Al-Quds University

Deanship of Graduate Studies

School of Public Health

Anxiety and Depression Among Pregnant Women in the Gaza Strip

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Thesis Approval

Anxiety and Depression among Pregnant Women in the Gaza Strip

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Dedication

I would like to dedicate my thesis

To my dear father, who encouraged me.

To my mother, To the meaning of love, the meaning of compassion

,dedication and way of success that taught me

To my dear brothers ,sisters and family who encouraged me

To my friends who have supported and encouraged me in my studies to

complete.

To all women in Palestine, particularly lived in the Gaza Strip.

And to everyone who contributed to make this study .

<div align="right">

With Love and Respect.

</div>

<div align="right">

Eslam Farhat Murtaja

</div>

Declaration

I declare that this thesis submitted for the degree of master in communitymental health is my own work , and it has not been submitted anywherefor a higher degree in any university or institution.

Signature:

Eslam Farhat Murtaja

Acknowledgment

First all praise to Allah,that help me to contioune my study.

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Also thanks for all pregnant women who participated in thestudy for their commitment and efforts.

With pleasure

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Abstract

This study aimed to explore the relationship between depression and anxiety among pregnant women in prenatal primary health care clinics in Gaza strip and identify the impact of other variables on this relationship. Descriptive analytic, cross sectional design was used. By using three applied tools as follow: socio-demographic characteristic questionnaire, Hamilton Anxiety Rating Scale, Beck Depression Inventory Scale and. The stratified sample was done and consisted of 400 pregnant women from five different governorates in Gaza Strip (North Gaza, Gaza, Middle Zone, Khan Younis and Rafah), Most of the participant's ages less than 35years. The study showed sever depression symptoms was (10.5%), moderate depression symptoms was (13.7%), and mild depression symptoms (34.8%). Also the results showed the pregnant women which follow ups in primary care have anxiety with low degree, the arithmetic mean for anxiety scale was 0.89, with standard deviation was 0.61. The study found there was positive correlation with statistical significance between depression & the anxiety for follow ups Pregnant women with primary care in Gaza Strip at the level of significance ($α ≤ 0.05$). And the study showed that there was significant differences in depression due to the Qualification, There are no statistically significant differences, at the level of significance ($α ≤ 0.05$) among the averages of the respondents answers about the depression and anxiety due to the age. And there was significant differences in depression and anxiety due to the educational qualification for the husband, and there was significant differences in depression due to the place of residence. the study found that there was significant differences in the depression and anxiety due to the family type, and the difference in favor of extended family. and there was significant differences in depression and anxiety due to the number of family members, and there was no differences in depression and anxiety due to the monthly income. and there was significant differences in the depression and anxiety due to the Clinic typeat the level of significance ($α ≤ 0.05$), and there was significant differences in favor of UNRWA Clinics.. The conclusion of study was psychological problem against pregnant women, is greatly influenced by the customs and cultures of each community, has a major contribution to the development of depression and anxiety in women.

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List of abbreviations

ACT	Acceptance and Commitment Therapy
ANOVA	Analysis of Variables
BA	Behavioral Activation
BDI	Beck Depression Inventory Scale
CBT	Cognitive-behavioral therapy
CTS	Conflict Tactics Scale
DSM	Diagnostic and Statistical Manual of mental disorders
GABA	Gamma-Amino Butyric Acid
GG	Gaza Governorates
GAD	Generalized anxiety disorder
HAMS	Hamilton Anxiety Rating Scale
IPT	Interpersonal Therapy
IPV	Intimate partner violence
MOH	Ministry of Health
MAOIs	Monoamine oxidase inhibitors
NGO	Non Governmental Organizations
OCD	Obsessive-compulsive disorder
PCBS	Palestinian Central Bureau of Statistics
PNGO	Palestinian Non Governmental Organizations
PTSD	post-traumatic stress disorder
SAD	Seasonal affective disorder
SPSS	Statistical Package for Social Sciences
UNRWA	United Nations Relief and Works Agency for Palestine
WHO	World Health Organization

Chapter One

Introduction

1.1 Background:

In the last seven years, three serious military war have been carried out by Israel occupation against the Palestinian people in Gaza strip, Women in Gaza face significant challenges particularly in light of the on-going Israeli occupation and siege as well as periodic military war in Gaza strip.in the absence of any solution, Palestinians especially women living in Gaza today remain athigh risk of mental illness due to on-going conflict, blockade, and the prolonged occupation, there are many forms of the suffering that the Palestinian people experience such as unemployment, poverty, security instability, and siege. All of these factors when combine together increases the domestic violence which may increase mental health disorders, The researcher consider this situation surely affects the pregnant women, as it is well known that they are the weakest group in the Palestinian community.

Historically, pregnancy has been viewed as a period of well-being that allowed women to feel biologically complete and provided protection for some women against psychiatric disorders, frequently seen as a period of emotional well-being, although for many womanist's time for enjoyment and fulfillment, at the same time   may also represent a moment of stress and changes. Stressful situations as domestic violence are considered to be mental disorder triggers, and such disorders are the most common health problems associated to pregnancy and postpartum period anxiety and depression (Dennis, 2007).

Traumatic stress is thought to be the main mechanism that explains why intimate partner violence may cause subsequent depression and suicide attempts. Exposures to traumatic events can lead to stress, fear and isolation, which, in turn, may lead to depression and suicidal behaviour(WHO, 2013)

The present study deals with pregnant women in trying to identify the relationship between depression and anxiety. Depression during the perinatal period can have devastating consequences, not only for the women experiencing it, but also for the women's children and family (Alder, 2007; Burke, 2003).

Antenatal depression and anxiety can also have a negative impact on the developing fetus and have been associated with premature births and lower birth weights (Field, 2004; Rondo, 2003).

Few studies have examined antenatal depression and anxiety among pregnant women in developing countries, despite (WHO) estimates that depressive disorders will be the second leading cause of the global disease burden by 2020 (WHO, 2002).

Rates of depressive illness in women of reproductive age are believed to be at least twice those observed in men (Ali, 2000).

The above mentioned data shows how much care should be given to this group of people by helping them to have normal life through the integration to all fields of the society. This requires improving mental health services and protections of women rights.

1.2 Research problem

in ten years ago Gaza strip exposed to three wars, everything not save, the human , animal until the stone, thousands of houses was destroyed , the war was end but the effect still to day. health worker dealing with a large number of injures , martyrs and increase   numbers of refuges in the schools.No one can deny that   unusual circumstances that the Palestinian people are living under stress . there are many forms of the suffering, the Palestinian people experience to unemployment, poverty, security instability, and siege. in addition to three war in the last ten years, which lead to psychosocial problems .

pregnant women   complain of many psychological problems consequence from family conflict and physical disability. Anxiety and depression are the major psychological problems, the change of self-image about body or future anxiety, these things consider trigger to develop mental health problems so we provide psychosocial support pregnant women through mental health services .

Although it is known that during the pregnancy women become sensitive, both physically and emotionally, and for that reason they may be in a more vulnerable condition, there are evidences that this is the right moment to investigate violence, based on the fact that, for many women, the pregnancy-puerperal cycle is the only opportunity to establish contact and bond with the health facility.

Also during the researcher work in EL-Shifa hospital" maternity department" she deals with pregnant women who are psychological injured, the researcher observe that the health team focused to offer psychological treatment leaving the underlying cause of those injuries not addressed. for all of the above the researcher become interested in investigating the relationship between and anxiety, depression Among pregnant women in Gaza strip.

1.3   Significance of the study

It is well-known that psychological problems is a global one and crosses geographical, linguistic, cultural and religious boundaries.So it is important   to determine the prevalence rate of anxiety and depression among pregnant women in Gaza strip., and no surveys had been done to explore the relationship between depression and anxiety, among pregnant women attending primary health care clinics in Gaza strip. lack of researches particularly in this field.

This study well attract the responsible persons in the ministry of health in order to begin to construct comprehensive biopsychosocialantinatal care for the pregnant women who attending the antinatal clinics in the primary health care unites this will to early detection and early treatment. This study will highlight the importance to build psychological programs to offer psychological antinatal caring for this women.

Understanding of the psychological aspect of pregnant women is essential to success of the intervention process including assessment, treatment and rehabilitation.

It is expected from this study to assist in focusing on psychological suffering of pregnant women that will help in introducing the required psychosocial support which will reduce the psychological pain and suffering of physical problem.

It is expected from this study to increase knowledge in the field of psychological, and to be as a source for information to conduct additional studies in this field .

In the other hand, this study will contribute in increasing the mental health body knowledge in Palestine and provide guidelines for other researchers to conduct future studies related to this field. Finally, it also provides recommendations to reduce the stigma problem about mental health as it will be a part of antinatalcare .

1.4   General objective:

The purpose of this study is to explore the relationship between depression and anxiety, among pregnant women attending primary health care clinics in Gaza strip.

1.5   Specific objectives:

1- To examine the level of anxiety and depression among pregnant women in Gaza strip.
2- To investigate the relationship between depression and anxiety among pregnant women In Gaza strip. .
3- To determine the relation between anxiety, depression and sociodemographic variables among pregnant women in Gaza strip.
4- To suggest recommendations for actions could be taken for comprehensive treatment programs about depression and anxiety among pregnant women.

1.6   Research Questions

1- What are the level of anxiety and depression among pregnant women in Gaza strip?
2- Is there a relationship between depression and anxiety Among pregnant women In Gaza strip.?
3- What is the relation between anxiety, depression and sociodemographic data Among pregnant women in Gaza strip.?
4- what are the recommendations and actions could be taken for comprehensive treatment program for anxiety, depression among pregnant women?

1.7   Context of the Study

1.7.1   GazaStrip

1.7.1.1   Demographic Context

Gaza strip is a small piece of land located in the southern area of Palestine with 1,7,143 inhabitants. It is divided into five governorates: North Gaza, GazaCity, Mid Zone, Khnunis and Rafah (PCBS, 2014). GG are characterized with high population density with more than4,500 individuals per square kilometer. This high population density and narrow place of land creates high demands for health care services and possible work overload for health care providers. On the other hand, it could be positive in terms of accessibility in contrast withWest Bank which is characterized by

wider spaces and presence of remote areas. The percentage of Gazonas who live in deep poverty has been steadily increasing within the last years (rised from nearly 22% in 1998 to nearly 35% in 2006). With the continued economic decline and the implementation of even stricter closures on Gaza, the poverty rate in 2008 is expected to be higher than it was in 2006 (Giacaman, *et. al.* 2009). This deterioration in economic situation might have its impacts on financial access to health care facilities. Furthermore, it might increase the burden of poverty related diseases such as malnutrition, iron deficiency anemia and sanitary related diseases (PNGO, 2009) which is directly related with PHC services. In addition, people might decrease utilizing health care services and they would be more prone for sudden financial disasters when they require more sophisticated health care services.

1.7.1.2   The population density:

MOH, (2014) In Gaza Strip, the population density is 3,808 inhabitants/km2 that comprises the following main five governorates: (MOH, 2014:2)

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.

1.7.1.3   Health care system

Palestinian health care system is complex as there are the four main providers for healthcare services; MOH, United Nations Relief and Works Agency (UNRWA),Non-Governmental Organizations (NGO) and the private for-profit service providers. MOH is the main healthcare provider in the governorates; it provides PHC, secondary and tertiary services for the whole population. It purchase advanced medical services through referring patients to the neighboring countries and other private and NGO health care facilities.

UNRWA provides PHC services to the refugee population, and purchases secondary and tertiary care services when needed. The NGO sector range from missionary hospitals, to facilities supported by international organizations, to community health centers. The private for-profit health sector also provides the three levels of care through a wide range of practices(WHO, 2005).

Although availability of various health providers does not necessarily guarantee covering all of the needed health services. The early mentioned demographic characters of the GG population imply that there is an increasing load on the health sector which should respond not only to the current challenges of occupation, siege and political divisions but also to the increasing demands for health services resulted from the ongoing increase in population size (PNGO, 2009). It's well known that health systems have three fundamental objectives which are improving population health; responding to people expectations and providing protection against sudden unplanned payment for health services specially for the poor. In the Palestinian context, MOH is not only responsible for providing those three objectives but also it is responsible for regulating the provision of health services provided by the other providers.

People satisfaction with governmental health care services is an important indicator for MOH performance. In general, people satisfaction with private and NGO sector health care services is higher than the governmental services (Abed, 2007). Another study showed that there are good levels of satisfaction with health care services, yet, people are not fully aware about their rights in receiving health care services (Abu

Dayya, 2000). In addition, there are low levels of clients participation in decisions related to treatment plans, choosing health provider and health facility regardless of their education levels. The study showed that the major areas of dissatisfaction were in long waiting times and the difficulties in dispensing medication(Abu Dayya, 2000).

1.7.1.4 Primary health care services

Regarding governmental PHC services, MOH runs well established and well-equipped primary health care centers (PNGO, 2009).

The five main health providers of health services in Palestine are Ministry of health,UNRWA, NGOs, Palestinian Military Medical Services (PMMS) and Private sector.MOH bears the heaviest burden, as it has the responsibility.InGaza strip, there are 163 primary health care centers run by four main providers: Government 54 primary health care centers, UNRWA 21 primary health care centers, NGOs 8 primary health care centers and PMMS 7 primary health care centers.(MOH, 2014)

PHC centers are classified from level two to level four, offering different health services according to the clinic level, these services include maternal and child health, care of chronic diseases, daily care, family planning, dental, mental services and others (MOH, 2006).

There is good health service coverage in GG, but the debate is on the quality of the health service delivery. A report mentioned that 81% of people are satisfied with the provided PHC services, yet refugees were more satisfied than non-refuges who receive PHC services mainly from governmental sector (Graduate institute of development studies, 2005).Generally, evaluating health system functioning depends on counting number of health care facilities, number of beds, beneficiaries and health personnel distribution which might underestimate or even mask low quality of care (Giacaman, *et. al.* 2009).

Though, studies which assess the quality of health care services would give clearer image and develop initiatives for improving health care services delivery.

According to MOH (2005),

There is a common problem of patients' flow where many of the patients arrive in the first hours of the day and in the first days of the month which is linked with drugs availability. Nearly 40% of all prescriptions are written in the first 4 days of the month while the last 4 days accounts only for 4%. This would create short examination times for patients as well as longer waiting time. mentioned that the

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average consultation time in PHC clinics is less than five minutes This status would not improve peoples' views about the quality of services (Palestine, MOH, 2005).Moreover, there are problems in the referral between PHC and hospital levels where people might refer themselves seeking for better care. mentioned that there is lack of confidence with PHC services due to diagnostic limitations, lack of drugs, inadequate specialized staff and finally, unavailability of afternoon shifts in most of PHC facilities (Abed,2007).

1.7.1.5 The effect of the war:

The target population of the survey consists of all Palestinian households living in Gaza Strip after the last war (December 27, 2008 – January 17, 2009). The sampling frame was established from the data of the Population, Housing, and Establishments Census (PCBS, 2009: 14)

• Findings showed that 45.7% of the Gaza Strip households had their dwellings partially or completely destroyed or slightly damaged. The highest percentage in this regard was registered in North Gaza Governorate at 63.5% followed by Rafah Governorate at 51.0%.

• 14.0% of the Gaza Strip households had their monthly expenditure reduced after the war. Khan Yunis; 23.8%, has the highest rate in this regard; whereas Deir Al Balahhas the lowest at 9.4%.

• 57.6% of households in Gaza Strip had to reduce the amounts of food they consume during war compared to 16.2% of households after the war. Moreover, 68.1% of households had to buy food of less quality during the war compared to 33.7% who had to do so after that war.

• 36.5% of households, or a member of the household, left their homes as a result of war, seeking secure places. North Gaza Governorate has the highest score in this regard at 50.9% followed by Deir Al Balah Governorate at 42.5%.

• 47.8% of Gaza Strip households cannot afford to pay their bills. 27.4% suffer power cut and 27.0% of households lack cooking gas.

The state of mental health care in Gaza strip:

Mental health care is provided by the government, and by the non-governmental sector. Government provision is offered through the BethlehemPsychiatric Hospital in the West Bank, which has a bed capacity of 320 patients, of whom 30% are chronic epileptic patients. GazaHospital, established in 1979 and rehabilitated in 1994, has 40 beds. Both hospitals use a traditional biological approach, with conventional pharmacological therapies and, at Bethlehem, electroshock therapy. Non-governmental and non-profit organizations working in this field is the Gaza Community Mental Health Programme (GCMHP). The GCMHP adopts a community-based approach to tackle mental health problems. It has centres across the whole Gaza Strip. The GCMHP offers community and clinical mental health services through its multidisciplinary teams, produces research studies, publishes articles in international journals, and gives training courses in community mental health. It has established a postgraduate diploma in community mental health and human rights that is unique in the Middle East (Afana et al, 2004).

1.8   Operational definitions:

1.8.1   Anxiety

Irrational and excessive fear, apprehensive and tense feelings difficulty managing daily tasks and/or distress related to these tasks(Rector,2011).

1.8.2   Depression

Is a common mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration. Moreover, depression often comes with symptoms of anxiety. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide. Almost 1 million lives are lost yearly due to suicide, which translates to 3000 suicide deaths every day. For every person who completes a suicide, 20 or more may attempt to end his or her life (WHO, 2012).

Chapter Two

TheoreticalFramework and Literature Review

2.1 Theoretical framework

2.1.1 Introduction

In this chapter, the researcher explained the a framework and literature reviews anxiety disorder and depression.

World Health Organization "WHO" defined the mental health 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 able to make contribution to his or her community (WHO, 2004).

The American Psychiatric Association "APA" defines a mental disorder as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom" (Videbeck, 2003).

Women have a substantially higher risk of developing lifetime anxiety disorders compared with men. In addition, research evidence has generally observed an increased symptom severity, chronic course, and functional impairment in women with anxiety disorders in comparison to men. However, the reasons for the increased risk in developing an anxiety disorder in women are still unknown and have yet to be adequately investigated. Evidence from various studies has suggested that genetic factors and female reproductive hormones may play important roles in the expression of these gender differences (Kinrys&Wygant, 2005).

Many women are surprised and disappointed when they find themselves feeling anxious during pregnancy or following the birth. After all, most people expect that this will be a joyous time — and for some women it truly is. But there are also a lot of other challenges and changes going on during this period that can make anxiety more likely during this time than at other times in a woman's life. For some women, this is the first time they have ever experienced anxiety. Other women who have had

problems with mood or anxiety in the past may find that their symptoms return or worsen during pregnancy or after the birth((Haring et al 2013).

Pregnancy and postpartum period has both positive and negative impact on women depending on an individual vulnerability. While it is a period of growth and hope, there is also a transformation in physiological, psychological and social perspective(financial constrains, inter personal relationships) which can in turn lead to emotional instability in women(Mina et al, 2012)

2.1.2 Conceptual framework[*]

This conceptual framework was developed by the researcher to portray the relationship between anxiety and depression among pregnant womeninGaza strip. And this diagram clarifies independent variable "pregnant women" and the dependent variable "anxiety and depression", the researcher focus on detail of this variable with relationship with demographic data .
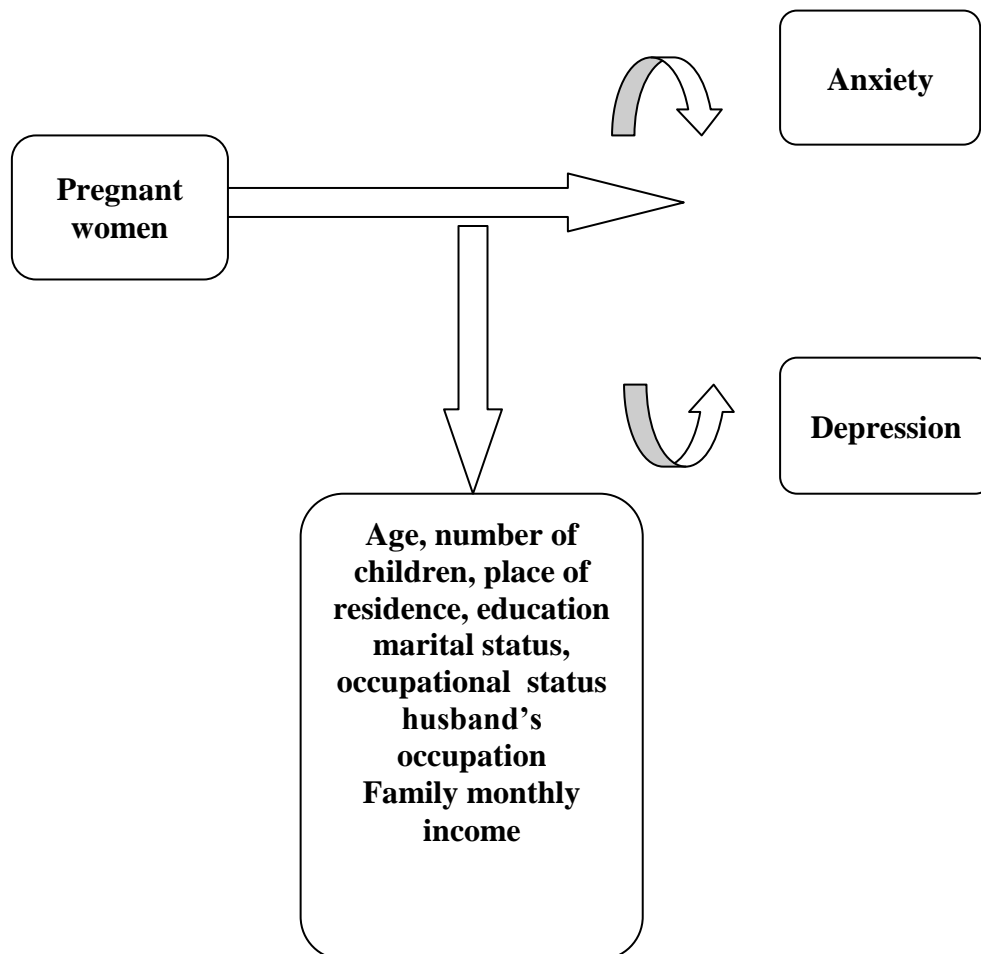
Figure (2.1): Conceptual framework diagram- self developed[*]

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2.1.3   Anxiety disorder

2.1.3.1   Definition

Anxiety is a vague feeling of dread or apprehension; it is a response to external or internal stimuli that can have behavioral, emotional, cognitive, and physical symptoms. Anxiety is distinguished from fear, which is feeling afraid or threatened by a clearly identifiable, external stimulus that represents danger to the person. Anxiety is unavoidable in life and can serve many positive functions such as motivating the person to take action to solve a problem or to resolve a crisis. It is considered normal when it is appropriate to the situation and dissipates when the situation has been resolved (Videbeck, 2010).

In other hand, anxiety defined as marked Distress that lead to marked interference with the person's normal routine, occupational or (academic) functioning, or social activities or relationships and this one of the core diagnostic criteria for most of the anxiety disorders(American Psychiatric Association 2000).

Also can be defined as the anticipation of future harm or misfortune, accompanied by a feeling of dysphoria (unpleasantness) and somatic symptoms of tension. It is an alert that a certain degree of anxiety is even desirable for the normal treatment of day-to day demands. Only when this exceeds certain intensity or the person's adaptive capacity anxiety become pathological, causing significant discomfort with symptoms that affect the person physically, psychologically, and behaviorally (Becker, 2003).

2.1.3.2   Prevalence rate

The prevalence rates for total anxiety disorders were 10.6% and 16.6%. Pooled rates for individual disorders varied widely. Women had generally higher prevalence rates across all anxiety disorder categories, compared with men, but the magnitude of this difference varied (Somers et al, 2006).

According study conducted by Jacobi et al (2004), Kessler et al (2005), Pirkola et al (2005).Sex differences in the prevalence of anxiety disorders are consistent across cultures and survey methods. Lifetime and 12-month prevalence rates of anxiety disorders among women are roughly twice the rates found among men (Simpson et al, 2010) .

2.1.3.3 Levels of Anxiety:

Anxiety concept is distinct and dependable and most of this dependency is the psychosocial physical impairment . On the other hand anxiety is a common experience to all of us on an almost daily basis. Many people meet the criteria of anxiety but they use individual coping mechanism to overcome this symptoms. Often, they use terms like jittery, high strung, and uptight to describe anxious feelings. By the way feeling anxious is normal and can range from very low levels to such high levels that social, personal, and academic performance is affected. At moderate levels, anxiety can be helpful because it raises our alertness to danger or signals that we need to take some action. When anxiety becomes excessive beyond what is tolerable problems arise in social, personal, and academic functioning may occur, resulting in an anxiety disorder(Balutt, 2013)

Anxiety has both healthy and harmful aspects depending on its degree and duration as well as on how well the person copes with it. Anxiety has four levels:

Mild anxiety: mild anxiety is a sensation that something is different and warrants special attention. Sensory stimulation increases and helps the person focus attention to learn, solve problems, think, act, feel, and protect him or her (Videbeck, 2010).

Moderate Anxiety: as the level of anxiety increases, the extent of the perceptual field diminishes. The moderately anxious individual is less alert to events occurring in the environment. The individual's attention span and ability to concentrate decrease, although he or she may still attend to needs with direction. Assistance with problem solving may be required (Townsend, 2009).

Severe Anxiety: according Townsend, (2009) attention span is extremely limited, and the individual has much difficulty completing even the 17 simplest tasks. Physical symptoms (e.g., headaches, palpitations, insomnia) and emotional symptoms (e.g., confusion, dread, and horror) may be evident. Discomfort is experienced to the degree that virtually all overt behavior is aimed at relieving the anxiety.

2.1.3.4 Theories of Anxiety

The two main schools of thought that attempt to explain the psychological influences on anxiety disorders are the cognitive and behavioral theories. The ideas expressed by these theories help us to understand cognitive-behavioral treatment; way of looking at the psychological causes of anxiety is the developmental theory, which

seeks to understand our experience of anxiety as adults by looking at what we learn as children. (Barlow, 2000).

1.Cognitive theory: suggests, however, that people with anxiety disorders are prone to overestimate danger and its potential consequences. For example, people may overestimate the danger of particular animals, such as spiders or snakes, and thus believe that harm from that animal is far greater and more common than it actually is thinking of the worst possible scenario, they may imagine that a snake will bite and poison them, when it may be completely harmless. This is known as catastrophizing, and is common among people with anxiety disorders. People who overestimate danger tend to avoid situations that might expose them to what they fear. For example, a person who fears flying will avoid trips that require air travel. Such behaviors are referred to as safety behaviors because they momentarily allow a person to feel less anxiety. However, when feared situations are avoided, the fears are strengthened. Cognitive theory suggests that fears can be reduced when people are able to experience the thing that they fear, allowing them to see that it is not as dangerous as they once believed (Decker, 2008).

2. Behavioral theory: suggests that people learn to associate the fear felt during a stressful or traumatic life event with certain cues, such as a place, a sound or a feeling. When the cues reoccur, they cause the fear to be re-experienced. Once the association between the fear and the cue is learned, it is automatic, immediate and out of conscious control. The fear is felt before there is time to tell if danger is near. Such cues may be external or internal. An example of an external cue might be a certain smell that occurred at the time of the stressful event. When this smell occurs again, even at a time when there is no danger present, the person is reminded of the event and becomes fearful. Internal cues, such as a rapid heart rate, may also provoke fear if the person's heart raced during the actual threat. Later, when the person's heart beats rapidly during a workout routine, he or she may become fearful. People with anxiety disorders may go to extreme lengths to avoid such cues; the original cues may even generalize to other similar cues (Borkovec, 2002).

3. Developmental Theory: According to developmental theory, the way in which children learn to predict and interpret life events contributes to the amount of anxiety they experience later in life. The amount of control people feel over their own lives is strongly related to the amount of anxiety they experience. A person's sense of control can range from confidence that whatever happens are entirely in his or her hands, to

feeling complete uncertainty and helplessness over upcoming life events. People who feel that life is out of their control are likely to feel more fear and anxiety. For example, these people may feel that no amount of preparation or qualifications will give them any control over the outcome of an upcoming job interview, and they arrive at the interview fearing rejection. (Copeland, 1998).

4. Biological theory: The biological causes and effects of anxiety disorders include problems with brain chemistry and brain activity; genetics; and medical, psychiatric and substance use issues. Regulation of brain chemistry. Research has revealed a link between anxiety and problems with the regulation of various neurotransmitters—the brain's chemical messengers that transmit signals between brain cells. Three major neurotransmitters are involved in anxiety: serotonin, nor epinephrine and gamma-amino butyric acid (Fanselow, 2000).

5.Medical factors: alcohol, medications and illicit substances Substance use may induce anxiety symptoms, either while the person is intoxicated or when the person is in withdrawal. The substances most often associated with generalized anxiety or panic symptoms are stimulants, including caffeine, illicit drugs such as cocaine, and prescription drugs such as methylphenidate (Neil, et al 2011).

6. Learning Models of Anxiety: Human learning involves long-lasting changes in cognition or behavior due to environmental experiences. According to learning theorists, anxiety is best viewed in terms of behavioral response tendencies learned as a result of the person's cumulative experience with environmental threats over time ,it seems reasonable that a person might learn through a series of unfortunate experiences that places, people, and events around which their life revolves are threatening, and, in consequence, become prone to anxiety responses. The scientific principles and models of human learning may be useful in accounting, in part, for an individual's acquisition of anxious behaviors in response to certain environmental stimuli. (Pekrun, 2009).

2.1.3.5 Types of anxiety:

American psychiatric association "APA" classified anxiety disorder by DSM-5. Anxiety disorders describe this group of conditions in annex No. (5), these classification explore types of anxiety disorder according criteria for signs and symptoms (APA, 2013).

2.1.3.6 Signs and symptoms

Psychological symptoms clarify by The American Psychiatric Association,(2000) (DSM-IV). They are excessive anxiety and worry about a number of events or activities (future oriented), occurring more days than not for at least 6 months Worry is difficult to control. * Worry is associated with at least three of the following symptoms: *Restlessness or feeling keyed up or on edge *Easily fatigued *Difficulty concentrating *Irritability * Muscle tension * Sleep disturbance *Anxiety and worry cause significant distress and impairment in social, occupational, or other daily functioning. And Physical symptoms Diarrhea Dizziness, light-headedness ,Hyperhidrosis, Hyper reflexia ,hypertension ,Palpitations, restlessness(e.g. Pacing) Syncope, Tachycardia tingling in the extremities, tremors, upset stomach ,Urinary frequency, hesitancy, urgency. (American Psychiatric Association, 2000) .

2.1.3.7   Women experience anxiety

The study conducted by Beck and Driscoll, (2006), showed there is now a growing realization that many women suffer from either new onset or exacerbation of existing anxiety disorders during prenatal period. Vythilingum, (2008) Studies of anxiety in pregnancy women show that a significant portion of them are affected . Heron et al., in a large community sample of pregnant women, found that 21% had clinically significant anxiety symptoms and, of these, 64% continued to have anxiety in postpartum (Anniverno et al, 2013)

The study conducted by Sockol, Epperson, & Barber, (2011). Showed to Screening for prenatal mood and anxiety disorders should be available in all facilities that provide care for new mothers, including obstetric, neonatal, and pediatric settings. Because prenatal mood disorders occur on a continuum, the importance of appropriate screening and early intervention strategies cannot be overstated. If a woman is contemplating suicide or contemplating harming her infant, emergency mental health interventions are necessary. A variety of effective treatment options exist for women with prenatal mood and anxiety disorders (the Association of Women's Health, 2015)

According to U.S. community surveys, women are significantly more likely than men to develop panic disorder (7.7% vs. 2.9%), GAD (6.6% vs. 3.6%), or PTSD (12.5% vs. 6.2%) during their lifetime.4 Though less pronounced, these surveys also suggest a gender difference in the risk for developing lifetime OCD (3.1% of women vs. 2.0% of men) and SAD (15.5% of women vs. 11.1% of men). The cause of the increased

risk in women for developing a lifetime anxiety disorder is not understood(Kinrys&Wygant, 2005).

2.1.3.8 Pregnant Women experience anxiety

Some of risk factors contribute to develop anxiety among pregnant women. women who have previously taken medications for depression or anxiety may choose to stop taking their medications prior to or during pregnancy. In some cases, this may lead to an increase in anxiety symptoms during pregnancy and the postpartum. The risk of anxiety during pregnancy and following the birth is greater if the woman has a prior history of anxiety or depression or is also experiencing other stressors, such as(Haring et al 2013):

- Recent stressful life events (e.g., death of a parent, moving, changing jobs)
- Relationship problems
- Unrealistic expectations of motherhood by the woman or others around her
- Lack of social support
- Infant health problems

2.1.3.9 Emotion regulation of pregnant women

Post and antenatal depression association "PANDA", referred to pregnancy is a time when there are many expectations about how you should feel, "you must be so happy" "how exciting for you". The physical changes of pregnancy are accompanied by many emotional changes and for some people emotional distress. You may be experiencing some uncertainty about the timing of the pregnancy, it may mean that career or long-term goals will be delayed or create financial problems. Feeling uncertain about your new role as a mother, fears about the pregnancy or how you will cope with labor and delivery, may add to feeling guilty about being unhappy, because everyone expects you to be content and blooming. These motions are not unusual, and are part of the common changes in emotion associated with each trimester(PANDA,2007).

first trimester: Mood swings tend to be most pronounced in the first 12 weeks of pregnancy, alongside the many physical changes such as fatigue, nausea, vomiting, and breast tenderness. Emotions can be unstable, and feelings of low mood are not uncommon. These mood swings can range from great joy to deep despair. Sometimes

you may become tearful without knowing the cause. It is commonly believed that changes in the hormones oestrogen and progesterone contribute to the mood changes early in pregnancy.

Second trimester: The second trimester is generally less turbulent. Morning sickness generally passes and worries about miscarriage tend to lessen. From about the twentieth week of pregnancy you might be able to feel the baby move and this realization that the baby is real can bring about excitement about the pregnancy. There is often an increase in energy and wellbeing in the second trimester.

Third trimester : The third trimester often brings anxiety about the birth, especially if there has been a difficult birth previously or if this is your first child and you don't know what to expect. During the final weeks of pregnancy these anxieties and fears may increase. You might also be concerned about the reality of becoming a mother and changes in relationships with your partner and family. You may experience sleeplessness, and it may be difficult to find a comfortable position. You may feel particularly vulnerable to rejection, loss or insult at this time. There will also be warm sensual feelings that can be very uplifting.

2.1.4   Depression

2.1.4.1   Definition

Depression defined as   is a state of low mood and aversion to activity that can affect a person's thoughts, behavior, feelings and sense of well-being , it's a common mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration. Moreover, depression often comes with symptoms of anxiety. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide. Almost 1 million lives are lost yearly due to suicide, which translates to 3000 suicide deaths every day. For every person who completes a suicide, 20 or more may attempt to end his or her life (Horwath, 2002).

Anxiety during pregnancy and following the birth is also often associated with other types of problems. For example, moderate to severe anxiety during this time period is often accompanied by depression. Part of the reason for this may be that it is depressing to be anxious all the time The symptoms of depression overlap to some extent with the symptoms of anxiety(Haring et al 2013)

Depression is a significant contributor to the global burden of disease and affects people in all communities across the world affect 350 million people. The World Mental Health Survey conducted in 17 countries found that on average about 1 in 20 people reported having an episode of depression in the previous year. Depressive disorders often start at a young age; they reduce people's functioning and often are recurring. For these reasons, depression is the leading cause of disability worldwide in terms of total years lost due to disability. The demand for curbing depression and other mental health conditions is on the rise globally (WHO, 2012).

2.1.4.2 Epidemiology of depression:
The prevalence depression in general population and onset period:
- % 2 of the general population develops a mood disorder.
- 21% of women and 13% of men develop major depression. Ratio M: F ≈ 1:2.
- Age of onset for major depression disorder ≈ 25.
- Depression occurs more frequently in lower socioeconomic groups.
- Bipolar disorders occur more frequently in higher socioeconomic groups.
- Age of onset of bipolar disorder ≈ 20.
- Prevalence of bipolar disorder ≈ 1%. Ratio M: F ≈ 2:3 (Newell and Gournay, 2009: 80).

A systematic review reports by Bennett et al, (2005) about prevalence rates of depression in pregnancy as 7.4%, 12.8%, and 12.0% for the first, second, and third trimesters, respectively(Mina et al, 2012).

2.1.4.3 Theory of depression
1.Cognitive theories: depression hypothesizes that particular negative ways of thinking increase individuals' likelihood of developing and maintaining depression when they experience stressful life events. According to these theories, individuals who possess specific maladaptive cognitive patterns are vulnerable to depression because they tend to engage in negative information processing about themselves and

their experiences. Beck hypothesized that depression-prone individuals possess negative self-schemata (beliefs), which he labeled the "cognitive triad." Specifically, depressed patients have a negative view of themselves (seeing themselves as worthless, inadequate, unlovable, deficient), their environment (seeing it as overwhelming, filled with obstacles and failure), and their future (seeing it as hopeless, no effort will change the course of their lives). This negative way of thinking guides one's perception, interpretation, and memory of personally relevant experiences, thereby resulting in a negatively biased construal of one's personal world, and ultimately, the development of depressive symptoms (McGinn, 2000).

2.Behavioral Activation (BA): is an idiographic and functional approach to depression. It argues that people with depression act in ways that maintain their depression and locates the origin of depressive episodes in the environment. While BA theories do not deny biological factors that contribute to depression, they assert that it is ultimately the combination of a stressful event in an individual's life and their reaction to the event that produces a depressive episode. Individuals with depression may display socially aversive behaviors, fail to engage in enjoyable activities, ruminate on their problems, or engage in other maladaptive activities. According to BA theory, these behaviors most often function as avoidance mechanisms while the individual tries to cope with a stressful life event, resulting in a decrease in positive reinforces or perceived control. Rumination is particularly important in the onset of depression. There are two main coping mechanisms, rumination and distraction. Ruminators spend time focusing on the stressful event and their feelings, while destructors engage in activities that distance them from the event and their feelings. Ruminators are much more likely to become depressed than distracters. Jacobson, (Neil, et al, 2001).

3.Neurotransmitter involvement: Varcarolis (2002) indicated there is much evidence to support the view that depression is a biologically heterogeneous disorder. This indicates that many neurotransmitters are implicated and the mechanisms of their interactions are not fully understood. Neurotransmitter dysregulation may result from environmental stressors, drug use, some medical conditions and/or an inherited vulnerability. Keltner& Warren (2003) describe three neurotransmitters that have attracted most medical research attention in relation to mood disorders are the catecholamine's, serotonin, nor epinephrine and dopamine. Also, acetylcholine and

gamma-amino butyric acid are likely to have modulating effects on those biogenic amines. It is known that stressful events overtax nor epinephrine, serotonin and acetylcholine systems and lead to depletion of these neurotransmitters, Serotonin is an important regulator of sleep, appetite and libido; and decreased levels may account for lowered energy levels, concentration difficulties and the inability to feel pleasure (Elder et al, 2005:245).

4. Psychodynamic theory of depression: The psychodynamic understanding of depression defined by Sigmund Freud and expanded by Karl Abraham is known as the classic view of depression. That theory involves four key points: disturbances in the infant mother relationship during the oral phase (the first 10 to 18 months of life) predispose to subsequent vulnerability to depression; depression can be linked to real or imagined object loss; introjections of the departed objects is a defense mechanism invoked to deal with the distress connected with the object's loss; and because the lost object is regarded with a mixture of love and hate, feelings of anger are directed inward at the self (Sadock, &Sadock, 2007:534).

5. 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. The efficacy of interpersonal psychotherapy treatment for major depression has been demonstrated in several controlled comparative depression treatment trials. According to Glassman and Shapiro(1998) The patient and therapist agree on the following four interpersonal problem areas that will be the focus of the depression treatment such as grief or complicated bereavement, b) role dispute or ongoing disagreements with a significant person in the patient's life, c) a recent role transition that results in major interpersonal role changes or alterations such as, (retirement, moving, being diagnosed with a major medical illness), and d) interpersonal deficits (recurrent difficulties in social interactions, in their extreme form classified as personality disorders (Davidson et al, 2004:167).

2.1.4.4   Types of depression

The Mood Disorders section includes disorders that have a disturbance in mood as the predominant feature the Mood Disorders are divided according DSM-IV into annex No (4): (APA,1994)

2.1.4.5   Signs and symptoms

Persistent sad, anxious, or "empty" feelings of hopelessness or pessimism Feelings of guilt, worthlessness, or helplessness Irritability, restlessness Loss of interest in activities or hobbies once pleasurable, including sex Fatigue and decreased energy Difficulty concentrating, remembering details, and making decisions Insomnia, early-morning wakefulness, or excessive sleeping Overeating, or appetite loss Thoughts of suicide, suicide attempts Aches or pains, headaches, cramps, or digestive problems that do not ease even with treatment.(Lyness, 2002).

2.1.4.6   DSM-5 criteria for Major Depressive Episode

The common feature of major depressive episode are the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function. What differs among them are issues of duration, timing, or presumed etiology. According DSM-5 in annex No. (5) Criteria for major depression episode (APA, 2013)

2.1.4.7   Women experience depression

Depression is more common among women than among men. Biological, life cycle, hormonal, and psychosocial factors that women experience may be linked to women's higher depression rate. Researchers have shown that hormones directly affect the brain chemistry that controls emotions and mood. For example, women are especially vulnerable to developing postpartum depression after giving birth, when hormonal and physical changes and the new responsibility of caring for a newborn can be overwhelming. Some women may also have a severe form of premenstrual syndrome called premenstrual dysphoric disorder is associated with the hormonal changes that typically occur around ovulation and before menstruation begins. During the transition into menopause, some women experience an increased risk for depression. In addition, osteoporosis may be associated with depression. Scientists are exploring all of these potential connections and how the cyclical rise and fall of estrogen and other hormones may affect a woman's brain chemistry. Finally, many

women face the additional stresses of work and home responsibilities, caring for children and aging parents, abuse, poverty, and relationship strains. It is still unclear, though, why some women faced with enormous challenges develop depression (Rohan, 2004).

The prevalence according DSM-5, twelve-month prevalence of major depressive disorder in the United States is approximately 7%, with marked differences by age group such that the prevalence in 18- to 29-year-old individuals is threefold higher than the prevalence in individual's age 60 years or older. Females experience 1.5- to 3 fold higher rates than males beginning in early adolescence (APA, 2013).

According DSM-4, a significant proportion of women report a worsening of the symptoms of a Major Depressive Episode several days before the onset of menses. Studies indicate that depressive episodes occur twice as frequently in women as in men (APA, 1994)

2.1.4.8 Pregnant women experience depression

Pregnancy is a period that can bring on worrying changes in the psyche of a woman, as she navigates a dramatic transition within herself. research has suggested that antenatal depression, or depression during pregnancy, may be even more common than postnatal depression. Locally, about one in five pregnant women is likely to have significant depressive symptoms associated with impairment of functioning, and about one in ten will have clinical depression that is, depression requiring medical attention. We also now understand that antenatal depression often marks the onset of depressive illness in women and increases the risk of postnatal depression. As the common features of depression such as loss of appetite, poor sleep, feeling tired and forgetful are so similar to those of pregnancy, women can sometimes dismiss these symptoms. More useful symptoms to look out for would be pessimism and mood swings(Chen, 2014).

2.1.4.9 The risk factors lead to depression or anxiety during pregnancy

While we cannot predict who will and won't develop depression and/or anxiety during pregnancy, there are some key factors that can make it more likely(Best start recourse center, 2013):

- A previous episode of depression or anxiety.
- Depression or anxiety during a previous pregnancy or after birth.

- A family history of depression, anxiety or other mental illness.

- Feeling isolated or not having a good support network.

- Stress prior to or during your pregnancy (for example: loss of a loved one, a new job or recent move, difficulties in important relationships, separation from your partner).

- Emotional, physical or sexual abuse including partner abuse now or in the past.

- Pregnancy complications.

- Difficulties in becoming pregnant. Having suffered a miscarriage, stillbirth or trauma during a previous pregnancy or birth

2.1.5 Summary

Anxiety is a part of thought as human being because the future is almost unknown may part of it can be expected to some extent but not hundred percent this remaining part is source of worry ,even the present is a source worry this may be related to our 21 limited ability to have full control all over the aspect of our life so we get worry at different level, some of us fall victims to their thought and worry,other may mange. As Muslims our beliefs that Allah is the only hundred percent justice and the most merciful and he decide what good to us this may enhance our patience and tolerance which in turn reduce our anxiety.

Anxiety disorder Anxiety disorder define according signs and symptom according DSM-4, anxiety is a normal part of our life but there are levels of anxiety can affect on daily function. anxiety disorders involve more than temporary worry or fear. For a person. There are several different types of anxiety disorders, examples include generalized anxiety disorder, panic disorder, and social anxiety disorder.

When we mentioned about women experience anxiety during domestic violence, there many of studies showed the impact of domestic violence among pregnant women and causes anxiety disorder The study conducted by Beck and Driscoll, (2006), showed there is now a growing realization that many women suffer from either new onset or exacerbation of existing anxiety disorders during prenatal period.

There are some of theories explain the psychological influences on anxiety disorders such as cognitive theory, develop theory, Behavioral theory, Biological theory and Medical factors. These theory help us to treat mental health disorder.

Depression is a significant contributor to the global burden of disease and affectspeople in all communities. % 2 of the general population develops a mood disorder.

Like anxiety disorder , depression have some of theories explain depression and factors can contribute in developing signs and symptoms. These theory focused on poor adaptation with life situation especially in trauma.

The treatment of Anxiety and depression disorder by tow points, the first on by medical treatment such as antidepressant drug and anti anxiety drug in other point by psychological treatment such as cognitive behavioral therapy "CBT"

2.2 Literature review

The researcher read many research reports and so he will present a lot of previous studies that conducted around this variables of the study he reached that these research reports interrelated with the proposal topic, most of study were about both of depression and anxiety, some of studies were about depression and anxiety separately, these of studies inferred the following:

2.2.1 Studies about anxiety and depression among pregnant women

the study conducted by Fairbroth et al (2015) to evaluate Depression and anxiety during the perinatal period. The sample of study was 660 English-speaking pregnant women. Participants for the portion of the research estimating the prevalence/incidence of perinatal mood disorders and AD (N = 347) were recruited proportionally from a geographically defined area. All participants were recruited via prenatal clinic visits at hospitals, physician offices and midwifery clinics, and via community outreach at events and through word of mouth. Recruitment took place between November 9, 2007 and November 12, 2010. Participants were administered questionnaires parentally at two time points (approximately 24 and 33 weeks gestation) and again at 4–6 weeks' postpartum and 6-months postpartum. Prevalence/incidence study participants who screened Mood and anxiety and related disorders (AD) account for a significant proportion of mental health conditions, with close to 30 % of the population (28.8 %) suffering from an AD at some time in their life, and over fifteen percent (16.2 %) suffering from a mood disorder. cut-off on one or more of the 4–6 week mood and anxiety questionnaires were also administered a diagnostic interview for mood disorders and AD at approximately 8–12 weeks postpartum. Discussion: This research addresses a number of gaps in our understanding of mood, anxiety and stress among pregnant and postpartum women. Specifically, gaps in our knowledge regarding the prevalence and incidence of (a) AD and mood disorders, and (b) anxiety and stress among women experiencing a medically high-risk pregnancy, interest in stress management training in pregnancy, mental health treatment barriers and access and screening for anxiety among pregnant and postpartum women are addressed.

This study conducted by Fadzil et al, (2013) to estimates of the prevalence of anxiety and depression during pregnancy vary according to the criteria used, variable

methodologies and population characteristics. The method of study was A cross-sectional survey design was used. A total of 175 antenatal mothers participated. Their socio-demographic and obstetric histories were recorded. The Hospital Anxiety and Depression Scale (HADS) and Mini International Neuropsychiatric Interview (M.I.N.I.) were used. The results of study were the prevalence of anxiety and depression disorders among antenatal mothers using diagnostic clinical interview were 9.1% and 8.6%, respectively. Factors associated with antenatal anxiety were marital status (being unmarried), positive history of mental illness, gestational age (<20weeks), unplanned pregnancy and depressive comorbidity. However, onlygestational age of less than 20 weeks and depressive disorder remained significant factors in the multivariate analysis. The prevalence rate of antenatal depression detected by HADS screening was comparable to the rate from diagnostic interview, but there was a slight overestimation for antenatal anxiety. Nonetheless, HADS as a screening tool offers a practical solution for detecting these two conditions in a busy antenatal clinic or a large epidemiological survey. In view of the deleterious effects of antenatal anxiety and depression on mothers and children, these two conditions should be screened and managed appropriately.

This study performed by Karmaliani et al, 2009 aimed to determine the prevalence of anxiety and depression and evaluate associated factors, including domestic violence, among pregnant women in an urban community in Pakistan. The sample of study was all pregnant women living in identified areas of Hyderabad, Pakistan were screened by government health workers for an observational study on maternal characteristics and pregnancy outcomes. Of these, 1,368 (76%) of eligible women were administered the validated Aga Khan University Anxiety Depression Scale at 20—26 weeks of gestation. Results of study aere eighteen per cent of the women were anxious and/or depressed. Psychological distress was associated with husband unemployment (p = 0.032), lower household wealth (p = 0.027), having 10 or more years of formal education (p = 0.002), a first (p = 0.002) and an unwanted pregnancy (p < 0.001). The strongest factors associated with depression/anxiety were physical/sexual and verbal abuse; 42% of women who were physically and/or sexually abused and 23% of those with verbal abuse had depression/anxiety compared to 8% of those who were not abused. Conclusions of study were anxiety and depression commonly occur during pregnancy in Pakistani women; rates are highest

in women experiencing sexual/physical as well as verbal abuse, but they are also increased among women with unemployed spouses and those with lower household wealth. These results suggest that developing a screening and treatment programme for domestic violence and depression/anxiety during pregnancy may improve the mental health status of pregnant Pakistani women.

This study conducted by Couto et al, (2009) aimed to compare the quality of life and the prevalence of symptoms of anxiety and depression among pregnant women with and without these antecedents. The design of study was An analytical cross-sectional study was performed in four settings (two high-risk and two low-risk prenatal clinics) in the city of Campinas, São Paulo, Brazil. The sample of study was A total of 240 women were interviewed by a single investigator between the 18th and 24th weeks of gestation: 120 women with prior adverse pregnancy outcomes (group 1) and 120 women with no such history (group 2), matched according to their numbers of living children. Sociodemographic variables were collected and two questionnaires were used: the Short Form-36 quality-of-life questionnaire and the Depression and Anxiety Scale. the results of study were The women in group 1 had lower scores in all the items on the quality-of-life questionnaire. Depression and anxiety were more frequent in group 1 ($P < 0.0001$). An inverse correlation was found between the Short Form-36 domains and anxiety and depression. Conclusion of study was women with histories of recurrent spontaneous abortion, fetal death, preterm birth or early neonatal death seem to have poorer quality of life and more symptoms of anxiety and depression during their subsequent pregnancy, compared with those without such antecedents.

Also Nasreen et al (2011) studied Prevalence and associated factors of depressive and anxiety symptoms during pregnancy: a population based study in rural Bangladesh.The aim of the study was to estimate the prevalence of depressive and anxiety symptoms and explore the associated factors in a cross-section of rural Bangladeshi pregnant .

It was cross-sectional, data originating from a rural community-based prospective cohort study, 720 randomly selected women in their third trimester of pregnancy from a district of Bangladesh.The researcher use Postnatal Depression Scale and trait anxiety inventory to assess general anxiety and depression symptoms. Background information was collected using a structured questionnaire at the respondents' homes.

Result was Prevalence of ADS was 18% and AAS 29%. Women's literacy (OR 0.59, 95% CI 0.37-0.95), poor partner relationship (OR 2.23, 95% CI 3.37-3.62), forced sex (OR 1.95, 95% CI 1.01-3.75), physical violence by spouse (OR 1.69, 95% CI 1.02-2.80), and previous depression (OR 4.62 95% CI 2.72-7.85) were found to be associated with ADS. The associated factors of AAS were illiteracy, poor household economy, lack of practical support, physical partner violence, violence during pregnancy, and interaction between poor household economy and poor partner relationship. Depressive and anxiety symptoms are found to occur commonly during pregnancy in Bangladesh, drawing attention to a need to screen for depression and anxiety during antenatal care. Policies aimed at encouraging practical support during pregnancy, reducing gender-based violence, supporting women with poor partner relationships, and identifying previous depression may ameliorate the potentially harmful consequences of ante partum depression and anxiety for the women and their family, particularly children

However, Karmaliani et al. (2009), studied prevalence of Anxiety, Depression and associated factors among pregnant women of Hyderabad, Pakistan, the general aim of the study was to determine the prevalence of anxiety and depression and evaluate associated factors, including domestic violence, among pregnant women in an urban community in Pakistan. All pregnant women living in identified areas of Hyderabad, Pakistan were screened by government health workers for an observational study on maternal characteristics and pregnancy outcomes.

The sample was 1368 (76%) of eligible women were administered the validated Aga Khan University, the researcher use Beck scale for Anxiety Depression at 20–26 weeks of gestation. as an instrument of the study, the result was 18 percent of the women were anxious and/or depressed. Psychological distress was associated with husband unemployment (p=0.032), lower household wealth (p=0.027), having 10 or more years of formal education (p=0.002), a first (p=0.002) and an unwanted pregnancy (p<0.001). The strongest factors associated with depression/anxiety were physical/sexual and verbal abuse; 42% of women who were physically and/or sexually abused and 23% of those with verbal abuse had depression/anxiety compared to 8% of those who were not abused. Anxiety and depression commonly occur during pregnancy in Pakistani women; rates are highest in women experiencing sexual/physical as well as verbal abuse, but they also are increased among women with unemployed spouses and those with lower household wealth. These results

suggest that developing a screening and treatment program for domestic violence and depression/anxiety during pregnancy may improve the mental health status of pregnant Pakistani women.

As Marcus (2004), studied depressive symptoms among pregnant women in Obstetrics Settings the aim of the study to describe the prevalence depressive symptomatology during pregnancy when seen in obstetric settings and the extent of treatment in this population, and specific risk factors associated with mood symptoms in pregnancy the total sample was 3472 pregnant women age 18 and older were screened while waiting for their prenatal care visits in 10 obstetrics clinics using a brief (10 minute) screening scale about use of antidepressant medications, past history of depression, and current treatment (i.e., medications, psychotherapy, or counseling).the result shows 20% (n = 689) screened women, scored above the cutoff score, and only 13.8% of those women reported receiving any formal treatment for depression. Past history of depression, poorer overall health, greater alcohol use consequences, smoking, being unmarried, unemployment, and lower educational attainment were significantly associated with symptoms of depression during pregnancy.

These data show that a substantial number of pregnant women screened in obstetrics settings have significant symptoms of depression, and most of them are not being monitored in treatment during this vulnerable time. This information may be used to justify and streamline systematic screening for depression in clinical encounters with pregnant women as a first step in determining which women may require further treatment for their mood symptoms. As elevations in depressive symptomatology have been associated with adverse maternal and infant outcomes, further study of the impact of psychiatric treatment in gravid women is essential.

2.2.2   Studies about depression among pregnant women

This study conducted by Kang et al, (2016) to investigate the prevalence of antenatal anxiety and associated factors among pregnant women and to provide scientific basis to reduce prenatal anxiety effectively. The method of study was A cross-sectional study was carried out at the Changchun Gynecology and ObstetricsHospital from January 2015 to march 2015, with 467 participants of at least 38 weeks' gestation enrolled. Antenatal anxiety was measured using the Self-Rating Anxiety Scale (SAS). _2 test and logistic regression analysis were performed to

evaluate the association of related factors of antenatal anxiety. Result of study was among the 467 participants, the prevalence of antenatal anxiety was 20.6% (96 of 467). After adjustment for women's socio-demographic characteristics (e.g., area, age, household income), multivariate logistical regression analysis revealed that antenatal anxiety showed significant relationship with education level lower than middle school (years ¤ 9), expected natural delivery, anemia during pregnancy, pregnancy-induced hypertension syndrome, disharmony in family relationship and life satisfaction. Conclusions: It is important to prevent or reduce antenatal anxiety from occurring by improving the health status of pregnant women and strengthening prenatal-related education and mental intervention.

This study conducted by Grenier et al, (2015)To identify risk factors for Anxiety Disorders and Post-Traumatic Stress Disorder (PTSD) in the general population. Knowledge of risk factors is useful for identifying at-risk populations, guiding the development of prevention programs, and improving early detection of these disorders. The method study of was a scoping review of English and French language articles published between 2003 and 2015 was conducted. Longitudinal studies of risk factors in the general population using definitions of anxiety disorders and PTSD as per the DSM-IV nomenclature were included. Associations between risk factors and anxiety disorders or PTSD were summarized and compared. Synthesis: Twenty-two longitudinal studies focusing on anxiety (N=17) and PTSD (N=5) were retained. The bulk of evidence came from ten large, population-based, longitudinal prospective studies. Six categories of risk factors emerged: 1) genetic/biological, 2) neurodevelopment, 3) environmental, 4) temperamental, 5) behavioral, and 6) stress-related. The conclusions of study were risk factors for anxiety disorders are multifactor and often mutually interactive. Childhood is a critical period. Children of parents with psychopathology, who demonstrate behavioral inhibition, who demonstrate antisocial behavior, who have low IQ, or who live in chronically adverse conditions such as poverty, are at risk of developing anxiety disorders. A history of juvenile disorders, severe maltreatment, poor quality of parental care, as well as symptoms of PTSD themselves, can increase the likelihood of PTSD. PTSD symptoms may develop in response to traumatic/life threatening events as well to accumulation of stressful, but non-traumatic events. Successful prevention of anxiety disorders and PTSD should focus on modifiable behavioural, environmental, and stress-related risk factors.

2.2.3   Studies about depression among pregnant women

This study conducted by Zayz et al,(2002) to assess level depression, social support, and life events in a sample of African-American and Hispanic women (N = 148) with uncomplicated pregnancies. Over half (51%) showed elevated depressive symptoms. Overall, women had fewer social supports and more negative life events than found in previous studies. African-Americans had more practical social support and persons in their support networks than Hispanics. Over a third of the sample (37%) had lost an important person in the past year. Depressed women reported more negative events than nondepressed women. Many negative life events and few social supports place minority women at risk for prenatal depression.

This study performed by Kazi et al (2006) to evaluates the relative power of social relations and social conditions in predicting depression among pregnant women in Pakistan. In the qualitative phase of the study, social environmental determinants were identified through literature search, and experts' opinions from psychologists, psychiatrists, gynecologists, sociologists and researchers. Along with this, 79 in-depth interviews were conducted with pregnant women drawn from six hospitals (public and private) and two communities in Karachi, Pakistan. Identified determinants of depression were grouped into themes of social conditions and social relations and pregnancy-related concerns. In the study's quantitative phase, the relative power of the identified themes and categories, based on their scores for predicting depression (determined by the Center for Epidemiological Studies—Depression Scale (CES-D scale)), was determined through multivariate linear regression. Social environmental determinants of pregnant women were described under the themes and categories of (1) social relations: involving husband, in-laws and children; (2) social conditions: involving the economy, illness, life events, household work, environmental circumstances and social problems; and (3) pregnancy-related concerns i.e. symptoms of pregnancy, changes during pregnancy, dependency and concern for unborn baby. Multivariate analysis found that among these themes, social relations and pregnancy-related concerns were significantly associated with total CES-D scores. Among the categories besides increasing age and less education, husband, in-laws, household work and pregnancy symptoms were significantly associated with total CES-D scores. The study highlights the importance of social relations compared to social conditions for determining depression in pregnant women.

This study conducted by Blaney et al,(2004) aimed to to assess the level of depressive symptoms among pregnant, HIV-infected racial and ethnic minority women and to identify potentially modifiable factors associated with prenatal depression in order to foster proactive clinical screening and intervention for these women. Baseline interview data collected from HIV-infected women participating in the Perinatal Guidelines Evaluation Project were analyzed. Participants were from prenatal clinics in four areas representative of the U. S. HIV/AIDS epidemic among women. Of the final sample (n = 307), 280 were minorities (218 blacks [African American and Carribean], 62 Hispanic). Standardized interviews assessed potential psychosocial factors associated with pregnancy-related depression and psychological distress (life stressors, inadequate social support, and ineffective coping skills) in a population for whom little work has been done. Depressive symptomatology was considerable, despite excluding somatic items in order to avoid confounding from prenatal or HIV-related physical symptoms. The psychosocial factors significantly predicted the level of prenatal depressive symptoms beyond the effects of demographic and health-related factors. Perceived stress, social isolation, and disengagement coping were associated with greater depression, positive partner support with lower depression. These findings demonstrate that psychosocial and behavioral factors amenable to clinical intervention are associated with prenatal depression among women of color with HIV. Routine screening to identify those currently depressed or at risk for depression should be integrated into prenatal HIV-care settings to target issues most needing intervention.

This study conducted by Flynn et al, (2006) to provide information on rates of depression treatment among pregnant women at risk for depression and among those with clinician-diagnosed current major depressive disorder (MDD) and to examine predictors of depression treatment. The method of study was Women seeking prenatal care completed a screening survey (including the Center for Epidemiological Studies-Depression Scale) in several hospital-based obstetrics clinics. Women identified as high risk for depression completed diagnostic interviews (n=276) during pregnancy, consisting of the Structured Clinical Interview for DSM-IV, measures of depression symptom severity (Beck Depression Inventory-II), health functioning (SF-36) and current and past psychiatric treatment. The Results of study were 33% were currently receiving any depression treatment. The presence of current MDD was not found to be related to use of treatment. Prior history of MDD, history of psychiatric treatment

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and depression severity were significant predictors of depression treatment during pregnancy. Conclusions of study were most women with current MDD were found to be either untreated or sub optimally treated, and prenatal MDD was not predictive of treatment. These findings point to the need for effective detection, targeted follow-up assessment and treatment linkage interventions to be studied in medical settings that encounter prenatal women.

The study conducted by Marcus et al (2004) aimed to describe the prevalence of depressive symptomatology during pregnancy when seen in obstetric settings, the extent of treatment in this population, and specific risk factors associated with mood symptoms in pregnancy. The sample of study a total of 3472 pregnant women age 18 and older were screened while waiting for their prenatal care visits in 10 obstetrics clinics using a brief (10 minute) screening questionnaire. This screen measured demographics, tobacco and alcohol, and depression measures, including the Center for Epidemiological Studies-Depression scale (CES-D), use of antidepressant medications, past history of depression, and current treatment (i.e., medications, psychotherapy, or counseling) for depression. The results of study were women screened, 20% (n = 689) scored above the cutoff score on the CES-D, and only 13.8% of those women reported receiving any formal treatment for depression. Past history of depression, poorer overall health, greater alcohol use consequences, smoking, being unmarried, unemployment, and lower educational attainment were significantly associated with symptoms of depression during pregnancy. Conclusion of study was these data show that a substantial number of pregnant women screened in obstetrics settings have significant symptoms of depression, and most of them are not being monitored in treatment during this vulnerable time. This information may be used to justify and streamline systematic screening for depression in clinical encounters with pregnant women as a first step in determining which women may require further treatment for their mood symptoms. As elevations in depressive symptomatology have been associated with adverse maternal and infant outcomes, further study of the impact of psychiatric treatment in gravid women is essential.

2.2.4 Studies about depression and anxiety with other variable among pregnant women

The study by Nur, (2012) showed Violence against women has been recognized as both a major public health problem and a human rights violation worldwide.

Research has documented the association between physical/sexual intimate partner violence (IPV) and mental health, measured by the 12-item General Health Questionnaire (GHQ-12) among women in reproductive age.

Cross-sectional survey was conducted in Sivas city center, Turkey, between September 2009 and April 2010. Sivas is a semirural province situated in the Middle Anatolia, with a population of about 700,000.

The socioeconomical level of the city is average compared with other cities of the country. There are significant disparities in the socioeconomic characteristics between the quarters of the city. The population aged 15 to 49 years in the city center was 86,419. This study underlines that different types of IPV is independently associated with mental health status. Results also showed the effects of IPV on mental health may not only be immediate but also be long term. These findings suggest that efforts to identify women with mental health problems should include screening for the types and history of IPV victimization.

Savas and Agridag (2011)the study aimed to examine the relationship between emotional disorders and domestic violence (DV) in 395 women of different ethnicities in Turkey. PRIME MD (Primary Care Evaluation of Mental Disorders) was used for diagnosis. This is a cross-sectional and epidemiological research.

Results showed that the prevalence of emotional disorders, anxiety, and somatoform disorders was 22.8%, 24.8%, and 16.9%, respectively. The mean DV score was 2.98 ± 1.32 over 10.00. DV scores were higher when women did not want to get married or did not have their family's blessing for marriage. Observed scores were also high for civil marriage cases, or when women had a job, had low income, or were afraid of their husbands ($P < .05$). The number of co morbid diagnoses increased with increase in DV scores ($P < .001$). Mean DV scores were higher for women diagnosed with major depression, partial remission or recurrence of major depression, panic disorder, and common anxiety ($P < .05$). The authors recommend that if physicians suspect any emotional disorders in women in primary care, they should evaluate for DV.

Another study conducted by Thabet et al (2015), the aim of this study is to find type and severity of domestic violence against Palestinian women in the Gaza Strip, and to investigate whether it is associated with mental health problems such as post-traumatic stress disorder, depression, and anxiety. The study sample included 622 Palestinian women randomly selected from the five areas of the Gaza Strip aged from

18 to 50 years (mean age = 31.5 years). They were interviewed using questionnaires including Sociodemogrophic variables, Conflicts Tactics Scale, post-traumatic stress disorder scale, Beck Depression Inventory, Taylor manifestation Anxiety Scale.

The study showed that psychological assault was 56.91%, physical assault 37.3%, physical injury 12.06%, and sexual assault was 7.14%. The study showed that domestic violence was significantly higher in women living in villages than in cities or camps. Also, women living in villages experienced more psychological abuse than women living in cities or camps. The study showed that 71 women (11.4%) had been diagnosed as post-traumatic stress disorder, 15% had moderate to severe depression, and 29.9% had very severe anxiety. The study showed that psychological assault toward women was positively correlated to depression, anxiety, and posttraumatic stress disorder. Also, there were significant positive relationships between physical assault and depression, anxiety, and posttraumatic stress symptoms. Physical injury and sexual assault were significantly positively related to post traumatic stress disorder, depression, and anxiety.

The study showed that one third Palestinian women exposed to physical violence and half of them exposed to psychological violence which lead to post-traumatic stress disorder depression, and anxiety. So, a great need for more programs for women victims of domestic violence in Palestinian society are needed with well trained professionals in the field of psychological support and therapy. More specific programs should be established in Gaza to enable women of using new coping strategies with difficulties. Also, training programs including primary health care professional such physicians, nurses, social service experts, and midwives should be provide to enable them of early detection of victims of violence and provide social support to these women.

Another study conducted by Machadoet al (2014) aimed to identify the relationship between intimate partner violence (IPV) during pregnancy and mental disorders in women in the pregnancy-puerperal cycle.

A review was conducted of papers published in Portuguese, English and Spanish regarding the study theme. The databases explored were PubMed, CINAHL, LILACS and PsycINFO.

The study result show that, 17 included papers studied the relationship between IPV and: pre- and postpartum depression (41%); pregnancy anxiety (23%) and

pregnancy posttraumatic stress disorder (12%). None of the studies investigated the association between IPV and suicidal ideation.

IPV against women during the pregnancy-puerperal cycle causes negative impacts on mental health. Concrete actions shall be proposed regarding the prevention, identification and treatment of women exposed to IPV during their pregnancy period.

Common mental disorders and intimate partner violence in pregnancy, it is study conducted by Ludermir et al (2014) aimed to investigate the association between common mental disorders and intimate partner violence during pregnancy. A cross sectional study was carried out with 1,120 pregnant women aged 18-49 years old, who were registered in the Family Health Program in the city of Recife, Northeastern Brazil, between 2005 and 2006. Common mental disorders were assessed using the Self-Reporting Questionnaire (SRQ-20). Intimate partner violence was defined as psychologically, physically and sexually abusive acts committed against women by their partners. Crude and adjusted odds ratios were estimated for the association studied utilizing logistic regression analysis.

The study result shows that, the most common form of partner violence was psychological. The prevalence of common mental disorders was 71.0% among women who reported all form of violence in pregnancy and 33.8% among those who did not report intimate partner violence. Common mental disorders were associated with psychological violence (OR 2.49, 95%CI 1.8; 3.5), even without physical or sexual violence. When psychological violence was combined with physical or sexual violence, the risk of common mental disorders was even higher (OR 3.45; 95%CI 2.3; 5.2). Being assaulted by someone with whom you are emotionally involved can trigger feelings of helplessness, low self-esteem and depression. The pregnancy probably increased women's vulnerability to common mental disorders.

Intimate partner violence and anxiety disorders in pregnancy, it is study conducted by Machado et al (2015) aimed to identify the relationship between posttraumatic stress disorder, trait and state anxiety, and intimate partner violence during pregnancy. This study is observational, cross-sectional study developed with 358 pregnant women. The Posttraumatic Stress Disorder Checklist - Civilian Version was used, as well as the State-Trait Anxiety Inventory and an adapted version of the instrument used in the World Health Organization Multi-country Study on Women's Health and Domestic Violence. The study result shows that, the prevalence of IPV,

during the current pregnancy, was 17.6% (63). Among the pregnant women that suffered IPV, 60 (95.2%) were in situation of psychological violence, 23 (36.5%) of physical violence, and 1 (1.6%) of sexual violence, among the 358 women, 61 (17.0%) had indication of PTSD. Of these, 24 (39.3%) were victims of IPV, during the current pregnancy. The results of this study indicate that intimate partner violence, occurred during pregnancy is a significant and independent predictor of indication of posttraumatic stress disorder in pregnant women.

2.2.5   Summary of previous studies

The researcher found most of previous studies support and agree with this study subject, objectives and target group as study conducted by Kang et al, (2016) , Grenier et al, (2015), Fairbroth et al (2015), Nasreen et al (2011), Karmaliani et al (2009), Marcus et al (2004), Marcus (2004), Hammoury et al (2009), Zareen et al (2009), Machado et al (2014), Ludermir et al (2014), Machado et al (2015), Naved and Persson (2008), Cardoza (2005). The previous studies share with the same goals as (to explore the relationship between domestic violence. depression and anxiety, among pregnant women).

From the researcher's view, the objectives of the previous studies are realistic, specific and measurable. By looking in the literature review the researcher found most of studies used different tools as study conducted by Nasreen,et al (2011) used Postnatal Depression Scale and trait anxiety inventory to assess general anxiety and depression symptoms, Karmaliani et al (2009) used Beck scale for Anxiety Depression at 20–26 weeks of gestation, Marcus (2004), used a brief (10 minute) screening scale about use of antidepressant medications, past history of depression, and current treatment. the Self-Rating Anxiety Scale used by Kang et al, (2016)

Where, The Abuse Assessment Screen instrument was used to screen for past and recent history of physical and emotional abuse among the participants in the study conducted by Thabet et al (2015) they used questionnaires including Sociodemogrophic variables, Conflicts Tactics Scale, post-traumatic stress disorder scale, Beck Depression Inventory, Taylor manifestation Anxiety Scale. Ludermir et al (2014) they used the Self-Reporting Questionnaire, finally Cardoza (2005) used In-depth interviews were conducted with women survivors to increase understanding of partner violence during pregnancy.

According to the researcher knowledge, the numbers of instruments are attempting to explore the relationship between depression and anxiety, among pregnant women is good and have a chance to measures and achievable. The current study consider important study in mental health field in Gaza Strip about the relationship between depression and anxiety, among pregnant women. That provides important information for decision makers about the present situation of these properties and this will aim to enhance psychological support and equal opportunity for pregnant women and improve mental health services.

The researcher found the design of most previous studies which related to current study is cross-sectional as study conducted by by Kang et al, (2016) , Grenier et al, (2015), Fairbroth et al (2015), Nasreen et al (2011).

The researcher took advantage of these previous studies and used it to develop tools, selecting study design, and writing the conceptual framework, definition of terminologies and explanation of issues and recommendations.

Finally: Most previous studies are related to this study, the researcher found the results of previous studies as the following:

High levels of symptoms of perinatal depression, anxiety, and PTSD are significantly study conducted by Kang et al, (2016) , Grenier et al, (2015), Fairbroth et al (2015), Nasreen et al (2011), Nasreen,et al (2011), Karmaliani et al.(2009) they found depressive and anxiety symptoms are found to occur commonly during pregnancy, the researcher thinks about strong relationship between anxiety and depression .

Past history of depression, poorer overall health, and greater alcohol use consequences, smoking, being unmarried, unemployment, gestational age, fear of husband or someone else in the house, and unintended pregnancy. and lower educational attainment were significantly associated with symptoms of depression during pregnancy as study conducted by Marcus (2004), Hammoury et al (2009), Zareen et al (2009), Savas and Agridag (2011).

The study conducted by Haddad et al (2011) found the Prevalence rate of lifetime abuse, 39% of women reported emotional abuse, 30% physical abuse, and 6% sexual abuse. While the conducted by Thabet et al (2015) showed that one third Palestinian women exposed to physical violence and half of them exposed to psychological violence which lead to post-traumatic stress disorder depression, and

anxiety. The researcher agrees with these results about the prevalence rate of psychological abuse and physical abuse is high while the sexual abuse low.

Study conducted by Ludermir et al (2014) showed that the most common form of partner violence was psychological. The prevalence of common mental disorders was 71.0% among women who reported all form of violence in pregnancy and 33.8% among those who did not report intimate partner violence. Finally the study conducted by Cardoza (2005) found high levels of emotional distress and attempted suicide were associated with violence during pregnancy. The researcher thinks many of problems in our the life have effect on psychological status, and the continuity of the stress can be trigger of mental disorder, especially when problems develop from partner or family member

Methodology

3.1 Introduction

This chapter illustrates the methodology used in conducting this study. It includes study design, study population, study setting, research sample, eligibility criteria, methods of data collection, entry and analysis, study instruments, scientific rigor (validity and reliability), ethical considerations, and limitations of the study.

3.2 Study Design

The design of this study is Descriptive ,analytical. It will be used to describe the relationship between domestic violence ,anxiety and depression among pregnant women in Gaza strip ,and also clarify new knowledge about concepts and identifies relationships between variables Cross sectional design reflects the existing facts at the same point of time of data collection, it consumes less time than other longitudinal studies and not expensive. In cross sectional studies, the data is gathered to represent what is going on at only one point in time.

The first phase of the research thesis proposal included identifying and defining the problems and establishment objective of the study and development research plan.

The second phase of the research included a summary of the comprehensive literature review. A literature on claim management was reviewed.

The third phase of the research included a field survey which was conducted with the relationship between domestic violence ,anxiety and depression among pregnant women in Gaza Strip

The fourth phase of the research focused on distributing questionnaire. This questionnaire was used to collect the required data in order to achieve the research objective.

The fifth phase of the research was data analysis and discussion. Statistical Package for the Social Sciences, (SPSS) was used to perform the required analysis. The final phase includes the conclusions and recommendations.

3.3 Study population

The study includes all the pregnant women who attending the primary health care centers of the ministry of health (government PHC and UNRWA primary health care centers).the study population number is about 60000 in Gaza Strip.

3.4 Study sample

The total study sample (400) women of followups in primary care in Gaza strip.

The total population in Gaza strip is approximately 1.8 million people (PCBS, 2014).

According to PCBS (2014) The total number of reported live births in Palestine was (121,330); 65,778 (54.2%) in West Bank and 55,552 (45.8%) in Gaza Strip and 10% abortion which means that the study population number is about 60000 in Gaza Strip.

3.5 Study Setting

Randomly selected antinatal clinics of the MOH include the five governorrates of Gaza strip,clinics must represent all area of Gaza strip regions to avoid bias.

The study setting includes five different areas of Gaza Strip (North Gaza, Gaza, Middle Zone, Khan Younis and Rafah). Annex 7shows the distribution and the names of PHC center.

3.6 Sampling

3.6.1 Sample calculation

By using sample size calculator software at confidence level 95% and confidence interval 5%, the recommended sample equals 382 women. The researcher increased the number of sample to 400 to cover for possible non-respondents. The respondents were 400pregnant women(response rate 97.%).

The sample was calculated according to the following equation, noting that the number of births is equal to 60,000
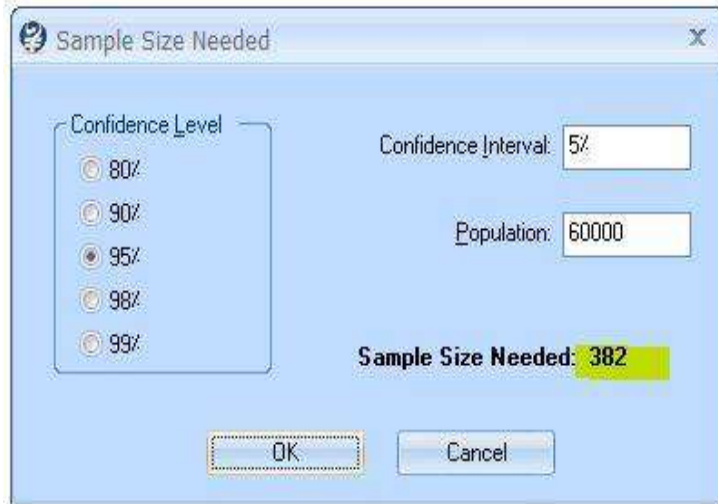
$$Or \quad n = \frac{M}{\left[\left(S^2 \times (M-1)\right) \div pq\right] + 1}$$

3.6.2 Distribution of the Sample

By simple random sampling method was selected clinics from the government clinics and UNRWA PHC Center from five different areas of Gaza Strip (North Gaza, Gaza, Middle Zone, Khan Younis and Rafah). the total number of clinics 10 that PHC chosen.

theresearcher exclusion the PHC that not follow up of pregnant from government PHC and UNRWA PHC. by simple random sampling method was selected clinics .

The PHC center that random simple selected was:

Government PHC Center: Kh\Younis,D\Balah, Tal Sultan, Sheikh Radwan, Rimal, BeitLahiya (Shaimaa)

UNRWA PHC Center: Bureij ,Kh\Younis, Jabalia, Naser(ALswedi).Annex 5 show that.

3.6.3 Sampling Process

By simple random sampling method was selected clinics from the government clinics and UNRWA PHC Center from five different areas of Gaza Strip.

sample: probability systematic selection will be done for the pregnant women with random start selected according to the registry of the pregnant women who are attending the antinatal clinics for the purpose of pregnancy follow up in the MOH

This mean every(nth)third women will be selected in the begining first women selected randomly from registry of the pregnant women who are attending the antinatal clinics in the beginning, middle and end of the month. the goal 40 pregnant women from each clinic

3.7 Study period

The study was performed from from December 2015 to October 2016 and that included preparing the proposal, writing chapter one and two, preparing the questionnaires, data collection, entry and analyses and finally writing chapters (three, four and five).

3.8 Eligibility criteria

3.8.1 Inclusion

Every pregnant women visiting the selected governmental receiving anti natal health care services during the data collection period and UNRWA

3.8.2 Exclusion

Pregnant women who visited other especial antinatalclinics or NGO clinics .

3.9 Study instruments

Data will be collected by using close-ended, administered questionnaires to assess the interrelation between study variables among study participants In order to get good and sure results, the researcher used the measurement that was designed to meet the goals of the study, which includes Conflict Tactics, Depression, and anxiety for followups Pregnant women with primary care in Gaza strip.

Three instruments will be used:

3.10 Socio Demographic scale

The demographic questionnaire is consist of age, Qualification, educational qualification for the husband, place of residence, type of housing, family type, number of family members, monthly income.

3.10.1 Hamilton Anxiety Rating Scale

The HAM-A was one of the first rating scales developed to measure the severity of anxiety symptoms, and is still widely used today in both clinical and research settings.

The scale consists of 14 items, each defined by a series of symptoms, and measures both psychic anxiety (mental agitation and psychological distress) and somatic anxiety (physical complaints related to anxiety). Although the HAM-A remains widely used as an outcome measure in clinical trials, it has been criticized for its sometimes poor ability to discriminate between anxiolytic and antidepressant effects, and somatic anxiety versus somatic side effects. The HAM-A does not provide any standardized probe questions. The items are rated on a five-point scale and summed to provide a score ranging from 0 to 56. A score of 17 or less represents mild anxiety, a score between 18 to 24 mild to moderate anxiety, and a score of 25 and above moderate to severe anxiety. The cut-off scores have not been validated with older adults and there are no published norms for older adults. For the study Chronbach's Alpha was .88 and split half was .82 (Thabet et al., 2009).

This checklist is to assist the physician or psychiatrist in evaluating each patient as to his degree of anxiety and pathological condition. With fill in the appropriate rating: none = 0 mild = 1 moderate = 2 severe = 3 severe, (very severe) grossly disabling = 4 In this study Cronbach alpha was 0.86, Split-half was 0.74.

3.10.2 Beck Depression Inventory Scale

Short form 13 item, translated into Arabic by Thabet 2007 The Beck Depression Inventory (BDI) is one of the most widely used instruments to assess depression. The main aim of Beck Depression Inventory is to measure depression symptoms and severity in persons age 13 and older. This inventory was validating in Palestine culture by Thabet 2007. The Beck Depression Inventory (BDI) has gone through multiple revisions, include BDI-I (1), BDI-IA (2), BDI-II (3), and BDI for Primary Care (BDI-PC), now known as BDI Fast Screen for Medical Patients (BDI-FS). A 13-item short form is more recent was used in this study. The severity of depression is classified on the basis of the total score; in a normal community sample, a BDI score <4 suggests no or minimal depression, 5 to 7 represents mild to moderate depression, 8 to 15 is moderate to severe, and <= 16 indicates a severe level of depression. It is a universal scale; its validity and reliability are already tested. The BDI demonstrates high internal consistency, with alpha coefficients of .86 and .80 for psychiatric and non-psychiatric populations respectively (Beck et al., 1988). In the study Alpha Chronbache was .86 and split half was .80 (Beck et al. 1988 ;Thabet, 2007). This

questionnaire consists of 13 groups of statement. After reading each group of statements carefully, circle the number (0,1,2,3) next to the one statement in each group which best describes the way you have been feeling the past week, including today.(0-4 non or minimal, 5-7 mild, 8-15 moderate, 16+ severe). in this study Cronbach alpha was0.89, Split-half was0.77

3.11 Scientific rigor

3.11.1 Validity

It refers to how well a test measures what it is purported to measure. The content of scales and questionnaires used were revised, modified, and applied previously by many researchers on Gaza population (e.g. Thabet, 2008).

3.11.2 Reliability

Reliability refers to the consistency of a measure; it is a condition for validity. A test is considered reliable if we get the same result repeatedly. To measure the internal consistency of the instruments, the researcher conducted "Cronbach alpha coefficient". Cronbach's alpha reliability coefficient normally ranges between 0 and 1. However, there is actually no lower limit to the coefficient. The closer Cronbach's alpha coefficient is to 1.0, the greater the internal consistency of the items in the scale. Split-half reliability was also done, in which all items were randomly divided, then measuring the same construct into two sets, and the scores for each half of the test were compared with one another. Table (3.1) shows the Cronbach alpha and Split-half reliability in the used scales.

Table (3.1): Cronbach alpha and Split-half reliability in the used scales

Name of scale	No. of items	Cronbach alpha	Split-half
Beck Depression Scale	13	0.89	0.77
Anxiety Scale	14	0.86	0.74

3.12 Data Collection

The researcher will astructural questionnaire for data collection and will be conducted through interview.

Regarding the timing of data collection, it will be in the first days (1, 2, 3) middle days (14, 15, 16) and last days (27, 28, 29) of the month. This would assure equal chances for sample selection and also represent various days of the month where different clients flow could be captured.

3.13 Data entry and analysis

The researcher will use Statistical Package of Social Science (SPSS) version 20. program for data entry and analysis. Frequency tables that show sample characteristics and pilot differences between various GG anti natal clinics and clients characteristics variables will be done. Moreover, cross tabulation for main findings and advanced statistical tests such as Chi-square test to compare categorical variables, and T test or One way ANOVA test to compare means of numeric variables will be done when required to analyze questionnaire data.

3.14 Ethical Considerations

1. Ethical approval from School of Public Health at Al-Quds University.
2. Moreover, Helsinki Committee.
3. An Admin approval from the Director General of MOH and the Director of NGOSs in Gaza.
4. Consent form in which the participants have the right to refuse or participate so to guarantee participants rights, 1. Privacy: questionnaire request that participants do not need to put their names anywhere on the questionnaires. 2. Expected risks of the study: There are no known risks for participating in the study. 3. If you have questions Please contact the researcher.

3.15 limitations of the Study

1. The study will include a sample from MOH clinics ,UNRWAand there are other PHC clinics forNGOs will not be included.
2. The study will assess govermental PHC,UNRWA no representative sample for all health providers.
3. This study employed a cross-sectional study design. Cross-sectional data does not allow causality to be established.
4. Need long time in collection data.
5. Culture of people in Gaza strip refuse genre of these research
6. Some pregnant women aren't cooperative and refuse to participate in this study; this takes long time to persuade them for participation in this study.
7. Lack of related text's and references.
8. Lack of logistic support (regular electricity cut).

Chapter (4)

Results

4.1 Introduction

This chapter will display the results according to the sequence of the study's questions. The following table illustrate the descriptive statistics of the study samples. This chapter presents the results of the study as following: first, the socio-demographic characteristics of the sample. Secondly, the level of anxiety and depression and the differences between these variables according to the socio-demographic characteristics of the study sample (age, Qualification, educational qualification for the husband, place of residence, type of housing, family type, number of family members, monthly income, Clinic type). Finally, the relationships between of demostic violence, anxiety and depression will be presented.

4.2 Socio demographic characteristic for study samples

Table (4.1): Distribution of the sample according to socio-demographic factors

Item	No.	%
Age		
Less than 25 years	149	37.3
25 to less than 35 years	194	48.5
more than 35 years	57	14.3
Qualification		
Illiterate	5	1.3
Primary	23	5.8
Preparatory	47	11.8
Secondary	149	37.3
Diploma	52	13.0
Academic	115	28.8
Higher Diploma	6	1.5
High study	3	0.8
Educational qualification for the husband		
Illiterate	11	2.8
Primary	26	6.5
Preparatory	56	14.0
Secondary	141	35.3
Diploma	42	10.5
Academic	104	26.0

Item	No.	%
Higher Diploma	8	2.0
High study	12	3.0
Place of residence		
City	237	59.3
Camp	121	30.3
Village	29	7.3
Other	13	3.3
Clinic type		
Government	240	60.0
UNRWA	160	40.0
Type of housing		
Rent	46	11.5
Ownership	241	60.3
With family	113	28.3
Family type		
Nuclear	246	61.5
Extended	154	38.5
Number of family members		
Less than 4	146	36.5
5 – 7	138	34.5
8 and above	116	29.0
monthly income		
Less than 1700 NIS	309	77.3
1700 -2220	48	12.0
2021-3000	28	7.0
3001-4000	13	3.3
4001 and above	2	0.5
Foreign assistance		
No	269	67.3
People of goodness	19	4.8
Relief Society	6	1.5
Zakah Committee	1	0.3
Government	48	12.0
UNRWA	57	14.3

Table 4.1 showed that the number of sample was 400 women,which will describe the study sample according to age, Qualification, educational qualification for the husband, place of residence, type of housing, family type, number of family members, monthly income, Clinic type.

According to age, 37.3% of the sample their age Less than 25 years, 48.5% 25 to less than 35 years, while 14.3% more than 35 years.

Regard qualification 1.3% of the sample did not learned, 5.8% Primary, 11.8% Preparatory, 37.3% Secondary, 13% Diploma, 28.8% Bachelor, 1.5% higher Diploma, while 3.0% have high study qualification.

Regard educational qualification for their husband 2.8% of the sample Educational qualification for their husband did not learned, 6.5% Primary, 14.0% Preparatory, 35.3% Secondary, 10.5% Diploma, 26.0% Bachelor, 2.0% higher Diploma, 3.0% high study.

Regard place of residence 59.3% live in city, 30.3% live in Camp, 7.3 live in Village, while 3.3% live in other place.

Regard clinic type.60.0% of the sample follow at Government clinic, while 40.0% follow at UNRWA clinic.

Regard type of housing 11.5% of the sample type of housing for them is rent, 60.3% Ownership, while 28.3% live with family.

Regard family type 61.5% of the sample type of their family is nuclear, while 38.5% extended family.

According to number of family 36.5% of the sample Number of their family members Less than 4, 34.5% from 5 to 7 member, while 29.0% 8 member and above.

Regard monthly income 77.3% of the sample their monthly income less than 1700 NIS, 12.0% from 1700 to 2220 NIS, 7.0% from 2021 to 3000 NIS, 3.3% from 3001 to 4000 NIS, while 0.5 4001 and above NIS.

Regard Foreign assistance 67.3% of the sample not received any Foreign assistance, 4.8% take from People of goodness, 1.5 from Relief Society, 0.3 Zakah Committee, 12.0 from Government, while 14.3% from UNRWA.

4.3   Medical history

The number of women who have been exposed to abortion 155 women from the study sample, which amounts to 400 women, with a rate of 38.7%.

4.4   Research questions analysis

Frequencies of the study variables and differences in demostic violence, anxiety and depression.

4.4.1   The level of the depression scale

The percentage of the depression for follow-ups pregnant women with primary care in Gaza strip.

The study showed that the most common depression symptoms were: Making decisions (10.5%), and Satisfied out of things as used to (7%), while My appetite is no worse than usual (7%).

Symptoms	None	Little	Much	Very Much
Feel sadness	40.0	45.8	8.5	5.8
Discouraged about the future	46.5	28.5	20.0	5.0
Failure	68.0	15.5	15.3	1.3
Satisfied out of things as used to	35.8	41.0	16.3	7.0
Guilty	38.0	39.8	18.5	3.8
Disappointed in self	67.8	22.5	7.3	2.5
Thoughts of killing self	84.3	12.8	1.0	2.0
Lost interest in other people	51.0	35.5	10.8	2.8
Making decisions	45.0	34.8	9.8	10.5
Feeling worse than used to	61.3	20.5	17.8	0.5
Work as usual	46.3	34.8	17.0	2.0
Get more tired than usual	29.3	46.5	21.3	3.0
My appetite is no worse than usual	41.0	37.0	15.0	7.0

4.4.2   Depression according to socio-demographic factors

Depression due to demographic characteristics are the following (age, Qualification, educational qualification for the husband, place of residence, type of housing, family type, number of family members, monthly income, Clinic type). at the level of significance ($\alpha \leq 0.05$) .

To verify this variable has been formulated following sub-factors:

1. Depression due to the age at the level of significance ($\alpha \leq 0.05$).

To verify this test was used (One Way ANOVA) to detect differences among the averages of the respondents answers about The depression due to the age, and the results are shown in the following table:

Table (4.2): One Way ANOVA of depression due to the age

age	Mean	F	Sig level
Less than 25 years	0.66		
25 to less than 35 years	0.73	2.611	0.075//
more than 35 years	0.83		

// Value of "sig" not statistically significant

It is indicated from the results in the table (4.18) the p-value (sig) corresponding to (One Way ANOVA) test more than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are no differences in The depression due to the age.

2. Depression due to the Qualification at the level of significance ($\alpha \leq 0.05$).

To verify this test was used (One Way ANOVA) to detect differences among the averages of the respondents answers about The depression due to the Qualification, and the results are shown in the following table:

Table (4.3): One Way ANOVA ofdepression due to the Qualification

Qualification	Mean	F	Sig level
Illiterate	1.17		
Primary	0.89		
Preparatory	0.83		
Secondary	0.73	5.451	0.000*
Diploma	0.91		
Academic	0.53		
Higher Diploma	0.50		
High study	0.23		

* Value of "sig" statistically significant

* p<0.05, **p<0.01, ***p<0.001

It is indicated from the results in the table (4.19) the p-value (sig) corresponding to (one way a nova) test less than the significance level (α ≤ 0.05), thus it can be concluded that there are differences in The depression due to the Qualification.

3. Depression due to the educational qualification for the husband at the level of significance (α ≤ 0.05) .

To verify this test was used (One Way ANOVA) to detect differences among the averages of the respondents answers about The depression due to the educational qualification for the husband, and the results are shown in the following table:

Table (4.4): One Way ANOVA of depression due to the educational qualification for the husband

educational qualification	Mean	F	Sig level
Illiterate	0.99		
Primary	0.83		
Preparatory	0.76		
Secondary	0.79	3.165	0.003*
Diploma	0.71		
Academic	0.60		
Higher Diploma	0.43		
High study	0.34		

* Value of "sig" statistically significant

* p<0.05, **p<0.01, ***p<0.001

It is indicated from the results in the table (4.21) the p-value (sig) corresponding to (One Way ANOVA) test less than the significance level (α ≤ 0.05), thus it can be

concluded that there are differences in The depression due to the educational qualification for the husband.

4. Depression due to the place of residence at the level of significance ($\alpha \leq 0.05$).

To verify this test was used (One Way ANOVA) to detect differences among the averages of the respondents answers about The depression due to the place of residence, and the results are shown in the following table:

Table (4.5): One Way ANOVA of depression due to theplace of residence

place of residence	Mean	F	Sig level
City	0.62		
Camp	0.87	8.105	0.000*
Village	0.87		
Other	0.70		

* Value of "sig" statistically significant

* p<0.05, **p<0.01, ***p<0.001

It is indicated from the results in the table (4.23) the p-value (sig) corresponding to (One Way ANOVA) test less than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are differences in The depression due to the place of residence.

5. Depression due to the type of housing at the level of significance ($\alpha \leq 0.05$).

To verify this test was used (One Way ANOVA) to detect differences among the averages of the respondents answers about The depression due to the type of housing, and the results are shown in the following table:

Table (4.6): One Way ANOVA of depression due to the type of housing

type of housing	Mean	F	Sig level
Rent	0.72		
Ownership	0.67	2.405	0.092//
With family	0.80		

// Value of "sig" not statistically significant

It is indicated from the results in the table (4.25) the p-value (sig) corresponding to (One Way ANOVA) test more than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are no differences in The depression due to the type of housing.

6. Depression due to the family type at the level of significance (α ≤ 0.05)

To verify this test was used (T) for two independent samples to detect differences among the averages of the respondents answers about the depression due to the family type, and the results are shown in the following table:

Table (4.7): Differences in The depression due to thefamily type

Family Type	Mean	STD	T	Sig
Nuclear	0.67	0.50	-2.059	0.040*
Extended	0.78	0.51		

* Value of "sig" statistically significant

* p<0.05, **p<0.01, ***p<0.001

It is indicated from the results in the table (4.26) the p-value (sig) corresponding to (T) test less than the significance level (α ≤ 0.05), thus it can be concluded that there are differences in The depression due to the family type, and the difference for extended family.

7. Depression due to the number of family members at the level of significance (α ≤ 0.05) .

To verify this test was used (One Way ANOVA) to detect differences among the averages of the respondents answers about The depression due to the number of family members, and the results are shown in the following table:

Table (4.8): One Way ANOVA of depression due to thenumber of family members

Thenumber of family members	Mean	F	Sig level
Less than 4	0.60	8.309	0.000*
5 – 7	0.70		
8 and above	0.87		

* Value of "sig" statistically significant

* p<0.05, **p<0.01, ***p<0.001

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It is indicated from the results in the table (4.27) the p-value (sig) corresponding to (One Way ANOVA) test less than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are differences in The depression due to the number of family members.

8. Depression due to the monthly income at the level of significance ($\alpha \leq 0.05$).

To verify this test was used (One Way ANOVA) to detect differences among the averages of the respondents answers about The depression due to the monthly income, and the results are shown in the following table:

Table (4.9): One Way ANOVA of depression due to themonthly income

monthly income	Mean	F	Sig level
Less than 1700 NIS	0.72		
1700 -2220	0.84		
2021-3000	0.52	8.309	0.113//
3001-4000	0.63		
4001 and above	0.50		

// Value of "sig" not statistically significant

It is indicated from the results in the table (4.29) the p-value (sig) corresponding to (One Way ANOVA) test more than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are no differences in The depression due to the monthly income.

9. Depression due to the Clinic type at the level of significance ($\alpha \leq 0.05$).

To verify this test was used (T) for two independent samples to detect differences among the averages of the respondents answers about The depression due to the Clinic type, and the results are shown in the following table:

Table (4.10): Differences in The depression due to the Clinic type

Clinic type	Mean	STD	T	Sig
Government	0.64	0.49		
UNRWA	0.81	0.52	-3.219	0.001*

* Value of "sig" statistically significant

* p<0.05, **p<0.01, ***p<0.001

It is indicated from the results in the table (4.30) the p-value (sig) corresponding to (T) test less than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are differences in The depression due to the Clinic type, and the difference for UNRWA Clinics.

4.4.3 The level of the anxiety scale

The level of the anxietyforfollowupsPregnant women with primary care in Gaza strip.

To know the anxietyforfollowupsPregnant women with primary care in Gaza strip, The researcher calculates the averages and standard deviations for each dimension of the anxiety, it is clear by the following table:

Table (4.11): Mean and standard deviation of anxiety scale

Anxiety scale	mean	STD
	0.89	0.61

It indicated of the show results on table (4.31) that the arithmetic mean for anxiety scale was 0.89, with standard deviation was 0.61, and this indicated that pregnant women are primary care followups in the Gaza Strip, have anxiety with low degree.

4.4.4 Anxiety according to socio-demographic factors

Anxiety due to demographic characteristics are the following (age, Qualification, educational qualification for the husband, place of residence, type of housing, family type, number of family members, monthly income, Clinic type) at the level of significance ($\alpha \leq 0.05$).

To verify this variable has been formulated following sub- **factors**:

1. Anxiety due to the age at the level of significance ($\alpha \leq 0.05$).

To verify this test was used (One Way ANOVA) to detect differences among the averages of the respondents answers about The anxiety due to the age, and the results are shown in the following table:

Table (4.12): One Way ANOVA of anxiety due to the age

Age	Mean	F	Sig level
Less than 25 years	0.82		
25 to less than 35 years	0.91	2.730	0.066//
more than 35 years	1.03		

// Value of "sig" not statistically significant

It is indicated from the results in the table (4.32) the p-value (sig) corresponding to (One Way ANOVA) test more than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are no differences in The anxiety due to the age.

2. Anxiety due to the Qualification at the level of significance ($\alpha \leq 0.05$).

To verify this test was used (One Way ANOVA) to detect differences among the averages of the respondents answers about The anxiety due to the Qualification, and the results are shown in the following table:

Table (4.13): One Way ANOVA of anxiety due to the Qualification

Qualification	Mean	F	Sig level
Illiterate	1.41		
Primary	1.09		
Preparatory	1.00		
Secondary	0.87	1.827	0.081//
Diploma	0.93		
Academic	0.82		
Higher Diploma	0.81		
High study	0.31		

// Value of "sig" not statistically significant

It is indicated from the results in the table (4.33) the p-value (sig) corresponding to (One Way ANOVA) test more than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are no differences in The anxiety due to the Qualification.

3. Anxiety due to the educational qualification for the husband at the level of significance ($\alpha \leq 0.05$).

To verify this test was used (One Way ANOVA) to detect differences among the averages of the respondents answers about The anxiety due to the educational qualification for the husband, and the results are shown in the following table:

Table (4.14): One Way ANOVA of anxiety due to the educational qualification for the husband

Educational qualification	Mean	F	Sig level
Illiterate	1.55		
Primary	1.09		
Preparatory	0.89		
Secondary	0.88	2.975	0.005*
Diploma	0.81		
Academic	0.88		
Higher Diploma	0.64		
High study	0.61		

// Value of "sig" not statistically significant

* p<0.05, **p<0.01, ***p<0.001

It is indicated from the results in the table (4.34) the p-value (sig) corresponding to (One Way ANOVA) test less than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are differences in The anxiety due to the educational qualification for the husband.

4. Anxiety due to the place of residence at the level of significance ($\alpha \leq 0.05$).

To verify this test was used (One Way ANOVA) to detect differences among the averages of the respondents answers about The anxiety due to the place of residence, and the results are shown in the following table:

Table (4.15): One Way ANOVA of anxiety due to theplace of residence

Source of variation	Mean	F	Sig level
City	0.83		
Camp	0.99	2.255	0.081//
Village	1.00		
Other	0.89		

// Value of "sig" not statistically significant

It is indicated from the results in the table (4.36) the p-value (sig) corresponding to (One Way ANOVA) test more than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are no differences in The anxiety due to the place of residence.

5. Anxiety due to the type of housing at the level of significance (α ≤ 0.05) .

To verify this test was used (One Way ANOVA) to detect differences among the averages of the respondents answers about The anxiety due to the type of housing, and the results are shown in the following table:

Table (4.16): One Way ANOVA of anxiety due to the type of housing

Type of housing	Mean	F	Sig level
Rent	0.86		
Ownership	0.82	5.095	0.007*
With family	1.04		

* Value of "sig" statistically significant

* p<0.05, **p<0.01, ***p<0.001

It is indicated from the results in the table (4.37) the p-value (sig) corresponding to (One Way ANOVA) test less than the significance level (α ≤ 0.05), thus it can be concluded that there are differences in The anxiety due to the type of housing.

6. Anxiety due to the family type at the level of significance (α ≤ 0.05).

To verify this test was used (T) for two independent samples to detect differences among the averages of the respondents answers about The anxiety due to the family type, and the results are shown in the following table:

Table (4.17): Differences in The anxiety due to thefamily type

Family Type	Average	STD	T	Sig
Nuclear	0.84	0.60		
Extended	0.97	0.61	-2.060	0.040*

* Value of "sig" statistically significant

* p<0.05, **p<0.01, ***p<0.001

It is indicated from the results in the table (4.39) the p-value (sig) corresponding to (T) test less than the significance level (α ≤ 0.05), thus it can be concluded that there are differences in The anxiety due to the family type, and the difference for extended family.

7. Anxiety due to the number of family members at the level of significance (α ≤ 0.05).

To verify this test was used (One Way ANOVA) to detect differences among the averages of the respondents answers about The anxiety due to the number of family members, and the results are shown in the following table:

Table (4.18): One Way ANOVA of anxiety due to thenumber of family members

number of family members	Mean	F	Sig level
Less than 4	0.78		
5 – 7	0.92	3.872	0.022*
8 and above	0.98		

* Value of "sig" statistically significant

* p<0.05, **p<0.01, ***p<0.001

It is indicated from the results in the table (4.40) the p-value (sig) corresponding to (One Way ANOVA) test less than the significance level (α ≤ 0.05), thus it can be concluded that there are differences in The anxiety due to the number of family members.

8. Anxiety due to the monthly income at the level of significance (α ≤ 0.05).

To verify this test was used (One Way ANOVA) to detect differences among the averages of the respondents answers about The anxiety due to the monthly income, and the results are shown in the following table:

Table (4.19): One Way ANOVA of anxiety due to themonthly income

monthly income	Mean	F	Sig level
Less than 1700 NIS	0.91		
1700 -2220	0.80		
2021-3000	0.78	0.953	0.433//
3001-4000	0.94		
4001 and above	1.39		

// Value of "sig" not statistically significant

It is indicated from the results in the table (4.42) the p-value (sig) corresponding to (One Way ANOVA) test more than the significance level (α ≤ 0.05), thus it can be concluded that there are no differences in The anxiety due to the monthly income.

9. Anxiety due to the Clinic type at the level of significance (α ≤ 0.05).

To verify this test was used (T) for two independent samples to detect differences among the averages of the respondents answers about The anxiety due to the Clinic type, and the results are shown in the following table:

Table (4.20): Differences in The anxiety due to theClinic type

Clinic type	Average	STD	T	Sig
Government	0.82	0.58	-2.780	0.006*
UNRWA	0.99	0.63		

// Value of "sig" not statistically significant

* p<0.05, **p<0.01, ***p<0.001

It is indicated from the results in the table (4.43) the p-value (sig) corresponding to (T) test less than the significance level (α ≤ 0.05), thus it can be concluded that there are differences in The anxiety due to the Clinic type, and the difference for UNRWA Clinics.

There is significant relations between Anxiety & the depression for Pregnant women with primary care in Gaza strip.

To test this hypothesis, Pearson correlation coefficient has been utilized to study the relation between Anxiety & the depression for follow ups Pregnant women with primary care in Gaza strip, and the results shown through the following table:

**Table (4.5) The results of Pearson Correlation Coefficient to study
the relation between Anxiety & the depression**

depression	Anxiety	
	Correlation coefficient	Significance level
	0.59	*0.000

* Correlation is statistical significant at $\alpha \leq 0.05$

It is indicated from the results shown in the table (4.5) there is positive correlation with statistical significance between Anxiety & the depression for follow ups Pregnant women with primary care in Gaza strip.

Chapter (5)

Discussion

5.1 Introduction

This chapter presents a discussion of the results of the study as presented in chapter four, these findings are discussed in line of literature review that is important to clarify them in comparison of other studies conducted by other researchers. The chapter also presents recommendations regarding to anxiety and depression among pregnant women in Gaza strip..

As discussed in Chapter Three, the literature confirms that the depression and anxiety was Spread widely among women. Also it considers the main barrier to achieve well mental health.In this study, the researcher uses three scales and data was collected by using close-ended, administered questionnaires to assess the interrelation between study variables among study participants.

In this chapter the researcher discusses the main findings of the study. This study is the first one on the field of mental health in Palestine according to the researcher's knowledge.

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In this chapter the researcher discusses the main findings of the study. This study is the first one on the field of mental health in Palestine according to the researcher's knowledge.

5.2   Discussion

5.2.1   What are the level of   anxiety and Depression

The study showed that high depression symptoms among pregnant women, and   the most common depression symptoms is Making decisions (10.5%), and Satisfied out of things as used to (7%), while appetite is no worse than usual (7%).this result agree with study conducted by Zayz et al,(2002) showed over a third of the sample (37%) had lost an important person in the past year. Depressed women reported more negative events than non depressed women. Many negative life events and few social supports place minority women at risk for prenatal depression.

The current study result consistent with previous study conducted by Marcus (2004), Kazi et al (2006) and Flynn et al, (2006)   which found that a substantial number of pregnant women screened in obstetrics settings have significant symptoms of depression. The researcher thinks that psychological problem regardless of type considers the main Stressful life events which lead to depression and anxiety.

the arithmetic mean for anxiety scale was 0.89, with standard deviation was 0.61, and this indicated that pregnant women are primary care follow ups in the Gaza Strip, have anxiety with low degree, the researcher thinks the women have high ability to express feeling and all time day busy with house keeping. This result confirm with study performed by Kang et al, (2016), the prevalence of antenatal anxiety was 20.6%.

The study showed that pregnant women in primary care follow-ups in the Gaza Strip, have anxiety with low degree, this result disagree with study conducted by Thabet et al (2015) showed that and 29.9% of pregnant women had very severe anxiety. This finding inconsistent with study conducted by Karmaliani et al. (2009) which found 18 percent of the women were anxious. And partially disagree with study conducted by Nasreenet al. (2011) found that Depressive and anxiety symptoms are found to occur commonly during pregnancy in Bangladesh. the prevalence of anxiety and depression disorders among antenatal mothers using diagnostic clinical interview were 9.1% and 8.6%, respectively.

pregnant women was positively correlated to depression, anxiety, and posttraumatic stress disorder according study conducted by Fadzil et al, (2013) the prevalence of

anxiety and depression disorders among antenatal mothers using diagnostic clinical interview were 9.1% and 8.6%, respectively.. Most of studies included both of depression and anxiety and conform

with this study as study conducted by Fadzil et al, (2013), Fairbroth et al (2015) and Karmaliani et al, 2009, the researcher thinks the relationship between anxiety and depression have strong correlation because the complication of anxiety is depression and the anxiety can impact on mood and body reaction.

5.3   Discussion of the research questions

5.3.1   What is the relationships between Depression and anxiety in Gazastrip ?

The study showed that there is positive correlation with between anxiety & the depression for follow ups Pregnant women with primary care in Gaza strip, Similarly with study by Fadzil et al, (2013), Nasreenet al. (2011), Fadzil et al, (2013), Fairbroth et al (2015). Results showed the direct relationships of women's symptoms of depression and anxiety.

Pregnant women was positively correlated to depression, anxiety, and posttraumatic stress disorder according study conducted by Fadzil et al, (2013) . Most of studies included both of depression and anxiety and conform

With this study as study conducted by Fadzil et al, (2013), Fairbroth et al (2015) and Karmaliani et al, 2009, the researcher thinks the relationship between anxiety and depression have strong correlation because the complication of anxiety is depression and the anxiety can impact on mood and body reaction.

5.3.2   Depressionandanxiety , depression, anxiety and socio- demographic factors

1. Depression and anxiety , depression and anxiety due to the age at the level of significance ($\alpha \leq 0.05$).

The study found that there are no differences in Depression and anxiety due to the age, the researcher thinks the emotional state may be impacted on all ages, but to varying degrees and all pregnant women exposed to physical and hormonal and emotional change during pregnancy and Mostly of the participant's ages less than 35years . the study found that there are no differences in the anxiety due to the age, the study conducted by Kang et al, (2016) showed no significant relationship between

depression and anxiety du to age study by Lafaurie (2015)   found maternal age under 19 years is a contributing risk factor in the urban area of Bangladesh and Mexico. The researcher thinks that Anxiety and depression commonly occur during pregnancy regardless ages.

2. Depression and anxiety due to the Qualification pregnant women at the level of significance (α ≤ 0.05).

The study found that there are differences in Depression and anxiety due to the Qualification, it found that the study sample who have Secondary Qualification their Depression and anxiety less than (Did not learn, Primary, Preparatory), and found that the study sample who have Academic Qualification their Depression and anxiety less than (Did not learn, Primary, Preparatory, Secondary, Diploma), and found that the study sample who have High study Qualification their Depression and anxiety less than (Did not learn, Primary, Preparatory). The study found that there are differences in The depression due to the Qualification, it found that the study sample who have Academic Qualification their the depression less than (Did not learn, Primary, Preparatory, Secondary, Diploma), and found that the study sample who have Higher Diploma Qualification their the depression less than (Did not learn, Diploma), and found that the study sample who have High study Qualification their the depression less than (Did not learn, Primary, Preparatory, Diploma).this study result agree with previous studies by Assaf et al.(2013), Hammoury et al. (2009), Marcus (2004)found lower educational attainment were significantly associated with symptoms of depression during pregnancy, the researcher think that the good education level of pregnant women play important role in avoid family problems and conflict with their husband which lead to psychological problem and improve problems solving and the women's education play role in improving their status within their households and improve communication skills, and thus reducing the level of violence. Also the current study showed that there are no differences in the anxiety due to the Qualification. Study conducted by Thabet et al. (2015) the study showed that one third Palestinian women exposed to physical psychological problem and half of them exposed to psychological problem which lead to post-traumatic stress disorder depression, and anxiety. Another study by Kang et al, (2016)   showed that one of the most prominent associated factors identified with psychological problem during pregnancy is the low educational level of women.

3. **Depression and anxiety due to the educational qualification for the husband at the level of significance (α ≤ 0.05).**

The study found that there are differences in Depression and anxiety due to the educational qualification for the husband, it found that the study sample their husband did not learn their Depression and anxiety more than (Secondary, Diploma, Academic, Higher Diploma, High study), and found that the study sample their husband Higher Diploma their Depression and anxiety less than (Did not learn, Primary, Preparatory).the study found that there are differences in the depression due to the educational qualification for the husband, it found that the study sample their husband Academic their the depression less than (Did not learn, Primary, Secondary), and found that the study sample their husband Higher Diploma their the depression less than (Did not learn, Primary, Secondary), and found that the study sample their husband High study their the depression less than (Did not learn, Primary, Preparatory, Secondary, Diploma).Also the study showed that that there are differences in the anxiety due to the educational qualification for the husband. It found that the study sample their husband did not learn their anxiety more than (Primary, Preparatory, Secondary, Diploma, Academic, Higher Diploma, High study), and found that the study sample their husband High study their anxiety less than (Did not learn, Primary).

Similarity to the previous study conducted by Naved and Persson (2008) found women having a husband with more than 10 years of education were negatively associated with psychological problem eg. Depression and anxiety that result from abuse. This result consistent with study conducted by Antai (2011) found women with husbands/partners with controlling behavior, those with primary or no education, had a higher likelihood of experiencing IPV. From the researcher views good education level of the husband improve communication skill and problem solving and reducing their vulnerability to experiencing psychological problem against his wife and family. Education level of husband considers as a protective factor against domestic violence

4. **Depression and anxiety due to the place of residence at the level of significance (α ≤ 0.05).**

The study showed that there are differences in Depression and anxiety due to the place of residence. It found that the study sample who lives in City their Depression

and anxiety less than Camp, Also the current study found that there are differences in the depression due to the place of residence. It showed that the study sample who live in City there the depression less than (Camp, Village).this study result agree with another study conducted by Thabet et al. (2015), Nur (2012), Naved and Persson (2008) which showed that psychological problem was significantly higher in women living in villages than in cities, Also, women living in villages experienced more psychological abuse than women living in cities or camps. This study result consistent with study by Assaf et al. (2013) which found region was found to be significant for psychological abuse. Conversely, the current study showed that there are no differences in the anxiety due to the place of residence. The researcher think that the women who live in camp are more prone to psychological abuse and develop depression and anxiety than women who live in Cites, it is associated to sociodemographic characteristics.

5. **Depression and anxiety due to the type of housing at the level of significance (α ≤ 0.05).**

The study showed that that there are no differences in depression and anxiety and depression due to the type of housing, the researcher think this hypothesis associated with other sociodemographic characteristics as income level, economic status and unemployment. Conversely, the current study showed that there are differences in the anxiety due to the type of housing. It found that the study sample individual who live with family Depression and anxiety for them more than (Rent, Ownership).

6. **Depression and anxiety due to the family type at the level of significance (α ≤ 0.05).**

The study showed that there are no differences in Depression and anxiety due to the family type. It is well-known that psychological problem(sometimes called 'family violence' the researcher think that psychological problem can occurs in all parts of society, families regardless of family type as the current study mentioned above In addition the study found that there are differences in the depression and anxiety due to the family type, and the difference for extended family.

7. **Depression and anxiety due to the number of family members at the level of significance (α ≤ 0.05).**

The study showed that there are differences in Depression and anxiety due to the number of family members, it found that the study sample who have (8 and above) their Depression and anxiety more than (less than 4, 5-7).Also found that there are differences in The depression due to the number of family members. It found that the study sample who have (8 and above) their depression more than (less than 4, 5-7). Also the study found that there are differences in the anxiety due to the number of family members, it found that the study sample who have (less than 4) their anxiety less than (5-7, 8 and above).

There were significant differences at significant level α ≤ 0.05 among the averages of the respondent's answers about Depression and anxiety , depression and anxiety due to the number of family members. The researcher thinks that when the family number increased the responsibilities and burden is increased this will lead to increased vulnerability to anxiety and depression.

8. **Depression and anxiety due to the monthly income at the level of significance (α ≤ 0.05).**

The study showed that there are no differences in Depression and anxiety , depression and anxiety due to the monthly income. This study result inconsistent with previous studies conducted by Assaf et al. (2013) which found unemployment were significant predictors of physical and psychological abuse.   Nasreenet al. (2011) which found poor household economy more risk of domestic violence, Similar with other study finding conducted by clark et al. (2010) which found economic effects of exposure were associated with increased odds of intimate-partner psychological problemin the Gaza Strip, and agree with study by Karmaliani et al. (2009) which found Psychological psychologicalproblemwas associated with husband unemployment.

9. **Depression and anxiety due to the Clinic type at the level of significance (α ≤ 0.05).**

The study showed that there are no differences in Depression and anxiety due to the Clinic type. There were no significant differences at significant level α ≤ 0.05 among the averages of the respondent's answers about Depression and anxiety due to the

Clinic type. Also the study found that that there are differences in the depression and anxiety due to the Clinic type, and the difference for UNRWA Clinics.

The results of the current study confirmed our hypotheses that many sociodemographic characteristics affect the likelihood of women's risk of being depressive and anxious.

5.4 Conclusion

Palestinian women, like many other women's in the regions, sustain both direct and indirect stresses. Women are subjected to different types of stress during pregnancy. The study identified the psychological problem s according to degree of occurrence among pregnant women in this study, the first type is Negotiation dimension, then Psychological aggression has second rank, physical assault has third rank, Physical injury has fourth rank, and Sexual assault has final and fifth rank.

Generally, this result clearly gives us evidence that there is strong relation between psychological problem against women during pregnancy and Socio-demographic factors. Mostly Socio-demographic conditions appear as prominent risk factors of psychological problem during pregnancy in different contexts and cultures. It is important to understand the risks of psychological problem they may face the pregnant women in the household. This study has found that age, education of pregnant women, educational qualification for the husband, place of residence and family members and decision-making power were significantly associated with psychological problem abuse in the household.

Psychological problem against pregnant women, is greatly influenced by the customs and cultures of each community, has a major contribution to the development of depression and anxiety in women, the psychological problem contributed to various problems including: physical, social, psychological and economic problems, the stressors that generated by the psychological problem affect the Palestinian women's psychological health and can trigger mental health problems including but not limited to anxiety, depression, stress, fear, nervousness, helplessness and low self-esteem

Psychological problem against women is global problem and deprives women from playing a central role in society. Puts women's health at risk, limits their participation in society and causes great human suffering

The results revealed that majority of the participants complain of anxiety and depression due to violence, these results considered critical indicators that must be taken into consideration by the policy-makers, researchers, and clinicians.

5.5 Recommendations

The researcher set some recommendations which might help the concerned parties from the authorities to fight psychological problem and improve mental health this would lead to better lives to the pregnant women's.

5.5.1 Practical recommendations

- Provide legal protection for women and fight psychological problem against them.
- Reinforce a secure social culture in fighting all forms of psychological problem against women through enforcing it in the school curriculum.
- Reinforce the role of religious discourse and direct it towards psychological problem against women.
- Reinforce the culture of dialogue and respect of the other in the Palestinian family through an enhancement of the concept of social roles from a gender perspective.
- Empowering women in the Palestinian society is an essential component for preventing psychological problem against them.
- Establish support psychological department specialized for pregnant women in each maternal clinic.
- Encourage positive and responsible reporting and discussion of psychological problem by the media and assigning to the Palestinian media the responsibility for removing the attitudinal barriers and changing behavior and attitudes towards this group.
- Provide Information on the rights of pregnant women's. MOH should bear the responsibility for protection of the Palestinian women's rights.
- Increase the spiritual support because the Islamic religion play important role in definitions the females right as daughter, sister, mother and wife as well as psychological problemreduction and management.

5.5.2 Research recommendations

According to study results and limitations, the researcher recommends the following:

- Further research is necessary to measure the level of anxiety and depression post-partum.
- Provide information about women's rights, depressive and anxiety disorders, symptoms, neurology, treatment, recovery, etc., This information might come in the form of written Materials, presentations, and contact with real people who are successfully managing depressive disorders.
- All professionals including nurses, obstetricians, physicians and psychologists must be educated about this issue and should be trained to identify the problem.
- Establish effective psychological program for treating anxiety and depression among pregnant women.

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Annex (1): Demographic data and the cover of scales

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مقياس غزة للحالة الاجتماعية الاقتصادية

</div>

عزيزتي الحامل:

يقـوم الباحـث بـإجراء دراسـة بعنـوان" **القلـق والاكتئـاب لـدي السـيدات الحوامـل المتابعـات لديالرعايـة الأوليـة فـي قطـاع غـزة"** حيـث أن هـذه الدراسـة هـي لاسـتكمال متطلبـات بحـث التخـرج لدراسـة ماجسـتير الصـحة النفسية المجتمعيـة بجامعة القدس ــ أبو ديس .

وتهـدف الباحثـة مـن خـلال هـذه الدراسـة للتعـرف علـى العلاقـة بـين العنـف الأسـري ،القلـق والاكتئـاب لـدي السـيدات الحوامـل ، ومـن ثـم الخـروج بتوصـيات تسـاعد فـي تخفيـف العـبء النفسـي وتحسـين الصـحة النفسـية لـدى هؤلاءالسيدات الحوامل.

لـذا أمـامكم عـدة أسـئلة لقيـاس الاكتئـاب والقلـق، أرجـو مـنكم الإجابـة بصـدق عـن كـل الأسـئلة التاليـة وسـوف تراعـى السـرية التامـة فـي هـذه الإجابـات مـع العلـم أنها سوف تستخدم لغرض البحث العلمي فقط.

ملاحظـة : المشـاركة فـي البحـث اختياريـة وليسـت إجباريـة ولا داعـي لكتابـة الاسم، ولذا أرجو أن تكون الإجابة دقيقة.

<div align="center">

وشكـــرا لكي على حسـن تعاونـك

</div>

الباحثة/ اسلام فرحات مرتجي

أولا / البيانات الأولية:

الاسم: ------------ **العمر**: ---------- عاماً **العنوان** :--------------------
----

تاريخ تعبئة الاستبانة   /   /

اسم العيادة

_____

منطقة العيادة

_____

عدد مرات الحمل ------------------ عدد مرات الاجهاض -------------

هل اجريت لك عمليات نسائية من قبل   نعم ------   لا ----------   اذا الاجابة نعم فما هي العملية ----------

المؤهل التعليمي:

☐لم أتعلم☐ابتدائي☐إعدادي☐ثانوي☐دبلوم متوسط ☐دبلوم ☐جامعية ☐دبلوم عالي ☐ دراسات عليا

المؤهل التعليمي للزوج:

☐ لم يتعلم ☐ابتدائي☐إعدادي ☐ثانوي ☐دبلوم ☐جامعي☐دبلوم عالي☐دراسات عليا

مكان السكن :

☐ مدينة   ☐معسكر   ☐قرية☐أخرى حدد _____

نوع السكن :

☐إيجار ☐ملك ☐مع العائلة   ☐أخرى حدد _____

نوع الأسرة:

☐ نووية   ☐ ممتدة

	عدد أفراد الأسرة

بالرقم: _____   □أقل من 4   7-5□   8-فما فوق □

	متوسط الدخل الشهري :

أقل من 1700 شيكل□ من1700- 2220شيكل□ 3000-2021شيكل□ 3000 شيكل-4000 □4001 شيكلفمافوق

هل تتلقى الأسرة مساعدات خارجية :

لا تتلقى□أهل الخير □جمعية الإغاثة □   لجنة الزكاة □الحكومة □ من الوكالة □

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Annex (2): The Beck Depression Inventory (BDI)

Beck Depression Inventory Screening-Short form

BDI (A)

Name:_____ **Date_____ Age_____ Sex_____**

This questionnaire consists of 13 groups of statement. After reading each group of statements carefully, circle the number (0,1,2,3) next to the one statement in each group which best describes the way you have been feeling the past week, including today. If several within a group seem to apply equally well, circle each one. *Be sure to read all the statements in each group before making your choice*.

I do not feel sad.	0	1
I feel sad.	1	
I am sad all the time and I cant snap out of it.	2	
I am so sad or unhappy that I cant stand it.	3	
I am not particularly discouraged about the future.	0	2.
I feel discouraged about the future.	1	
I feel I have nothing to look forward to.	2	
I feel that the future is hopeless and that things cannot improve.	3	
I do not feel like a failure	0	3.
I feel have failed more than the average person.	1	
As I look back on my life, all I can see is a lot of failures.	2	
I feel I am a complete failure as a person.	3	
I get as much satisfied out of things as I used to.	0	4.
I don't enjoy things the way I used to	1	
I don't get real satisfaction out of anything anymore.	2	
I am dissatisfied or bored with everything.	3	
I don't feel particularly guilty.	0	5.
I feel guilty a good part of the time.	1	
I feel quite guilty most of the time.	2	
I feel guilty all of the time.	3	
I don't feel disappointed in myself.	0	6.
I am disappointed in myself.	1	
I am disgusted with myself.	2	
I hate myself.	3	
I don't have any thoughts of harming my self	0	7.
I feel I would be better off dead	1	
I have definite plans about committing suicide	2	
I would kill myself if I had the chance	3	

I have not lost interest in other people.	0	8
I am less interested in other people than I used to be.	1	
I have lost most of my interest in other people.	2	
I have lost all of my interest in other people.	3	
I make decisions about as well as ever.	0	9
I try to put off making decisions	1	
I have greater difficulty making decisions.	2	
I can't make decisions at all anymore.	3	
I don't feel I look any worse than I used to.	0	10
I am worried that I am looking old or unattractive.	1	
I feel that there are permanent changes in my appearance that make me look unattractive.	2	
I believe that I look ugly or repulsive looking.	3	
I can work as well as before.	0	11.
It takes extra effort to get started at doing something.	1	
I have to push myself very hard to do anything.	2	
I cant to any work at all.	3	
I don't get more tired than usual.	0	12
I get tired more easily than I used to	1	
I get tired from doing almost anything.	2	
I am too tired to do anything.	3	
My appetite is no worse than usual.	0	13.
My appetite is no as good as used to be.	1	
My appetite is much worse now.	2	
I have not appetite at all any more.	3	

0-4 non or minimal   5-7 mild   8-15 moderate   16+ severe

اختبار بك القصير

ترجمة و تقنين على البيئية الفلسطينية أ. د عبد العزيز موسى محمد ثابت

تعليمات :

يتضمن هذا الاختبار 13 مجموعة من العبارات الرجاء أن تقرأ كل مجموعة من العبارات بعناية ، ثم تختار عبارة واحدة والتي تصف بطريقة أفضل الطريقة التي تشعر بها خلال الأسبوعين الأخيرين بما في ذلك اليوم. ضع دائرة حول الرقم جوار العبارة التي اخترتها . ولو بدا لك أكثر من عبارة في مجموعة العبارات تنطبق عليك بطريقة متساوية ، ضع دائرة حول أعلى رقم في هذه المجموعة وتأكد أنك لا تختار أكثر أكثر من عبارة في اى مجموعة.

البند		
1- الحزن	0	لا أشعر بالحزن
	1	أشعر بالحزن أغلب الوقت
	2	أنا حزين طول الوقت
	3	أنا حزين أو غير سعيد لدرجة لا أستطيع تحملها.
2- التشاؤم	0	لم تفتر همتى فيما يتعلق بمستقبلي.
	1	أشعر بفتور الهمة فيما يتعلق بمستقبلي بطريقة أكبر مما اعتدت.
	2	لأتوقع أن تسير الأمور بشكل جيد بالنسبة لي.
	3	أشعر في المستقبل بانه سوف يزداد سوءا.
3- الفشل السابق	0	لا أشعر بأننى شخص فاشل
	1	لقد فشلت أكثر مما ينبغى.
	2	كلما نظرت إلي الوراء ارى الكثير من الفشل
	3	أشعر بأنى شخص فاشل تماما
4- فقدان الاستمتاع	0	أستمتع بالأشياء قدر استمتاعى بها من قبل.
	1	لا أستمتع بأشياء بنفس القدر الذى اعتدت عليه
	2	أحصل علي قدر قليل جدا من الاستمتاع من الأشياء التى اعتدت أن أستمتع بها.
	3	لا أستطيع الحصول علي أى استمتاع من الأشياء التى اعتدت الاستمتاع بها.
5- مشاعر الإثم (تأبين الضمير)	0	لا أشعر بالإثم (تأنيب الضمير)
	1	أشعر بالأثم (تأنيب الضمير) عن العديد من الأشياء التى قمت بها أو أشياء كان يجب أن أقوم بها.
	2	أشعر بالأثم (تأنيب الضمير) أغلب الوقت.
	3	أشعر بالأثم (تأنيب الضمير) طول الوقت .
6- عدم حب الذات	0	شعورى نحو نفسي كما هو .
	1	فقدت الثقة في نفسي.
	2	خاب رجائي في نفسي.

	3	لا أحب نفسي.
7– الأفكار أو الرغبات الانتحارية	0	ليس لدى أي أفكار انتحارية.
	1	لدى أفكار للانتحار ولكن لا يمكنني تنفيذها.
	2	أريد أن انتحر.
	3	قد انتحر لو سنحت لي الفرصة.
8– فقدان الاهتمام		لم أفقد الاهتمام بالآخرين أو بالأنشطة .
		أهتم بالآخرين أو بالأمور أقل من قبل.
		فقدت أغلب اهتمامي بالآخرين والأمور الأخرى.
		من الصعب أن أهتم بأي شيء.
9– اتخاذ القرارات	0	اتخذ القرارات بنفس كفاءتي المعتادة.
	1	أجد صعوبة أكثر من المعتاد في اتخاذ القرارات.
	2	لدى صعوبة أكثر بكثير مما اعتدت في اتخاذ القرارات.
	3	لدى مشكلة اتخاذ أي قرارات.
10– الشكل العام	0	لا اشعر بأنني أبدو أسوء مما تعودت عليه
	1	أقلق دائما من أن أبدو مسنا في العمر و غير جذاب .
	2	أشعر بأن هناك تغيرات دائمة في شكلي تظهرني بشكل غير جذاب .
	3	أؤمن بأنني أبدو قبيحا/ة
11– العمل اليومي	0	استطيع العمل كما تعودت
	1	يحتاج مني البدء في فعل الأشياء اليومية لجهد أكثر من المعتاد
	2	أضغط على نفسي بشدة لفعل أي شيء عادي
	3	لا أستطيع أن أعمل أي شيء كالمعتاد
12– فقدان الطاقة	0	لا أشعر بالتعب أكثر من المعتاد.
	1	احتاج لمجهود إضافي للبدء في عمل أي شيء
	2	احتاج للضغط على نفسي بشدة لانجاز أي شيئ.
	3	لا استطيع أن أعمل أي شيء.
13– تغيرات في الشهية	0	شهيتي للطعام ليست أسوء من الأول
	1	شهيتي للطعام ليست جيدة مثل الأول
	2	شهيتي للطعام الآن أسوء من الأول
	3	ليس لدي شهية للطعام

Annex (3):Hamilton Anxiety Rating Scale(HAM-A)
Hamilton Rating Scale for Anxiety

Instructions: This checklist is to assist the physician or psychiatrist in evaluating each patient as to his degree of anxiety and pathological condition. Please fill in the appropriate rating: none = 0 mild = 1 moderate = 2 severe = 3 severe, (very severe) grossly disabling = 4

	Very sever	Sever	Moderate	Mild	NO
Anxious Mood (Worries, Anticipates worst)					
Tension (Startles, Cries easily, Restless, Trembling)					
Fears (Fear of the dark, Fear of strangers, Fear of being alone, Fear of animal)					
Insomnia (Difficulty falling asleep or staying asleep, Difficulty with Nightmares)					
Intellectual (Poor concentration, Memory Impairment)					
Depressed Mood (Decreased interest in activities, Anhedonia, Insomnia)					
Behavior at Interview (Fidgets, Tremor, Paces)					
Somatic Complaints: Sensory (Tinnitus, Blurred vision)					
Somatic Complaints: Muscular (Muscle aches or pains, Bruxism					
Cardiovascular Symptoms (Tachycardia, Palpitations, Chest Pain, sensation of feeling faint					
Respiratory Symptoms (Chest pressure, Choking sensation, Shortness of Breath					
Gastrointestinal symptoms (Dysphagia, Nausea or Vomiting, Constipation, Weight loss, Abdominal fullness					
Genitourinary symptoms (Urinary frequency or urgency, Dysmenorrhea, Impotence					
Autonomic Symptoms (Dry Mouth, Flushing, Pallor, Sweating					

مقياس هاملتون لتقدير مدى القلق

يقيس هذا المقياس مدى شدة الأعراض النفسية والجسمية للقلق فيضع الفاحص درجة الاستجابة للمريض وفقا لخمسة مستويات هي :

صفر== لا توجد أعراض
1 == أعراض طفيفة
2 == أعراض متوسطة
3 == أعراض شديدة
4= أعراض شديدة جدا

مقياس هاملتون لتقدير مدى القلق

الاسم:.....................................رقم الملف.............................. التاريخ ....

فيما يلي هذا الاختبار يتضمن 14 مجموعة من العبارات الرجاء أن تقرأ كل مجموعة من العبارات بعناية ، ثم تضع علامة صح في الخانة التي تصف بطريقة افضل الطريقة التي تشعر بها خلال الأسبوعين الأخيرين بما في ذلك اليوم.

شديدة جدا	أعراض شديدة	أعراض متوسطة	أعراض طفيفة	لا توجد أعراض	الفقرة	
					هل تشعر بالتوجس والشك ،توقع الأسوأ أو الأشياء الخيفة ،سهولة الاستثارة	1-
					هل لديك مشاعر عدم الارتياح، سهولة الإجهاد، الفزع ، سهولة البكاء، الارتجاف، لا يستقر على حال، لا يستطيع أن يترك نفسه على سجيتها.	2-
					هل تخاف من الظلام- الغرباء الوحدة الحيونات وزحمة المرور والحشود	3-
					هل لديك صعوبة الاستسلام للنوم ، النوم المتقطع ، نوم غير مشبع والاحساس بالتعب عند الاستيقاظأحلام وكوابيس ومخاوف ليلية .	4-
					هل لديك صعوبة التذكر وضعف الذاكرة	5-
					هل تشعر باللامبالاة ، لا تستمتع بالهويات ، الحزن ، الاستيقاظ البكر ، انتقال الانفعالات من النقيض الى النقيض في اليوم الواحد	6-
					هل تتململ ،لا تستقر في مكانه ، و لديك اهتزاز الايدي ، وتقطيب الحاجبين، وجه مشدود	7-
					هل لديك طنين في الأذن، زغللة البصر، نوبات من السخونة والبرودة، احساس بالضعف	8-
					هل تشكوى من آلام ، أوجاع ، التواء العضلات أو تتيبسها ، انتفاخ العضلات ، صرير الأسنان، حشرجة الصوت	9-
					هل تشكوى من سرعة ضربات القلب ، الام الصدر،خفقان القلب ، انتفاض العروق ، مشاعر الدوار	10-
					هل لديك ضيق الصدر او اختناق، مشاعر بالاختناق ، التنهد ، عسر التنفس	11-
					هل تشكومن صعوبة البلع،ارياح،الام في البطن، حرقان المعدة ،لين البراز،الشعور بامتلاء المعدة ، الغثيان ، القيئ ، نقص الوزن ،الامساك،أصوات البطن والامعاء	12-
					هل تشكو من زيادة عدد مرات التبول، ضغط البول في المثانة انقطاع العادة الشهرية، البرودة الجنسية ، سرعة القذف ، فقدان الرغبة الجنسية ، العنة	13-
					هل تشكو من جفاف الفم ،احمرار الوجه ، شحوب اللون، العرق،الدوار ، صداع التوتر،	14-

Annex (4): DSM-5 criteria for 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 individual 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 having been 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 anxiety, worry, or physical symptoms cause clinically significant distress or impairmentin social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The disturbance is not better explained by another mental disorder (e.g., anxiety orworry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

Annex(5):DSM-5 criteria for Major Depressive Episode:

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.

- 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.

- 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).

- Significant weight loss when not dieting or weight gain (e.g., a change of morethan 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.

- Insomnia or hypersomnia nearly every day.

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

- Fatigue or loss of energy nearly every day.

- Feelings of worthlessness or excessive or inappropriate guilt (which may be

- delusional) nearly every day (not merely self-reproach or guilt about being sick).

- Diminished ability to think or concentrate, or indecisiveness, nearly every day

- (either by subjective account or as observed by others).

- 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 (American psychiatric association.2013).

Annex (6):UNRWA PHC Center

S\NO	Health Center	SMOS name
1	B\Hanoun	Tawfiq El Jabari
2	Jabalia	Kefah El Najjar
3	Beach	Niveen Telbani
4	Sheikh Radwan	Randa Zaqqout
5	Saftawi	Imad El Awour
6	Rimal	Jamil Uliyan
7	Gaza Town	Mohd Shahatto
8	Sabra	A\Qader habil
9	Bureij	A\Fattah El Agha
10	Nuseirat	Khalil Hamad
11	West Nuseirat	Manal Abu Samra
12	Maghazi	Hend Harb
13	D\Balah	Sawsan Hamad
14	Japanese	Mustafa Shaath
15	Kh\Younis	Rafat Sabha
16	Maen	Rihab Qouqa
17	Naser	Enaam Abu Hashem
18	Shouka	Usama Hammad
19	Rafah	Mahfous Othman
20	Shaboura	Radwan Awadalla
21	Tal Sultan	Imad Afana

Source: UNRWA ,Gaza Strip,Health information system unit,2016

Annex (7):Distribution of Governmental PHC Center that Follow-up of pregnant women

Gaza		North	
Rimal	1	Martyrs of Beit Lahiya (Shaimaa)	1
AL-salam	2	Jamila Ashi	2
AL-falah	3	Martyrs Jabalia	3
Martyrs AL-daraj	4	Abu Shabak Medical	4
		Martyrs of Beit Hanoon	5
Ataa habib	5		
AL-Rahmaa	6		
AL-Zaetoun	7		
AL-Kopa	8		
Sheikh Radwan	9		
AL-horria	10		
Sourani	11		
Sabha Harazin	12		

Rafah		Khan Younis		Deir AlBalah	
Martyrs Rafah	1	Martyrs Khan Younis	1	Dair Al Balah	1
Tal al-Sultan	2	Bani Suhaila	2	Zawayda	2
		Absan AL-sagera	3	Valley Salqa	3
		Jouret AL-lOot	4	Joher ALdeek	4
		Khaza'a	5		
		Absan AL-Kabera	6		
		Qarara	7		

Source: MOH ,Gaza Strip,Health information system unit,2016

By simple random sampling method was selected clinicsAccording to the ratioBy calculating the ratio and proportionality to the number of government clinics and UNRWA PHC center.

UNRWA PHC Center		Governmental PHC Center	
Bureij	1	Kh\Younis	1
Kh\Younis	2	D\Balah	2
Jabalia	3	Tal Sultan	3
Naser(ALswedi).	4	Sheikh Radwan	4
		Rimal	5
		Beit Lahiya (Shaimaa)	6

ملخص باللغة العربية
القلق والاكتئاب لدى النساء الحوامل في قطاع غزة.

إعداد: إسلام فرحات مرتجى.

إشراف: د. عبد العزيز ثابت.

هدفت هذه الدراسة إلى كشف العلاقة بين الاكتئاب والقلق بين النساء الحوامل في عيادات الرعاية الصحية الأولية قبل الولادة في قطاع غزة مع وجود اثر لبعض المتغيرات على هذه العلاقة. تم استخدام المنهج الوصفي التحليلي . قام الباحث باستخدام ثلاثة أدوات تطبيقية على النحو التالي: المعلومات الديموغرافية للمشاركات، مقياس تقييم القلق هاميلتون، مقياس بيك للاكتئاب و. تم استخدام العينة الطبقية العينة الطبقية المكونة من 400 امرأة حامل من خمس محافظات مختلفة في قطاع غزة) شمال غزة،مدينة غزة، المنطقة الوسطى، خان يونس ورفح،وكان معظم أعمار المشاركات أقل من 35 عاما. وأظهرت الدراسة أن أعراض الاكتئاب الحادة كانت (10.5٪)، وكانت أعراض الاكتئاب بالمتوسطة (13.7٪)، وأعراض الاكتئاب الخفيف (34.8٪). كما أظهرت النتائج أن النساء الحوامل اللواتي يتبعن الرعاية الأولية لديهن قلق بدرجة منخفضة، وكان الوسط الحسابي لمقياس القلق 0.89، وكان الانحراف المعياري 0.61. ووجدت الدراسة وجود علاقة ارتباط ذات دلالة إحصائية بين الاكتئاب والقلق لدى النساء الحوامل اللاتي لديهن رعاية أولية في قطاع غزة عند مستوى دلالة (0.05 ≥ α). وأظهرت الدراسة وجود فروق ذات دلالة إحصائية في عرض الاكتئاب بسبب المؤهل العلمي، ولا توجد فروق ذات دلالة إحصائية عند مستوى دلالة (0.05 ≥ α حول الاكتئاب والقلق بسبب العمر. وكانت هناك فروق ذات دلالة إحصائية في الاكتئاب والقلق بسبب المؤهلات التعليمية للزوج، وكانت هناك اختلافات كبيرة في الاكتئاب بسبب مكان الإقامة. توصلت الدراسة إلى وجود فروق ذات دلالة إحصائية في الاكتئاب والقلق بسبب نوع الأسرة والفرق في صالح الأسرة الممتدة. وكانت هناك فروق ذات دلالة إحصائية في الاكتئاب والقلق بسبب عدد أفراد الأسرة، ولم تكن هناك فروق في الاكتئاب والقلق بسبب الدخل الشهري. وكانت هناك فروق ذات دلالة إحصائية في الاكتئاب والقلق بسبب نوع العيادة عند مستوى الدلالة (0.05 ≥ α)، وكانت هناك فروق ذات دلالة إحصائية لصالح عيادات الأونروا .. وكانت الدراسة الختامية مشكلة نفسية ضد النساء الحوامل، التي تتأثر كثيرا بعادات وثقافات كل مجتمع، إسهاما كبيرا في تنمية الاكتئاب والقلق لدى النساء.

Annex (9): Palestine Map