيب)					
25- تنظم حياتك وتقرر ماذا ستفعل بعد ذلك.					
26- تشتم الآخرين					
27- تشتغل بجد في واجبك الدراسي أو نشاطات تخص المدرسة.					
28- تلوم الآخرين على الأشياء السيئة التي حصلت.					
29- تذهب لتكون قريب من شخص تهتم به					
30- تحاول أن تساعد الآخرين في حل مشاكلهم					
31- تتكلم مع والديك على ما يضايقك .					
32- تحاول أن تجد حلول لمستقبلك بنفسك.					
33- تمارس هوايات تحبها (مثل لعب الكره، الذهاب للاستحمام في البحر، الجري)					
34- تذهب للمشورة من أخصائية في مجال حل المشاكل (طبيب نفسي، أخصائي نفسي)					
35- تحاول أن تحتفظ بصداقاتك أو تكوين أصدقاء جدد					
36- تقول لنفسك بأن المشكلة غير مهمة.					
37- تذهب لمشاهدة فيلم في التلفزيون أو الفيديو.					
38 تسرح في أحلام اليقظة عن تصورك لحل المشكلة.					
39- تتكلم مع أخوك أو أختك عن ما تشعر به .					
40- تقوم بممارسة عمل شاق ومجهد.					
41- تعمل أشياء مفيدة مع عائلتك مثل ترتيب البيت و مساعدة والديك.					
42- تدخن سجائر أو أرجيلة.					
43- تشاهد التلفاز ليقل تفكيرك في المشكلة.					
44- تصلي أكثر من المعتاد عندما تصادفك مشكلة.					
45- تحاول أن ترى الأشياء على أنها جيده في مواقف صعبه (كله خير).					

عندما تواجه مشاكل أو تشعر بالقلق ماذا تفعل	لا	قليلا	بعض الأحيان	عادة	دائما
46- تشرب وتتعاطي مواد منومة أو مخدرة.					
47- تحاول أن تقرر ما تريد بنفسك.					
48- تنام					
49- تقول أشياء مفيدة للآخرين وتكون مفيد لنفسك.					
50- تتكلم مع والدك عما يشغل بالك.					
51- تتحدث مع صديق لك عن شعورك.					
52- تنفس عن غضبك بأن تشكو همومك لأصدقائك.					
53- تذهب لممارسة العاب الفيديو، وتنس طاوله.					
54- تقوم بمجهود عضلي شاق(مثل الركض، و التمارين الرياضية)					

Annex 10

DSM-IV-TR Diagnostic Criteria for Major Depressive Episode (American Psychiatric Association, 2000):

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either
(1) depressed mood or
(2) loss of interest or pleasure.
Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.

(4) Insomnia or Hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Annex 11

DSM-IV-TR Diagnostic Criteria for Generalized Anxiety Disorder (American Psychiatric Association, 2000):

According to the Diagnostic and Statistical Manual IV-Text Revision (DSM-IV-TR), the following criteria must be met for a person to be diagnosed with Generalized Anxiety Disorder.

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The person finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). **Note:** Only one item is required in children.

(1) restlessness or feeling keyed up or on edge
(2) being easily fatigued
(3) difficulty concentrating or mind going blank
(4) irritability
(5) muscle tension
(6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.

E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

Annex 12

DSM-IV-TR Diagnostic Criteria for Post-Traumatic Stress Disorder (American Psychiatric Association, 2000):

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
(2) the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
(2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
(2) efforts to avoid activities, places, or people that arouse recollections of the trauma
(3) inability to recall an important aspect of the trauma
(4) markedly diminished interest or participation in significant activities
(5) feeling of detachment or estrangement from others
(6) restricted range of affect (e.g., unable to have loving feelings)
(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

العنوان: الآثار النفسية و استراتيجيات التأقلم لدى المراهقين الفلسطينيين الناجمة عن الحرب على قطاع غزة.

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ملخص:

هذه دراسة وصفية تحليلية تهدف إلى معرفة الآثار النفسية الناجمة عن حرب غزة على المراهقين الفلسطينيين في قطاع غزة وآليات التأقلم التي يستخدمونها لمواجهة الأحداث الصادمة الناجمة عن العدوان الإسرائيلي. في هذه الدراسة يعرف الباحث الحرب: بكل أعمال العنف التي ترتكب من قبل إسرائيل ضد الشعب الفلسطيني. في هذه الدراسة اخذ الباحث عينة طبقية عنقودية عشوائية تتكون من 358 مراهقا (بنسبة 55.9% ذكور و 44.1% إناث) تتراوح أعمارهم بين 15 – 18 عاما. استخدم الباحث بعض المقاييس و الأدوات منها قائمة غزة للأحداث الصادمة بسبب الحرب على غزة، مقياس القلق (SCAS)، و مقياس الاكتئاب (DSRS)، و مقياس كرب ما بعد الصدمة (UCLA PTSD Index for DSM-IV)، و مقياس التكيف والتأقلم للمراهقين (A-Cope Adolescent). وقد توصلت الدراسة للنتائج التالية: الحدث الصادم الأكثر تكرارا بسبب العنف الإسرائيلي لدى أفراد العينة هو "مشاهدة صور الجرحى و الأشلاء و الشهداء في التلفاز" بنسبة 90.8%. نسبة انتشار الأحداث الصادمة بسبب العنف الإسرائيلي 23.4%. توصلت الدراسة إلى أن الأحداث الصادمة التالية (سماعك للقصف المدفعي للمناطق المختلفة من قطاع غزة، سماعك لاعتقال أو خطف أحد الأشخاص، مشاهدة عمليات الاغتيالات لرجال المقاومة من قبل الطائرات أو القصف المدفعي، تعرضك للتهجير مع عائلتك وأقاربك، سماعك لأصوات الطائرات الحربية عند اختراقها لحاجز الصوت) لها تأثير على درجة القلق النفسي و كرب ما بعد الصدمة لدى المراهقين، وان 37% من التغير الحاصل في درجات القلق النفسي و كرب ما بعد الصدمة يرجع إلى بنود الخبرات الصادمة السابقة ، في حين 63% يرجع إلى عوامل أخرى.و أن الأحداث الصادمة التالية (سماعك لاعتقال أو خطف أحد الأشخاص، مشاهدة عمليات الاغتيالات لرجال المقاومة من قبل الطائرات أو القصف المدفعي، تعرضك للتهجير مع عائلتك وأقاربك، مشاهدة استشهاد صديق لك أمامك) لها تأثير على درجة الاكتئاب النفسي لدى المراهقين، و أن 27% من التغير الحاصل في درجات الاكتئاب النفسي

يرجع إلى بنود الخبرات الصادمة السابقة، في حين 73% يرجع إلى عوامل أخرى . نسبة انتشار القلق و الاكتئاب و كرب ما بعد الصدمة على التوالي هي 37.0% ، 76.3% ، 37.6% و نسبة انتشار آليات المواجهة و التكيف هي 56.5%. توجد علاقة طردية بين الاكتئاب مع آليات المواجهة بينما لا توجد علاقة ذات دلالة إحصائية بين القلق و كرب ما بعد الصدمة مع آليات المواجهة. توصلت الدراسة أيضا إلى وجود فروق ذات دلالة إحصائية بين الذكور والإناث بالنسبة للخبرات الصادمة والفروق كانت لصالح الذكور و أظهرت الدراسة وجود فروق ذات دلالة إحصائية بين الذكور والإناث بالنسبة للقلق النفسي وأبعاده و كرب ما بعد الصدمة والفروق كانت لصالح الإناث بينما يوجد فروق ذات دلالة إحصائية بين الذكور والإناث بالنسبة للاكتئاب والفروق كانت لصالح الذكور و لا توجد فروق ذات دلالة إحصائية بين الذكور والإناث بالنسبة لأساليب التأقلم والتكيف لدى المراهقين.