

School of Public Health

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**Effects of Political Violence on Mental Health of
Adolescence in The Gaza Governorates**

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Effects of Political Violence on Mental Health of Adolescence in The Gaza Governorates

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بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

{ يُرْفَعُ اللَّهُ الَّذِينَ آمَنُوا مِنْكُمْ وَالَّذِينَ أُوْتُوا الْعِلْمَ
دَرَجَاتٍ وَاللَّهُ بِمَا تَعْمَلُونَ خَيْرٌ }

صدق الله العظيم

سورة المجادلة

" الآية " 11 "

Declaration

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

Signed:.....

Ahmed El-Kahlout

12 / 4 /2008

Dedication

I dedicate this work to the spirit of martyrs

To spirit of my parents

To my wife

To my family

Ahmed

Acknowledgment

I would like to acknowledge my supervisor Dr. Abedl Aziz Thabet, for his extraordinary supervision, guidance, patience, support, and encouragement. He generously offered me the opportunity to continue my study in Gaza Strip. I am deeply grateful to him for realizing my life time wish.

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Researcher

Ahmed M. El-Kahlout

Abstract

The aim of the study is to investigate levels of political violence that adolescence encountered in Gaza governorates and their effects on the mental health. The researcher defined two types of political violence: 1) Israel violence: acts of violence committed by Israel against the Palestinian people. 2) Factional fighting: acts of violence committed by two Palestinian political factions; Palestinian National Liberation Movement (Fatah) and Islamic Resistance Movement (Hamas) against each others. A stratified cluster random sample survey of 394 adolescents; (51.5% males 49.5% females) aged between 15-18 years were assessed. The researcher used descriptive analytical design to represent the entire sample of the population. However, the researcher used some of modified scales from which; Gaza traumatic events checklist for Israelis violence, Gaza traumatic events checklist for factional fighting, the revised children's manifest anxiety scale (RCMAS), child depression inventory (CDI), UCLA PTSD Index for DSM IV. The major findings were: the most common traumatic events due to Israel violence revealed by children was "watching mutilated bodies in TV" by 90.4%, the most common traumatic events due to factional fighting was "hearing the shootings and bombardment due to fighting in the streets" by 87.1%. The prevalence of severe Israel violence events was 23.6%. The prevalence of severe factional fighting events was 22.1%. There were a significant association between Israel violence and factional fighting. The prevalence of anxiety, depression, and PTSD were 20.8%, 31.0%, 12.7% consecutively. There were positive significant correlation between anxiety, PTSD, depression and political violence. There were no significant differences between the means Israel Violence levels and factional fighting levels according to the educational classes, type of residence, number of sibling,

mothers education, fathers education, mothers work, fathers work. The study found significant differences between the means of Israel violence according to monthly income, however, the results shown no significant differences between the means of factional fighting according to the monthly income. The study found significant differences in anxiety levels according to sex , but there were no significant differences in PTSD and depression levels according to sex. There were significant differences between the means of anxiety, PTSD, and depression levels according to the educational classes (10th class, 11th class, and 12th class). The study found significant differences between the means of anxiety levels according to type of residence, however, the results showed that there were no significant differences between the means of PTSD and depression levels according to type of residence. The study found significant differences between the means of anxiety, PTSD, and depression levels according to fathers education. But there were no significant differences between the means of anxiety, PTSD, and depression levels according to number of siblings, mothers education, mothers work, and fathers work. The study found significant differences between the means of anxiety, PTSD and depression levels according to Israel violence and factional fighting levels.

ملخص

هذه دراسة وصفية تحليلية تهدف إلى معرفة مستويات العنف السياسي التي يواجهها المراهقين في محافظات غزة وتأثيرها على الصحة النفسية لديهم. في هذه الدراسة يعرف الباحث نوعين من العنف السياسي: النوع الأول العنف الإسرائيلي: وهو أعمال العنف التي ترتكبها إسرائيل ضد الشعب الفلسطيني. والنوع الثاني القتال بين الفصائل: وهو أعمال العنف التي ترتكب من قبل اثنين من الفصائل السياسية الفلسطينية؛ وهما حركة التحرير الوطني الفلسطيني (فتح) وحركة المقاومة الإسلامية (حماس) ضد بعضها البعض. تمأخذ عينة طبقية عشوائية تتكون من 394 مراهقاً (بنسبة 51.5% ذكور و 49.5% إناث) تتراوح أعمارهم بين 15-18 عاما. استخدم الباحث بعض المقاييس والأدوات منها قائمة غزة للأحداث الصادمة بسبب العنف الإسرائيلي، قائمة غزة للأحداث الصادمة بسبب القتال بين الفصائل ، مقياس القلق (RCMAS) ، ومقاييس الاكتئاب لدى الأطفال (CDI) ، ومقاييس كرب ما بعد الصدمة (UCLA for DSM-IV). وقد توصلت الدراسة للنتائج التالية: الحدث الصادم الأكثر تكراراً بسبب العنف الإسرائيلي لدى أفراد العينة هو "مشاهدة صور الجرحى والأشلاء والشهداء في التلفاز" بنسبة 90.4 % ، الحدث الصادم الأكثر تكراراً بسبب القتال بين الفصائل لدى أفراد العينة هو "سمع الرصاص والقصف نتيجة الاشتباكات في الشوارع" بنسبة 87.1 %. نسبة انتشار الأحداث الصادمة العنيفة بسبب العنف الإسرائيلي 23.6%. نسبة انتشار الأحداث الصادمة العنيفة بسبب القتال بين الفصائل 22.1%. توصلت الدراسة إلى أنه توجد علاقة طردية بين مستويات العنف بسبب العنف الإسرائيلي والقتال بين الفصائل . نسبة انتشار القلق والاكتئاب وكرب ما بعد الصدمة على التوالي هي 20.8% ، 31.0% ، 12.7%. توجد علاقة طردية بين مستويات القلق ، والاكتئاب، وكرب ما بعد الصدمة مع مستويات العنف السياسي. توصلت الدراسة أيضاً أن لا توجد فروق ذات دلالة إحصائية بين مستويات العنف السياسي بنوعية وفقاً للمستوى التعليمي ، نوع السكن، عدد الإخوة ، تعليم الأب، عمل الأم وعمل الأب. توصلت الدراسة إلى أنه توجد فروق ذات دلالة إحصائية بين مستويات العنف الإسرائيلي وفقاً للدخل الشهري ، ولا توجد فروق ذات دلالة إحصائية بين مستويات القتال بين الفصائل وفقاً للدخل الشهري. توجد فروق ذات دلالة إحصائية بين مستويات القلق لدى أفراد العينة وفقاً للجنس ، ولا توجد فروق ذات دلالة إحصائية بين مستويات الاكتئاب وكرب ما بعد الصدمة وفقاً لنوع الجنس. أظهرت الدراسة وجود فروق ذات دلالة إحصائية بين مستويات القلق والاكتئاب وكرب ما بعد

الصدمة وفقاً للمستوى التعليمي لأفراد العينة (الصف العاشرة ، الحادي عشر ، والثاني عشر).
توجد فروق ذات دلالة إحصائية بين مستويات القلق وفقاً لنوع السكن، ولا توجد فروق ذات دلالة إحصائية بين مستويات الاكتئاب وكرب ما بعد الصدمة وفقاً لنوع السكن. توصلت الدراسة إلى وجود فروق ذات دلالة إحصائية بين مستويات القلق والاكتئاب وكرب ما بعد الصدمة وفقاً لمستوى تعليم الأب، ولا توجد فروق ذات دلالة إحصائية بين مستويات القلق والاكتئاب وكرب ما بعد الصدمة وفقاً لعدد الإخوة والأخوات، تعليم الأم، عمل الأم، وعمل الأب. أخيراً توصلت الدراسة إلى أنه توجد فروق ذات دلالة إحصائية بين مستويات القلق والاكتئاب وكرب ما بعد الصدمة وفقاً لمستويات العنف السياسي بنوعيه العنف الإسرائيلي والقتال بين الفصائل.

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Chapter 1

Introduction

Chapter 1: Introduction

1.1 Background

No country or community is untouched by violence. Images and accounts of violence pervade the media; it is on our streets, in our homes, schools, workplaces and institutions. Violence is a universal scourge that tears at the fabric of communities and threatens the life, health and happiness of us all. Each year, more than 1.6 million people worldwide lose their lives to violence. For everyone who dies as a result of violence, many more are injured and suffer from a range of physical, sexual, reproductive and mental health problems. Violence is among the leading causes of death for people aged 15–44 years worldwide, accounting for about 14% of deaths among males and 7% of deaths among females (WHO 1999).

From a health point of view, the impact of violence in general may be seen within a traumatization framework, i.e. that the different types of violence, including political violence, induce physical and/or mental harm to (i.e. traumatize) individuals, groups or populations. A separation of physical and mental traumatization is difficult, since physical traumatization can hardly occur without being accompanied by mental traumatization (Krug et al. 2002).

The violence and cruelty of conflict are associated with a range of psychological and behavioural problems, including depression and anxiety, suicidal behaviour, alcohol abuse and post-traumatic stress disorder. Furthermore, psychological trauma may become evident in disturbed and antisocial behaviour, such as family conflict and aggression towards others. This situation is often exacerbated by the availability of weapons and by people becoming inured to violence after long exposure to conflict. The impact of conflicts on mental health is, however, extremely complex and unpredictable. It is influenced by a host

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

Gaza Strip

Gaza strip is a narrow piece of land lying on the coast of the Mediterranean sea. Its position on the crossroads from Africa to Asia made it a target for occupiers and conquerors over the centuries. The last of these was Israel who occupied the Gaza strip from Egyptians in 1967. Gaza Strip is very crowded place with area 365 sq. Km and constitute 6.1% of total area of Palestinian territory land. In mid year of 2005 the population number is to be 1,389,789 mainly concentrated in the cities, small village, and eight refugee camps that contain two thirds of the population of Gaza Strip. In Gaza Strip, the population density is 3,808 inhabitants/km² that comprises the following main five governorates: North of Gaza, Gaza City, Mid-Zone, Khan-younis, and Rafah (MOH 2006).

On September 2000, the Al Aqsa Intifada erupted. That resulted in many Palestinians were killed and several thousand were injured. Palestinians have been exposed to a variety of traumatic events, ranging from hearing of killing, to bombardment of the entire Gaza Strip by helicopters.

Beginning in early 2006, Palestinian Legislative Council elections which were held. In these elections the Islamic Resistance Movement (Hamas) won 74 of the 132 council seats. Following the election, the international community, through statements issued by the Quartet members for the Gaza Disengagement, the United Nations (UN) and the European Union (EU) asked the Hamas-led government to commit to non-violence, to the recognition of Israel and to the acceptance of previous obligations (the Roadmap of solving the Israeli

Palestinian conflict) as conditions to allow international donors to continue providing funds to the Palestinian Authority (PA) (Thabet et al. 2008).

The last six months of 2006 were characterized by the escalation of the crisis after the capture of an Israeli soldier by a Palestinian militant group in Gaza. Consequently, Israel started numerous of campaigns and imposed strict closure by sealing off the entire Gaza Strip. As a result Gaza suffered from the shortage of food, fuel and Medical supplies, and the destruction of the infrastructures. There was also a sharp increase of the state of lawlessness, insecurity and the misuse of weapons which resulted in bloody clashes between Fatah and Hamas, and resulted in the death of more than 200 people. This has led to paralysis in civil and governmental institutions (Thabet et al. 2008).

Another round of fighting began on June 10 and ended on June 14. Throughout the four days of fighting, Hamas had taken control of the Gaza Strip from Beit Hanoun in the north to Rafah in the south. The Israeli government closed all check-points on the borders of Gaza in response to the violence.

1.2 Problem statement

The Problem statement determined by the following question:

What are the levels of political violence that adolescence encountered in Gaza Governorate and their effects on the mental health?

1.3 Study justification

The researcher choose this topic, because it is highly interesting subject and because each year, more than 1.6 million people worldwide lose their lives to violence. For everyone who dies as a result of violence, many more are injured and suffer from a range of physical,

sexual, reproductive and mental health problems. Violence is among the leading causes of death for people aged 15–44 years worldwide, accounting for about 14% of deaths among males and 7% of deaths among females (WHO 1999).

The outbreak of the second Intifada in October 2000 ushered in a period of particularly intense political violence both within Israel and in the areas governed by the Palestinian Authority. Because much of the violence and counter-violence was focused in densely populated areas, civilians on both sides of the conflict bore the brunt of it. Children and adolescents were not spared, whether as direct victims, participants, or emotionally involved observers, or through the general upset in their life that ensued.

The Palestinian Ministry of Health reported that there has been a 105 per cent increase in new cases at mental health clinics since October 2000, and that children under 18 constitute a majority of these. Further, in 2003 UNICEF reported that 75 per cent of parents have noticed behavioral changes and greater emotional problems in their children compared with one year ago, including sleeping problems, being afraid, and finding it hard to concentrate (UNICEF report, 2003). These findings are hardly surprising given the severe disruptions of normal childhood and youth activities that characterize the daily lives of Palestinian children and youth.

Factional struggles between Palestinian parties particularly Fatah and Hamas which leaded to armed-fighting, mutual kidnapping, media war and other different types of struggle that had their adversities on the Palestinian community texture, especially children and adolescences.

1.4 Aim & Objectives

1.4.1 Aim of the study

The aim of the study is to investigate the levels of political violence that adolescence encountered in Gaza governorates and their effects on the mental health.

1.4.2 Objectives

1. To measure levels of political violence among Palestinian adolescents.
2. To explain the relations between political violence and demographic variables.
3. To demonstrate prevalence of anxiety, depression, and PTSD among adolescents.
4. To investigate the relations between anxiety, depression, PTSD, and demographic variables.
5. To investigate relationship between political violence and depression, anxiety, and PTSD.
6. To provide recommendations that can encountered political violence and mental health problems among Palestinian adolescents.

1.5 Study questions

1. What are levels of political violence among Palestinian adolescents?
2. What are the relations between political violence and demographic variables?
3. What are prevalence of anxiety, depression, and PTSD among Palestinian adolescents?
4. What are the relations between anxiety, depression, PTSD, and demographic variables?
5. What are the relationship between political violence and depression, anxiety, and PTSD?

1.6 Definitions:

Definition of political violence

Political violence refers to acts of violence committed for political reasons such as riots, the repressive actions of security forces against people opposing this government, battles between hostel dwellers and township residents. (Stavrou 1993).

Researcher operational definitions:

The researcher defined two types of political violence:

- **Israel violence:** Acts of violence committed by Israel against the Palestinian people.
- **Factional fighting:** Acts of violence committed by two Palestinian political factions; Palestinian National Liberation Movement (Fatah) and Islamic Resistance Movement (Hamas) against each others.

The researcher adopted the following definitions:

Depression

Depression is defined as emotional state or mood characterized by one or more of these symptoms: sad mood, low energy, poor concentration, sleep or appetite changes, feelings of worthlessness or hopelessness, and thoughts of suicide (Strickland, 2001).

Anxiety

Anxiety is an unpleasant emotional state, the sources of which are less readily identified. It is frequently accompanied by physiological symptoms that may lead to fatigue or even exhaustion (Goldman, 2000).

Posttraumatic stress disorder (PTSD)

An anxiety disorder characterized by the persistent reexperience of traumatic events through distressing recollections, dreams, hallucinations, or dissociative flashbacks; develops in response to rapes, life-threatening events, severe injuries, and natural disasters (Roecklein 1998).

1.7 General view of the study chapters

This study consists of six chapters. The first chapter speaks about the background of study subject, problem, objectives, and study questions. The second chapter views the literature review that is related to the study subject, which was collected from scientific researches, published magazines, and other scientific ways. The third chapter speaks about theoretical framework. The fourth chapter views the operations of the study, the important operations are the distribution of the sample and the pilot study so as to calculate and estimate the validity and reliability of the instruments. In fifth chapter the researcher views the results and its tables. which the results will discussed in the sixth chapter followed by a conclusion about the study as well as a recommendation.

Chapter 2

Literature review

Chapter 2: literature Review

2.1 Introduction:

In this chapter the researcher well show the literature reviews in three main axis, the first axis is about violence theories, the second axis divided into two sections; the first is about theories of depression, the second section is about theories of anxiety. Where the third axis is about the previous studies that related to the field of this study.

2.2 Theories of violence and aggression:

Roberts (1981) classified the major theories of aggression under the umbrella of psychology. The authors traced various theories and identified empirical, religious and biblical influences, often in the form of human goodness or evil. Psychologists and behavioural scientists generally use two basic research strategies: naturalistic and experimental (Brennan 1998).

2.2.1 Biological studies

Some biologists believe that aggression is 'shaped by the brain'. Examples of biological studies of the origins of aggression are those involving genetic factors, endocrine influences and examination of brain structures. The neurotransmitters "noradrenalin, dopamine and serotonin" have all been found in increased concentration in the limbic system in the brain, and have been associated with fighting behavior in animals (Brennan 1998).

The sociobiological theories are used to explain rape, child abuse, infanticide, and other forms of domestic violence. These explanations of intimate violence are based on the

inclusive fitness theory which postulates that individuals will behave in ways to increase the probability that their genes will be transmitted to future generations. There are, indeed, associations between cases of child abuse and paternal uncertainty, handicapped or stepchild status, and among poor families when the allocations of limited resources require the hierachal ranking of offspring (Dekeseredy & Perry 2006).

Siann evaluated the range of investigations into specific biological processes and functions that control aggression and violence. These have included:

- The limbic system
- Head injuries
- Biochemistry
- Epilepsy-related disorders
- Autonomic nervous system and skin conductance level
- Genetics.

(Brennan 1998)

2.2.2 Ethological studies

Klopfer defined ethology as the study of behaviour from a biological viewpoint. Ethology applies the method of biology to behavioral phenomena, examining similarities and differences between species by both naturalistic observation and experimentation (Brennan 1998). The ethologists consider any class of behaviour, they are concerned with four issues, which are:

- What immediately causes it – this includes specific stimuli called releasers which trigger instinctive patterns of behaviour, and some of these are known as 'fixed action patterns' (FAPs)
- How such behaviour has developed over the animal's lifecycle (ontogeny)
- What the useful consequences of such behaviour are (its function)
- How the behaviour has evolved within the species (phylogeny). (Brennan 1998).

2.2.3 Psychoanalytical theory

Freud (1920) initially believed that aggression was a "primary response" to the thwarting of pleasure-seeking or pain-avoiding behavior. Freud (1922, 1933) adopted a new instinctual system of motivation, with the opposition being between life instincts (Eros) aimed at enhancing and prolonging life and death instincts (Thanatos) that continuously strove for destruction of life within the organism. In this conceptual revision, aggression became an inborn drive rather than a by-product of thwarting libidinal strivings. Freud considered aggression to be instinctual and inevitable. According to Freud, the aim of all instincts is to reduce tension or excitation to a minimum and eventually to its total elimination, thus allowing humans to return to the idyllic state previously enjoyed within the womb. The only way of achieving this is through a state of nothingness from which it had emerged, in other words death (Brennan 1998).

2.2.4 Learning theory

Learning theory is central to the Behaviourist approach. The key concept to grasp this theory is that an external stimulus leads to a behavioural response. In this particular topic frustration is the stimulus which leads to an aggressive response. Barker, Dembo and Lewin, 1941, showed children a roomful of attractive toys. The first group were made to wait a long time before being allowed to play with the toys in view. The second group were allowed to play with the toys straight away. Results showed that the first, frustrated group were much more aggressive in their play (smashing the toys etc.) than the second group. The idea behind this is normally called the Frustration-Aggression Hypothesis (Dekeseredy & Perry 2006).

One form of this view is the concept of displacement of aggression, where a substitute object is found for the expression of aggressive feelings because they cannot be vented openly and directly towards their real target (Gross 1992). For example, an employee who is rebuked by his or her superior may in turn displace their feelings of anger onto a junior member of staff (Brennan 1998).

The mere presence of an aggressive stimulus may make us more prone to an aggressive response. If we are surrounded by guns we may be more likely to use them. Archer and Gartner, 1984, attempted to demonstrate the parallels between gun laws and violent crime (Dekeseredy & Perry 2006).

Another aspect of learning theory, based on the interaction between man and the environment, is that humans are born with the cognitive and morpho- logical potential to behave aggressively, but whether or not they do depends on what happens within this environment (Brennan 1998).

2.2.5 Social learning

Social learning theory is interested in observational learning and modelling. Peers are seen as role models. In sport, athletes are seen as role models and the most aggressive seem to be the ones who win. McCarthy and Kelley, 1978, found that a large percentage of physically abusive parents were abused themselves (Dekeseredy & Perry 2006).

Bandura and other social learning theorists believed in the value of observational learning or modelling as an introduction to aggression and violence. The authors also believed that children show a high degree of imitation of both aggression and violence. Bandura was concerned with how people learn to be aggressive in any particular situation and what

makes them continue to be aggressive. He divided his theory into three separate parts, which are:

- The origins of aggression
- The instigators of aggression
- Reinforcers of aggression.

(Brennan 1998).

Bandura showed that by simply seeing another person behaving aggressively will increase our own aggressive behaviour. In the experiment a group of children were exposed to an adult who hit, kicked and screamed at a “bobo doll”. When the group were allowed to play with the doll themselves they almost exactly copied the actions of the adult. A second control group were just allowed to play with the doll, and they showed hardly any aggression to the doll at all (Dekeseredy & Perry 2006).

2.3 Theories of depression:

2.3.1 Psychoanalytic Theory of Depression:

Psychoanalytic theory, which argues that depression results from the loss of an ambivalently loved person or loss of a “love object,” which leads to a self-directed hostility and constitutes the depressive experience (Marsella, 1994). This approach suggests that the self-punishment that accompanies depression may actually be an unconscious effort to regain maternal love and support, or that in cases of traumatic experiences in childhood there is resultant faulty ego and libido development with fixation at an earlier state of insecurity and helplessness, (Roecklein, 1998).

2.3.2 Behavioral theory

John Watson (1878 - 1958) is best known as the founder of behaviorism, which he defined as an experimental branch of natural science aimed at the prediction and control of behavior. Watson considered the ultimate aim of psychology to be the adjustment of individual needs to the needs of society (Strickland, 2001).

Skinner described depression as loneliness due to the interruption of established sequences of behavior which have been positively reinforced in the past. The conceptualization of depression as an extinction phenomenon has been central to all behavioral position. Depression for him is defined as: (1) retardation of psychomotor and thought processes, and (2) reduction or absence of previously reinforced behaviors. He suggested that the depressive's failure to produce adaptive behaviors may be due to a number of factors, including (a) sudden environmental changes that require the establishment of new sources of reinforcement; (b) engaging in a punishable behavior that preempts the opportunity for positive reinforcement; (c) inaccurate observation of the environment, resulting in socially inappropriate behavior; and (d) a low frequency of positive reinforcement (Thabet, 2005).

2.3.3 Humanistic theory

Abraham Maslow (1908-1970). A central figure in humanistic psychology and in the human potential movement, Maslow is known especially for his theory of motivation or needs. Maslow placed the need of self actualization at the peak of his hierarchy of human motivations, the concept for which he is best known today. This hierarchy is generally portrayed as a pyramid with five levels, ranging from the most basic needs at the bottom to the most complex and sophisticated at the top. From bottom to top, the levels are biological

needs (food, water, shelter); safety; belongingness and love; the need to be esteemed by others; and self-actualization, the need to realize one's full potential (Strickland, 2001).

In this theory depression results when a person feels responsible for his hopelessness in regard to the attainment of goals. The author distinguishes three forms of depression, which vary with the kind of goal—a specific situation, a behavior style, or a generalized goal—to which the person directs his expectancy (Beck, 1970).

2.3.4 Cognitive Theory

According to Beck, there are three important aspects of these distortions or depressive cognitions. First, they are automatic—that is, they occur without reflection or forethought. Second, they appear to be involuntary. Some patients indicate that these thoughts occur even though they have resolved not to have them. Third, the depressed person accepts these thoughts as plausible, even though others would not view them in the same manner (Piotrowski, 2005). Beck refers to such illogicalities as ‘schemata’. The depressed person interprets all events from the schema of self-depreciation and self-blame. Four types of logical error are possible here (Strongman, 2003):

1. arbitrary inference, when there is no evidence for a conclusion drawn (I am useless because the shop was closed when I went to buy something);
2. selective abstraction, in which a conclusion is drawn from only one element of the many possible (it is my fault that the firm that I work for is full of unintelligent people);
3. overgeneralization, or the making of a massive conclusion from a trivial starting point (I am completely thick because I did not understand that one point);
4. magnification and minimization, which simply involve errors in judging performance (I told one white lie and completely lost all integrity).

2.3.5 Biological and Physiological Theories

The biological theories include the genetic theories, in which it is assumed that genetic factors interact with environmental factors and where heredity influences emotional lability, cellular functioning, basic arousal levels, stimulus threshold levels, and other physiological substrates of behavior (Marsella, 1994).

The role of genetic factors in depression was addressed long ago by Robert Burton in *The anatomy of Melancholy*, in which he noted that the “inbred cause of melancholy is our temperature, in whole or part, which we receive from our parents” and “such as the temperature of the father is, such is the son’s, and look what disease the father had when he begot him, his son will have after him.” More than 350 years later, the role of family factors in depression was addressed in a major collaborative study in the United States. In what was called the National Institute of Mental Health Collaborative Study of the psychobiology of depression, a large number of standardized instruments were developed to assess prevalence and incidence of depression, life histories, psychosocial stressors, and outcome of depression. The family members of depressed persons were assessed along with the depressed individual. It was found that bipolar depression was largely confined to relatives of individuals with bipolar disorder. Unipolar depression, however, was common among relatives of both unipolar- and bipolar-depressed individuals. The different patterns of familial transmission for bipolar and unipolar disorders strengthen the general conviction that these two disorders should be kept distinct from each other (Piotrowski, 2005).

2.4 Theories of anxiety

2.4.1 Psychoanalytic Approach

Sigmund Freud, who said that understanding anxiety “would be bound to throw a flood of light on our whole mental existence,” had two theories of anxiety, an early one, in 1917, and a later one, in 1926. In the early theory, libido (mental energy, often equated with sexual drive) builds up until it is discharged by some pleasurable activity. In Freud’s first theory, repression causes anxiety. In psychoanalytic theory, repression is a defense mechanism that keeps unacceptable thoughts and impulses from becoming conscious. In the later theory, the relationship between them has changed: Anxiety causes repression. In this theory, anxiety acts as a signal to the ego (in Freud’s theory, the rational, conscious part of the mind). This object can arouse all the emotions associated with the forbidden impulse, including the signal anxiety (Piotrowski, 2005).

Furthermore, the situation or the object is usually one that the person can avoid; with the additional defense mechanism of avoidance, the person can escape suffering serious anxiety. The end result is that the three combined defenses (repression, displacement, and symbolization) may eliminate the anxiety. The anxiety is controlled at the cost of creating a phobic neurosis, however. Freud first discussed the theoretical formulation of phobia formation in his famous case history of "Little Hans", a 5-year-old boy who feared horses (Sadock & Sadock, 2007).

2.4.2 Behavioral approach:

Watson's hypothesis invoked the traditional pavlovian stimulus-response model of the conditioned reflex to account for the creation of the phobia: Anxiety is aroused by a

naturally frightening stimulus that occurs in contiguity with a second inherently neutral stimulus. As a result of the contiguity, especially when the two stimuli are paired on several successive occasions, the originally neutral stimulus becomes capable of arousing anxiety by itself. The neutral stimulus, therefore, becomes a conditioned stimulus for anxiety production (Sadock & Sadock, 2007).

Behavioral therapists hold that anxiety is a learned response to some noxious situation or stimulus. When a situation or stimulus provokes anxiety in a person, the person learns to reduce the anxiety by avoiding the situations that provoke it. Generalized anxiety disorder may result from the unpredictability of positive and negative reinforcement the person is uncertain when and if avoidance behaviors will be effective in reducing anxiety. It is also possible to develop anxiety in response to generally positive or neutral stimuli if these are associated with a noxious or aversive stimulus. This conditioning process is held to be responsible for the avoidance of neutral or benign situations in which distressing anxiety (such as panic) has occurred. Pairing of a recurrent anxiety-inducing thought (such as “contamination”) with a compulsive behavior (such as hand washing) that reduces anxiety is thought to explain the development of obsessive-compulsive disorder (Goldman, 2000).

2.4.3 Cognitive Theories

Cognitive theories of anxiety illustrate how theory is applied to develop a treatment. There are many different cognitive models of anxiety, but all are similar in that they assume that there is a cognitive cause of the fear state. This cognitive step is sometimes called an irrational belief (Piotrowski, 2005).

Cognitive therapy is designed to change unproductive thought patterns by learning to examine feelings and distinguish between rational and irrational thoughts. Relaxation

techniques focus on breathing retraining to relax and resolve the stresses that contribute to anxiety (Strickland, 2001).

Cognitive models of anxiety disorders emphasize the role of specific beliefs and appraisals of threat and of one's ability to cope. These models are becoming increasingly popular, perhaps because they attempt to give a fairly comprehensive account of anxiety disorders and seem credible in doing so. However, cognitive models have generally not been sufficiently tested, and the treatment based on them has yet to demonstrate whether it is as efficacious as behavior therapy. The attractiveness of cognitive models and cognitive therapy also lies in their radical dismantling of the psychological mechanisms in anxiety disorders and in their proposition that therapeutic change should occur as a result of changes in the more fundamental patterns of thinking. At the same time, this ambitious proposition may be the reason why cognitive therapy seems less pragmatic and perhaps less applicable to all patients with anxiety disorders (Starcevic, 2005).

2.4.4 Physiological Theories

Physiological theories of anxiety are increasing in importance. As with behavioral, psychodynamic, and cognitive theories, there are many physiological theories. They differ with respect to the brain areas, pathways, or chemicals implicated in anxiety. It is likely that many physiological theories contain an element of truth. Anxiety is a complex state, involving multiple interacting parts of the nervous system, and it will take much additional research to develop a complete model of the brain's role in anxiety (Piotrowski, 2005)

When compared with normal controls, patients with anxiety disorders have significantly different physiological functioning (e.g., higher heart rate, higher blood lactate levels, and greater oxygen debt during moderate exercise) (Goldman, 2000).

One physiological variable that has been integrated into many theories of anxiety is the panic attack. This is a sudden and usually short-lived attack that includes trouble with breathing, heart palpitations, dizziness, sweating, and fear of dying or going crazy. These attacks appear purely physiological in that they seem to come “out of the blue” at first; however, psychological factors determine whether they progress into a full-blown disorder. People can become anxious about having panic attacks, and this added anxiety leads to more attacks, producing panic disorder. Some people become afraid of having an attack in a place where they will be unable to cope or receive help. These people may progressively avoid more and more places. This is known as agoraphobia, which at its worst can result in people who are afraid to leave their homes (Piotrowski, 2005).

2.5 Studies review

2.5.1 Community violence and Mental health Studies

In the study of Silove et al. (1997) forty consecutive asylum-seekers attending a community resource centre in Sydney, Australia, were interviewed using structured instruments and questionnaires. Anxiety scores were associated with female gender, poverty, and conflict with immigration officials, while loneliness and boredom were linked with both anxiety and depression. Thirty subjects (79%) had experienced a traumatic event such as witnessing killings, being assaulted, or suffering torture and captivity, and 14 subjects (37%) met full criteria for PTSD. A diagnosis of PTSD was associated with greater exposure to pre-migration trauma, delays in processing refugee applications, difficulties in dealing with immigration officials, obstacles to employment, racial discrimination, and loneliness and boredom.

Thabet and Vostains (1998) were study social adversities and anxiety disorders in gaza strip, which aimed to investigate the rate and nature of anxiety symptoms and disorders in children, and their relation to social adversities in a cultural sample not previously researched. Methods: 237 children aged 9 to 13 years living in the Gaza Strip were selected randomly from 112 schools. Children completed the revised manifest anxiety scale (RCMAS), and teachers completed the Rutter scale. The findings were children reported high rates of significant anxiety problems (21.5%) and teachers reported high rate of mental health problems in the children (43.4%) that would justify clinical assessment.

In study of LeBlanc (2002) the purpose of this study was to investigate the relations among school violence exposure, neighborhood violence exposure, family violence exposure, parent-adolescent relationship skills, and outcomes. Participants consisted of 100 adolescents, aged 13 to 20 years. Adolescents completed the Screen for Adolescent Violence Exposure, the Behavior Assessment System for Children- Self Report of Personality, The Child Health and Illness Profile-Adolescent Edition, and the Parent-Adolescent Relationship Questionnaire. Parents/guardians completed the Behavior Assessment System for Children-Parent Report, The Parent-Adolescent Relationship Questionnaire, and a demographic questionnaire. Results revealed that family violence exposure moderated the association between school and neighborhood violence exposure and conduct. For neighborhood violence exposure, there was no relation between exposure and conduct at low levels of family violence exposure. However, there was an inverse association between neighborhood violence exposure and conduct, at high levels of family violence exposure. For school violence exposure, there was no relation between school violence exposure and conduct at low levels of family violence exposure. At high levels of family violence exposure, there was a positive link between school violence exposure and

conduct. Lastly, adolescent-rated communication/problem solving skills moderated the association between school violence exposure and psychological distress, including anxiety, depression, and social stress.

In the study of Guerra et al, (2003) the effects of witnessing community violence on aggressive cognitions and behavior were investigated in an ethnically diverse sample of 4,458 children living in urban neighborhoods. Results revealed that prior violence exposure had a significant effect in increasing aggression, normative beliefs about aggression, and aggressive fantasy. Although exposure to violence predicted aggressive behavior both in Grades 1 through 3 (ages 5–8) and Grades 4 through 6 (ages 9–12), the effects on social cognition were only evident in the later grades. Furthermore, the effect of violence exposure on aggression in the later grades was partially mediated by its effect on social cognition. These findings suggest that witnessing community violence has an effect on children's aggressive behavior through both imitation of violence and the development of associated cognitions as children get older.

The study of Rosenthal and Wilson (2003) examined longitudinal relationships among exposure to chronic community violence during high school, psychological distress during the first semester of college, and academic performance during the first three semesters of college. The sample comprised 385 students of color in a large city. Exposure to community violence and psychological distress were measured with additive scales; academic performance (school persistence, grade point average) was obtained from transcripts. Results found that exposure to community violence and academic performance were not related; exposure to community violence and psychological distress were related; psychological distress and college persistence were related; and psychological distress and grade point average were not related.

The study of Pearce et al, (2003) examined the protective effects of religiousness and parent involvement for the development of conduct problems beyond the effects of risk factors. Measures of violence exposure, conduct problems, parent involvement, and religiousness, from the longitudinal Social and Health Assessment survey, were completed by 1,703 high-risk urban adolescents (12.5 ± 1.7 years; 53% female). Results revealed witnessing of and victimization by community violence appeared to be significant risk factors for an increase in conduct problems over a 1-year period. Religiousness and parental involvement were each uniquely associated with a decrease in conduct problems.

The study of Bravo-Mehmedbasić et al. (2003) aimed to examine differences and specificities of psychological symptoms as a response to the trauma of torture and displacement. The sample includes two groups of 50 subjects. The first group experienced the trauma of displacement, and the second group beside the displacement experienced also the trauma of torture. The drop in social and economic status is much more profound in torture victims compared to refugees. All nine SCL 90-R suscales show statistically significant difference in more pronounced psychopathological responses in torture victims relative to refugee population. The Mississippi questionnaire shows significant differences in PTSD between the two groups and higher scores for torture victims. Based on the results torture is the most intense form of trauma leading to intensive psychopathological responses including chronic PTSD.

In the study of Momartin et al. (2003) Refugee survivors of inter-ethnic warfare vary greatly in the extent and range of their trauma experiences. Discerning which experiences are most salient to generating and perpetuating disorders such as posttraumatic stress disorder (PTSD) is critical to the mounting rational strategies for targeted psychosocial interventions. In a sample of Bosnian Muslim refugees (n=126) drawn from a community

centre and supplemented by a snowball sampling method, PTSD status and associated disability were measured using the clinician-administered PTSD Scale (CAPS) for DSM-IV. A principal components analysis (PCA) based on a pool of trauma items yielded four coherent trauma dimensions: Human Rights Violations, Threat to Life, Traumatic Loss and Dispossession and Eviction. A cluster analysis identified three subgroupings according to extent of trauma exposure. There were no differences in PTSD risk for the group most exposed to human rights violations (internment in concentration camps, torture) compared to the general war-exposed group. Logistic regression analysis using the dimensions derived from the PCA indicated that Threat to Life alone of the four trauma factors predicted PTSD status. Both Threat to Life and Traumatic Loss contributed to symptom severity and disability associated with PTSD.

Shannon, (2004) the purpose of this study was to delineate the relations among community violence exposure and family factors, including family violence and parental psychopathology, on adolescent psychological symptomatology and personal adjustment. Participants consisted of 121 pairs of junior high or high school students and their parent/guardian. Adolescents completed the Screen for Adolescent Violence Exposure, the Trauma Symptom Checklist for Children, and the Behavior Assessment System for Children-Self Report of Personality. The parents/guardians completed a Demographic Questionnaire, the Behavior Assessment System for Children-Parent Report, the Symptom Checklist-90-R, and the Posttraumatic Stress Diagnostic Scale. Hierarchical regression analyses were conducted and results indicated that family violence exposure did not serve as a moderator variable in the association between adolescent community violence exposure and positive or negative adolescent outcome. In contrast, parental psychopathology was found to be a moderator variable in the relationship between

community violence exposure and adolescent-rated PTSD and psychological distress, but not in the relationship between community violence exposure and parent-rated adolescent internalizing and externalizing problems or adolescent-rated personal adjustment.

The study of Momartin et al. (2004) examined whether a subgroup of refugees with comorbid PTSD and depression were at particularly high risk of disability. We also investigated whether specific trauma experiences were linked to this comorbid pattern. Consecutive Bosnians (and one or two compatriots nominated by them) were recruited from a community centre, yielding a total sample of 126 participants (response rate 86%). Measures included a trauma inventory, the Clinician Administered PTSD Scale (CAPS) and the depression module of the Structured Clinical Interview (SCID). Three diagnostic groupings emerged: normal (n=39), pure PTSD (n=29), and comorbid PTSD and depression (n=58). Of four trauma dimensions derived from principle components analysis (human rights violations, dispossession and eviction, life threat and traumatic loss), life threat alone was associated with pure PTSD, with life threat and traumatic loss both being associated with comorbidity. Compared to normals and those with pure PTSD, the comorbid group manifested more severe PTSD symptoms as well as higher levels of disability on all indices (global dysfunction: odds ratio=5.0, P<0.001, distress: odds ratio=6.0, P<0.001, social impairment: odds ratio 5.9, P<0.001, and occupational disability: odds ratio 5.0, P<0.001).

The study of Heptinstall et al, (2004) described the effect of pre-migration and post-migration experiences on the mental health of a sample of 40 refugee children aged 8-16 who lived in London with at least one parent or a refugee relative. Children's post-traumatic stress disorder (PTSD) and depression symptoms were assessed with standardized self-report measures (Impact of Event Scale and Depression Self-Rating Scale for Children,

respectively). Information regarding past and present experiences were gathered during an interview with parents. The results showed there was a significant correlation between the number of pre-migration traumas experienced by the families and the children's PTSD scores. There was also a significant correlation between the families' number of post-migration stresses and children's depression scores. Higher PTSD scores were significantly associated with the pre-migration experience of violent death of family members and the post-migration experience of an insecure asylum status. Higher depression scores were significantly associated with insecure asylum status and severe financial difficulties.

The study of Sams and Truscott (2004) investigated the relationships between use of violence, empathy and exposure to community violence among urban at-risk adolescent males. Participants completed a battery of self-report measures to assess their levels of empathy, exposure to community violence and use of violent behavior. Data were examined using a multiple regression analysis; results indicate that while low empathy alone does not predict use of violence, low empathy coupled with high levels of exposure to community violence is a significant predictor of use of violence.

The study Paxton et al, (2004) examined exposure to community violence and depressive and post-traumatic stress disorder (PTSD) symptoms within a non-random sample of low-income, African-American male adolescents ($n=77$) were recruited from an inner-city, Midwestern high school and surveyed on exposure to violence, depression, post-traumatic stress, and social support. Regression analyses revealed that exposure to violence was significantly associated with both depressive and PTSD symptoms. However, social support was not found to moderate the relationship between exposure to community violence and psychological distress.

The study of Roussos et al, (2005) evaluated the severity of posttraumatic stress and depressive reactions among children and adolescents 3 months after the 1999 earthquake in Ano Liosia, Greece, and additionally assessed the relationship of these reactions to objective and subjective features of earthquake exposure, sex, school level, postearthquake difficulties, death of a family member, and thoughts of revenge. This school-based study of 1,937 students was conducted in two differentially exposed cities with an earthquake exposure questionnaire, the UCLA Posttraumatic Stress Disorder (PTSD) Reaction Index, and the Depression Self-Rating Scale. Endorsement of earthquake-related exposure items between the two cities was congruent with the extent of earthquake impact in each city. Median PTSD Reaction Index scores were significantly higher in Ano Liosia. The estimated rates of PTSD and clinical depression for both cities combined were 4.5% and 13.9%, respectively. Depression, subjective and objective earthquake-related experiences, and difficulties at home accounted for 41% of the variance in severity of PTSD reactions. PTSD score was the single most powerful variable predicting depression (36% of the variance), with only sex making a small but significant additional contribution.

2.5.2 Political violence and Mental health Studies

In the study of Baker (1990) the mental health of 796 Palestinian children living in the occupied West Bank and Gaza Strip was assessed in terms of reported psychological status and behavioral symptoms. Results, interpreted within the context of the 1987 uprising (Intifada), indicate that exposure to political and military violence may be associated with the onset of conduct problems and fears, although active participation in the conflict may enhance self-esteem and shield children from development of psychological symptoms.

In the study of Punamäki and Suleiman (1990) Relationships between exposure to political hardships, social-economic status and mother's psychological responses, and children's coping modes, were analyzed among 66 Palestinian boys and girls aged 8-14 who lived in the West Bank and the Gaza Strip. The effectiveness of children's coping modes in protecting their mental health from the negative impact of political hardships was also analyzed. The coping modes were assessed on the intentional (passive-active), cognitive (defensive-purposive), and emotional (helpless-courageous) levels. The results showed that the more children were exposed to political hardships, the more they employed active and courageous coping modes. Furthermore, the more mothers showed psychological symptoms the more their children used active coping modes. The more political activity the mothers used as a coping mode, the more their children used purposive coping. Exposure to political hardships increased children's psychological symptoms, and none of the children's psychological coping modes were effective in mitigating this relationship.

Where Quota (1992) explain about the level of anxiety in Gaza Before and After the Intifada. Was aimed to estimate the level of anxiety among the Palestinian people in Gaza strip as a measure of the effect of stress. The sample were 160 people (80 males, 80 females) were randomly selected to represent the four groups; camp refugee, re-settled refugees, town Refugee, and Citizens were selected from the middle social class were divided into males and females. Results found there were no significant differences in the level of anxiety in all of the three groups of refugees between 1984 and 1991. The level of anxiety have increased among the citizens compared to their previous state in 1984, The difference is significant.

Qouta et al, (1995) this research examined the impact of the Israeli-Palestinian peace treaty and Palestinian children's perception of it on their self-esteem and neuroticism. Also

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

In the study of Garbarino and Kostelny (1996) interviews with 150 Palestinian mothers and their children living amidst the Intifada in the West Bank were conducted to assess exposure to political violence and family negativity as risk factors associated with behavioral problems as measured by the Child Behavior Checklist. The number of risks present in the child's life was significantly correlated with the number of behavioral problems the child exhibited ($R = .53$, $p < .001$). The analysis further examined the role of gender, age, and community context in moderating the impact of high levels of accumulated risk on children's behavioral problems. Under conditions of high accumulated risk, boys evidenced more problems than girls, and younger children exhibited more

problems than older children. Community context (as indicated by a high or low level of political violence) was a significant factor for girls but not for boys.

Başoğlu et al, (1997) the aim of this study was to examine the role of 'psychological preparedness' for trauma in post-traumatic stress responses in survivors of torture. (34) torture survivors who had no history of political activity, commitment to a political cause or group, or expectations of arrest and torture were compared with 55 tortured political activists, using structured interviews and measures of anxiety, depression, and post-traumatic stress disorder. Compared with tortured political activists, tortured non-activists were subject to relatively less severe torture but showed higher levels of psychopathology. Less psychological preparedness related to greater perceived distress during torture and more severe psychological problems, explaining 4% of the variance in general psychopathology and 9% of the variance in post-traumatic stress disorder symptoms.

Michultka (1998) conducted study that investigated civilian war trauma in Central American refugees, focusing on the diagnosis of posttraumatic stress disorder (PTSD) as related to war experience and demographic characteristics. 68% of the refugees met the diagnostic criteria for PTSD. Diagnosis was best predicted by number of war experiences, severity of war trauma and level of anxiety/depression. Higher numbers of war experiences predicted PTSD severity. In examining the PTSD symptom cluster scores, it was found that number of war experiences was a significant predictor in all clusters.

Holtz (1998) a retrospective cohort study of 35 refugee Tibetan nuns and lay students who were arrested and tortured in Tibet matched with 35 controls who were not arrested or tortured was carried out in India. Subjects were administered the Hopkins Checklist-25, evaluating anxiety symptoms, effective disturbances, somatic complaints, and social impairment. The prevalence of symptom scores in the clinical range for both cohorts was

41.4% for anxiety symptoms and 14.3% for depressive symptoms. The torture survivors had a statistically significant higher proportion of elevated anxiety scores than did the nontortured cohort (54.3% vs. 28.6%, $p = .05$). This was not true for elevated depressive scores. The results suggest that torture has long-term consequences on mental health. Political commitment, social support in exile, and prior knowledge of and preparedness for confinement and torture in the imprisoned cohort served to foster resilience against psychological sequelae.

In the study, Thabet et al. (1999) was aimed to estimate the rate of post traumatic stress reaction in Palestinian children who experienced war traumas, and to investigate the relationship between trauma – related factors and PTSD reactions. Sample consisted of 239 children of 6 to 11 years of age. The study used Rutter A2 (parent) and B2 (teacher) Scales. The Gaza Traumatic event checklist, and the child post stress reaction Index (CPTSD–RI). The findings were 174 children (72.8%) reported PTSD reaction of at least mild intensity, while 98 (41%) reported moderate/severe PTSD reaction of at least mild intensity, while detected in 64 children (26.8%), which correlated well with detection of PTSD reactions, but not with teacher detected caseness. The total number of experienced trauma was the best predictor of present and severity of PTSD.

The study of Mollica et al. (1999) aimed to determine if risk factors, such as demographics, trauma, health status, and psychiatric illness, are associated with disability in Bosnian refugees. Cross-sectional survey conducted in 1996 of Bosnian refugee adults living in a camp established by the Croatian government near the city of Varazdin. One adult aged 18 years or older was randomly selected from each of 573 camp families; 534 (93%) agreed to participate (mean age, 50 years; 41% male). Culturally validated measures for depression and posttraumatic stress disorder (PTSD) included the Hopkins Symptom Checklist 25 and

the Harvard Trauma Questionnaire, respectively. Disability measures included the Medical Outcomes Study Short-Form 20, a physical functioning scale based on World Health Organization criteria, and self-reports of socioeconomic activity, levels of physical energy, and perceived health status. RESULTS: Respondents reported a mean (SD) of 6.5 (4.7) unduplicated trauma events; 18% (n=95) had experienced 1 or more torture events. While 55.2% reported no psychiatric symptoms, 39.2% and 26.3% reported symptoms that meet DSM-IV criteria for depression and PTSD, respectively; 20.6% reported symptoms comorbid for both disorders. A total of 25.5% reported having a disability. Refugees who reported symptoms comorbid for both depression and PTSD were associated with an increased risk for disability compared with asymptomatic refugees.

Dyregrov et al (2000) they aimed to assess trauma exposure and psychological reactions to genocide among Rwandan children. A total of 3030 children age 8–19 years from Rwanda was interviewed about their war experiences and reactions approximately 13 months after the genocide that started in April 1994. Rwandan children had been exposed to extreme levels of violence in the form of witnessing the death of close family members and others in massacres, as well as other violent acts. More than two-thirds of the sample actually saw someone being injured or killed, and 78% experienced death in their immediate family, of which more than one-third of these children witnessed the death of their own family members. A shortened form of the Impact of Event Scale used in a group of 1830 of these children documented high levels of intrusion and avoidance. While children living in shelters were exposed to more traumas, they evidenced less posttraumatic reactions. Analyses showed that reactions were associated with loss, violence exposure, and, most importantly, feeling their life was in danger.

The study of Papageorgiou et al, (2000) described the pattern of psychopathology in a sample of 95 children of 8-13 years, who had experienced war in Bosnia. The children were assessed with a battery of standardized measures during a psychosocial support programme in Northern Greece. They either came from refugee families (44%) or had suffered significant family loss (a parent had been killed in 28% and the father was injured or absent in 27% of cases). Children recalled a substantial number of war traumatic experiences. According to previously established cut-off scores on self-report measures, 45 children (47%) scored within the clinical range on the Depression Self-Rating Scale for Children, 28 (23%) on the Revised Children's Manifest Anxiety Scale, and 65 (28%) on the Impact of Event Scale (IES) measuring PTSD reactions. There was a significant association between the number of war traumatic experiences and the intrusion and avoidance scores on the IES.

In the study of Goenjian et al, (2000) the authors sought to assess the severity and longitudinal course of posttraumatic stress, anxiety, and depressive reactions among two groups of adults differentially exposed to severe and mild earthquake trauma and a third group exposed to severe violence. They also examined interrelationships among these reactions and predictors of outcome and compared posttraumatic stress disorder (PTSD) symptom category profile and course between those exposed to earthquake and those exposed to violence. 78 non-treatment-seeking subjects were assessed with self-report instruments approximately 1.5 and 4.5 years after the 1988 Spitak earthquake in Armenia and the 1988 pogroms against Armenians in Azerbaijan. The two groups that had been exposed to severe trauma (earthquake or violence) had high initial and follow-up PTSD scores that did not remit over the 3-year interval. Overall, depressive symptoms subsided. Posttraumatic stress, anxiety, and depressive reactions were highly intercorrelated within and across both time intervals. No significant differences in PTSD severity, profile, or

course were seen between subjects exposed to severe earthquake trauma versus those exposed to severe violence.

However in another study were Thabet et al., (2000) Aimed to establish rates of post traumatic stress disorder PTSD reaction and general mental health problems in children who had experienced war trauma. on 234 children aged 7 to 12 years, who had experienced war conflict, at 1 year after the initial assessment, that is, during the peace process. Children completed the child posttraumatic stress Reaction Index (CPTSD-RI), While the Rutter A2 and B2 parents and teachers completed scales. Which The rate of children who reported moderate to severe PTSD reactions at follow-up had decreased from 40.6% (No=102) to 10.0% (No=74). 49 children (20.9%) were rated above the cut – off for mental health problems on the Rutter B2 (teacher) Scales the total scores on all three measures had significantly decreased during the 1-year period, the total (CPTSD – RI) score at follow up was best predicted by the number of traumatic experiences, recalled at the first assessment.

In the study of Punamäki et al, (2001) the effects of cognitive capacity, perceived parenting, traumatic events, and activity, which were first measured in the midst of the political violence of the Intifada in 1993, were examined on post-traumatic stress disorder (PTSD), emotional disorders, school performance, and neuroticism three years later in more peaceful conditions among 86 Palestinian children of 14.04 ± 0.79 years of age. The results showed, first, that PTSD was high among the children who had been exposed to a high level of traumatic events and had responded passively (not actively) to Intifada violence. Discrepant perceived parenting was also decisive for adjustment: Children who perceived their mothers as highly loving and caring but their fathers as not so showed a high level of PTSD. High intellectual but low creative performance was also characteristic of the children suffering from emotional disorders. Second, the hypothesis that cognitive capacity

and activity serve a resiliency function if children feel loved and nonrejected at home was confirmed. Third, neuroticism decreased significantly over the three years, especially among the children who had been exposed to a high number of traumatic events.

El Majdalawi, (2002).The over all aim of this study was to assess the relationship between psychic trauma and school performance among preparatory school children in Gaza Strip. Data was collected through indirect method using a structural interviewed questionnaire and reviewing school records, trauma was classified to three levels mild. moderate and severe according to Gaza Traumatic Chick list. The most traumatic events was watching martyrs and injured people on TV, which rated 96.9% of study sample. School performance was assessed by getting scores in Math, Arabic language, and total average in the first half of scholastic year. Concentration, attention and participation in class activities. Results showed that 19.7% of study sample exposed to mild trauma, 72.4% of them exposed to moderate trauma and 7.9% of the study sample exposed to severe trauma. 71.2 % of the study sample developed post traumatic stress disorder. There is a positive relation and association between trauma, PTSD and school performance.

In another study by Thabet et al, (2002) aimed to assess the nature and severity of emotional problems in Palestinian children whose homes had been bombarded and demolished during the crisis in Palestine, compared with children lining in other parts of the Gaza Strip. Methods, 91 children exposed to home bombardment and demolition during Al-Aqsa Intifada and 89 controls who had been exposed to other types of traumatic events related to political violence completed self – repot measures of post traumatic stress and anxiety and fear and CPTSD – RI and RCMAS scales were used to assess anxiety and PTSD. The results were found significantly more children exposed to bombardment and home demolition reported symptoms of post traumatic stress and fear that reported

posttraumatic stress reaction of clinical importance. Exposed to bombardment was the strongest socioeconomic predictor of post traumatic stress reaction. By contrast children exposed to other events mainly through the media and adults, reported more anticipatory anxiety and cognitive expressions of distress.

Silove et al, (2002) the present study examines the effect of torture in generating post-traumatic stress disorder (PTSD) symptoms by comparing its impact with that of other traumas suffered by a war-affected sample of Tamils living in Australia. Traumatic predictors of PTSD were examined among a subsample of 107 Tamils (refugees, asylum seekers, and voluntary immigrants) who had endorsed at least one trauma category on the Harvard Trauma Questionnaire. Principal components analysis (PCA) yielded five trauma factors that were applied to predicting PTSD scores. Tamils exposed to torture returned statistically higher PTSD scores than other war trauma survivors after controlling for overall levels of trauma exposure. The torture factor identified by the PCA was found to be the main predictor of PTSD in a multiple regression analysis.

Abu Laila, (2003) this study aims to determine the effect of trauma on mental health of ambulance drivers whom exposed for direct or indirect traumatic events during Al-Aqsa Intifada on 29th Sep, 2000 to 5th March, 2003. A total of 227, there were 115 ambulance drivers, 112 control group were included in the study sample. Data for this study was collected by using trauma check list, Davidson trauma Scale, Hopkins Symptoms check list and Beck Depression Inventory to determine the differences between two groups in traumatic events level. The result of study showed that both groups are complain from different level of traumatic events, PTSD symptoms, anxiety and depression, ambulance drivers ($M=16.22$) there were complain from traumatic events more than control group ($M=10.59$) PTSD symptoms, ambulance drivers ($M=15.39$) there were complain from

PTSD symptoms less than control group ($M=17.58$). HScl-25, depression subscale, ambulance drivers ($M=7.99$) complain from depression less than control group ($N=11.49$), anxiety subscale ambulance drivers ($M=4.00$) complain from anxiety less than control group ($M=6.70$), BDI-II to investigate depression symptoms, ambulance drivers ($M=13.73$) there were complain from depression less than control group ($M=19.75$).

The study of Eisenman et al, (2003) aimed to determine rates of exposure to political violence among Latino adult primary care patients who have immigrated to the United States its impact on mental health. Reports of exposure to political violence in home country before immigrating to the United States; symptoms of depression, anxiety, and alcohol disorders using the Primary Care Evaluation of Mental Disorders (PRIME-MD); and symptoms of posttraumatic stress disorder (PTSD) using the PTSD Checklist-Civilian Version (PCL-C). A total of 638 (69%) of 919 eligible patients participated. In weighted analyses, 54% of participants reported political violence experiences in their home countries, including 8% who reported torture. Of those exposed to political violence, 36% had symptoms of depression and 18% had symptoms of PTSD vs 20% and 8%, respectively, among those not exposed to political violence.

Rosner et al, (2003) the goals of this study were to estimate the lifetime prevalence of traumatic events, the current prevalence of Posttraumatic Stress Disorder (PTSD), and the connection between the kinds of traumatic events experienced and the probability of developing PTSD in three study samples in Sarajevo, Bosnia-Herzegovina, three years after the end of the war. A total of 311 people surviving the siege of Sarajevo were assessed with the Checklist for War Related Experiences (CWE) and an adapted version of the Posttraumatic Diagnostic Scale (PDS). The study groups consisted of a randomly selected residents sample ($n = 98$), a group of individuals in psychological treatment ($n = 114$), and

a group in medical treatment ($n = 99$). Each individual survived an average of 24 traumatic events. According to the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. criteria, 18.6% of individuals in the residents sample, 32.7% of those in medical treatment, and 38.6% of those in psychological treatment developed PTSD.

In the study of Qouta et al, (2003) the prevalence and determinants of PTSD were assessed among 121 Palestinian children (6-16 years; 45% girls and 55% boys) living in the area of bombardment. The mothers (21-55 years) and the children themselves reported their exposure to military violence (being personally the target of violence or witnessing it towards others) and symptoms of posttraumatic stress disorders (PTSD: intrusion, avoidance and hypervigilance). The results showed that 54% of the children suffered from severe, 33.5 % from moderate and 11 % from mild and doubtful levels of PTSD. Girls were more vulnerable; 58% of them suffered from severe PTSD, and none scored on the mild or doubtful levels of PTSD. The child's gender and age, mother's education and PTSD symptoms were significant, and the exposure to traumatic experiences marginally significant determinants of children's PTSD symptoms. The most vulnerable to intrusion symptoms were younger girls whose mothers showed a high level of PTSD symptoms, whereas those most vulnerable to avoidance symptoms were children who had personally been targets of military violence and whose mothers were better educated and showed a high level of PTSD symptoms.

Thabet et al., (2004) search about comorbidity of PTSD and depression among refugee children during war conflict. Were aimed to examine the prevalence and nature of comorbid post – traumatic stress reactions and depressive symptoms, and the impact of exposure to traumatic events on both types of psychopathology, among Palestinian children during war conflict in the region. 403 children aged 9-15 year, who lived four refugee

camps, were assessed by completing the Gaza traumatic event checklist, the child post traumatic stress reaction index (CPTSD-RI), and the short mood and feeling questionnaire (MFQ). The study findings were children reported experiencing a wide range of traumatic events, both direct experience of violence and through the media. CPTSD- RI, and MFQ scores were significantly correlated. Both CPTSD-RI and MFQ Scores were independently predicted by the number of experienced traumatic events, and this association remained after adjusting for socioeconomic variables, Exposure to traumatic event, strongly predicted MFQ scores. As well as sleep disturbance, somatic complaints, constricted affect, impulse control, and difficulties in concentration.

The study of Scholte et al, (2004) aimed to determine the rate of exposure to traumatic events; estimate prevalence rates of symptoms of posttraumatic stress disorder (PTSD), depression, and anxiety. A cross-sectional multicluster sample survey of 1011 respondents aged 15 years or older, conducted in Nangarhar province. Posttraumatic stress disorder symptoms and traumatic events using the Harvard Trauma Questionnaire; depression and general anxiety symptoms using the Hopkins Symptom Checklist; and resources for emotional support through a locally informed questionnaire. During the past 10 years, 432 respondents (43.7%) experienced between 8 and 10 traumatic events; 141 respondents (14.1%) experienced 11 or more. High rates of symptoms of depression were reported by 391 respondents (38.5%); anxiety, 524 (51.8%); and PTSD, 207 (20.4%). Symptoms were more prevalent in women than in men. Higher rates of symptoms were associated with higher numbers of traumas experienced. The main resources for emotional support were religion and family.

Benyamin and Solomon (2005) this study examined the association of initial combat stress reaction (CSR), chronic post-traumatic stress disorder (PTSD) and cumulative life stress on

physical health 20 years after the 1982 war with Lebanon, in a sample of 504 Israeli veterans of the war. Two groups were assessed: male veterans who fought and suffered from CSR and a matched group of male veterans from the same units who did not exhibit such reactions. Twenty years following the war, participants were asked to rate their general physical health status, report health complaints and risk behaviors, and were screened for PTSD. CSR and, to a greater extent, PTSD, were found to be associated with general self-rated health, chronic diseases and physical symptoms, and greater engagement in risk behaviors. CSR and PTSD were also related to greater cumulative life stress since the war. Both negative and positive life events were independently related to most of the physical health measures but did not account for the associations of CSR and PTSD with poorer health. Tests of the interactions between CSR, PTSD and life stress in their association with physical health and risk behaviors showed that PTSD suppressed the effects of additional life stress (negative life events had a weaker effect on health among participants with PTSD).

The study of Giacaman et al, (2007) aimed to investigate the influence of exposure to humiliation in war-like conditions on health status in 10th- and 11th-grade students living in the Ramallah District, West Bank, Occupied Palestinian Territory. A stratified single-stage cluster sample of 3415 students from cities, towns, villages and refugee camps of the Ramallah District. Survey questions were derived from the World Health Organization's Health Behaviour in School-aged Children Survey, the Gaza Community Mental Health Programme Traumatic Event Checklist, and focus group discussions with young people. The survey questionnaire was completed by students in their classrooms, under the supervision of a trained field worker. There was a significant association between a high number of subjective health complaints and demographic variables, particularly for females

compared with males, and refugee camp dwellers compared with village dwellers. In addition, exposure to humiliation was significantly associated with an increased number of subjective health complaints. Students experiencing three forms of humiliation were found to be 2.5 times more likely to report a high number of subjective health complaints compared with those who had never been exposed to humiliation (52% vs 21%), while those experiencing four forms of humiliation were three times more likely to report a high number of subjective health complaints (62% vs 21%). A multiple logistic regression model revealed that humiliation was significantly associated with a high number of subjective health complaints, even after adjusting for sex, residence and other measures of exposure to violent events.

In the study of Elbedour et al, (2007) the purpose of the present investigation was to evaluate and describe the psychological effects of exposure of war-like circumstances on this population. Participants for this study were 229 Palestinian adolescents living in the Gaza Strip who were administered measures of post-traumatic stress disorder (PTSD), depression, anxiety, and coping. Of the 229 participants, 68.9% were classified as having developed PTSD, 40.0% reported moderate or severe levels of depression, 94.9% were classified as having severe anxiety levels, and 69.9% demonstrated undesirable coping responses. A canonical discriminant analysis revealed that adolescents diagnosed with PTSD tended to be those who reported the highest levels of depression, anxiety, and positive reappraisal coping, and the lowest levels of seeking guidance and support coping.

Thabet et, al. (2007) the aim of the study was to determine the prevalence of PTSD, anxiety, behavioural, and emotional problems of Palestinian children in relation to traumatic events and other socioeconomic status. A sample of 409 children from the entire Gaza Strip aged 9-18 years was survey using self-report questionnaires. Children were

interviewed using Gaza Trauma Checklist, Child Revised Impact of Event Scale-13, and Child Revised Manifest Anxiety Scale, and their parents reported about their children behavioural and emotional problems using Strength and Difficulties Questionnaire. The results estimated mean traumatic experiences were 7.7. There was significant relationship between number of traumatic events and PTSD of children, intrusion, avoidance, and arousal. No gender differences in PTSD symptom. Children coming from families with monthly income less than 271 \$ reported more traumatic events. Total IES score of children was significantly associated with PTSD symptoms. No relationships between number of traumatic events and SDQ total or subscales. Prevalence of PTSD in children was 65.5%. The result showed that there were no sex differences in PTSD symptoms. Children coming from families with 4 and less children had more PTSD symptoms. Prevalence of anxiety disorder was (33.9%). No gender differences in anxiety disorder. General mental health problems rated by parents SDQ was (52.2%); conduct disorder (42.2%); hyperactivity (28.1%), emotional problems (32.8%), peers problems (69.9%), and prosocial problems (14%).

The study of Qouta et al, (2007) the aim was to examine how traumatic and stressful events, responses to violence, child characteristics, and mothering quality, as measured in middle childhood predict psychological distress and positive resources in adolescence. The participants were 65 Palestinian adolescents (17+/-8.5 years; 52% girls), who had been studied during the First Intifada (T1), during the Palestinian Authority rule (T2) and before the Second Al Aqsa Intifada (T3) in Gaza. Psychological distress was indicated by PTSD, and depressive symptoms and positive resources by resilient attitudes and satisfaction with quality of life, all measured at T3. The predictors that were measured at T1 were exposure to military violence, active coping with violence and children's intelligence, cognitive

capacity, and neuroticism. Mothering quality and stressful life-events were measured at T2, the former reported by both the mother and the child, and the latter by the mother. Adolescents' PTSD symptoms were most likely if they had been exposed to high levels of traumatic and stressful experiences and had poor cognitive capacity and high neuroticism in middle childhood. Only high levels of childhood military violence and stressful life-events predicted high depressive symptoms and low satisfaction with quality of life in adolescence.

The study of Alexander (2007) described symptoms of anxiety, depression and PTSD among Bosnian (n=17) and Colombian (n=17) torture survivors served by the Florida Center for Survivors of Torture. Types of torture experienced by clients are documented using HURIDOCs and the number of family and friends affected by extreme trauma are counted. Employment and education levels attained are also identified. Findings show that 100% of Bosnians are symptomatic for depression and over half possess symptoms of PTSD compared to 35% of Colombians for depression and 18% for PTSD, despite the differences in years since trauma occurred. High incidences of torture experienced by Bosnian clients and high numbers of family and friends affected support the high rates of symptoms. For the Colombian clients, high rates of employment and years of education, as well as earlier intervention, may contribute to their lower rates of symptoms. The two client groups are distinguished by the unique circumstances experienced by each, including punctuated wartime versus a prolonged insurgency, as well as the refugee versus asylum seeker experience.

2.6 Summary of the previous studies:

The researcher will discuss previous studies in three axis; the first is tools were used in these studies, the second is samples of the studies, and the third about the results of the previous studies, as the following:

2.6.1 Tools of the previous studies:

Thabet and Vostains (1998), Thabet et al. (1999), and Thabet et al. (2000) used Rutter scale for measuring children's behaviors. While Shannon (2004), and Bravo-Mehmedbasić et al. (2003) used Symptom Checklist-90-R (SCL-90-R)

Thabet and Vostains (1998), Thabet et al, (2002) revised manifest anxiety scale (RCMAS). While Papageorgiou et al, (2000), and Thabet et al. (2007) used Revised Children's Manifest Anxiety Scale. However Holtz (1998), Abu Laila, (2003), Scholte et al, (2004), Hopkins Checklist-25 (The HSCL-25) for anxiety and depression

Clinician-Administered PTSD Scale (CAPS) for DSM-IV are used by studies of Momartin et al. (2003), and Momartin et al. (2004). While Roussos et al. (2005) used UCLA Posttraumatic Stress Disorder (PTSD) Reaction Index. However Thabet et al. (1999), Thabet et al. (2000), Thabet et al. (2002), and Thabet et al. (2004), used child post stress reaction Index (CPTSD-RI).

Heptinstall et al. (2004), Papageorgiou et al. (2000), and Thabet et al. (2007) used Child Revised Impact of Event Scale. While Heptinstall et al. (2004), Roussos et al. (2005), and Papageorgiou et al. (2000) used Depression Self-Rating scale. However Mollica et al. (1999), Silove et al. (2002), and Scholte et al, (2004) used Harvard Trauma Questionnaire.

2.6.2 Samples of the previous studies

In the field of samples of the previous studies, the study samples were ranged between small samples as the study of Silove et al. (1997) among 40 consecutive asylum-seekers, Heptinstall et al, (2004) among 40 refugee children aged 8-16 who lived in London, and Qouta et al, (2007) among 65 Palestinian adolescents.

However the medium samples in the studies of Thabet et al. (1999) among 239 children of 6 to 11 years of age, Rosenthal and Wilson (2003) among 385 students high school, and Baker (1990) among 796 Palestinian children.

While; some studies have large samples as studies of Pearce et al, (2003) among 1,703 high-risk urban adolescents, Roussos et al, (2005) among 1,937 students, and Mollica et al. (1999) among 1996 of Bosnian refugee adults.

In addition there were some studies had too large samples as Guerra et al, (2003) among 4,458 children living in urban neighborhoods, and Giacaman et al. (2007) among 3415 students from cities, towns, villages and refugee.

2.6.3 Results of the previous studies

The studies of Thabet et, al. (2007) and El Majdalawi, (2002) found that the most common traumatic events children reported was watching mutilated bodies and wounded people on TV 98.5%, 96.9% respectively. That appeared to be consistent with our current results.

The prevalence of anxiety in the previous studies were: Thabet and Vostains (1998) (21.5%), Papageorgiou et al. (2000) (23.0%), Thabet et al. (2007) (33.9%), Holtz (1998) (41.4%), and Scholte et al. (2004) (51.8%).

The prevalence of depression in the previous studies were: Alexander (2007) (35.0%), Eisenman et al. (2003) (36.0%), Scholte et al. (2004) (38.5%), Mollica et al. (1999)

(39.2%), Elbedour et al. (2007) (40.0%), Papageorgiou et al. (2000) (47.0%), and Roussos et al. (2005) (13.9%)

The prevalence of PTSD levels in the previous studies were: Silove et al. (1997) (37.0%), Thabet et al., (2000) (40.6%), Thabet et al. (1999), (41.0%), Qouta et al. (2003) (54%), Thabet et, al. (2007) (65.%), Michultka (1998) (68.0%), Elbedour et al. (2007) (68.9%), El Majdalawi, (2002) (71.2%), Eisenman et al. (2003) (18.0%), Scholte et al. (2004) (20.4%), Mollica et al. (1999) (26.3%), Papageorgiou et al. (2000) (28.0%).

The study of Eisenman et al, (2003) that pointed to of those exposed to political violence, (36%) had symptoms of depression. While the study of Scholte et al, (2004) found that higher rates of symptoms were associated with higher numbers of traumas experienced. Also Qouta et al, (2007) and Paxton et al, (2004) exposure to violence was significantly associated with depressive symptoms.

Bravo-Mehmedbasić et al. (2003) that indicated torture is the most intense form of trauma leading to intensive psychopathological responses including chronic PTSD. Also Paxton et al, (2004), Punamäki et al, (2001) and Thabet et al, (2002) found that exposure to violence was significantly associated with PTSD symptoms. While study of Michultka (1998) and Thabet et al. (1999) found that higher numbers of war experiences predicted PTSD severity. While Scholte et al, (2004) conclude as general that higher rates of symptoms were associated with higher numbers of traumas experienced. Also the study of Qouta et al, (2007) indicated that adolescents' PTSD symptoms were most likely if they had been exposed to high levels of traumatic and stressful experiences.

The studies of Silove et al. (1997), Garbarino and Kostelny (1996), and Qouta et al, (2003) that found that anxiety scores were associated with female gender. While the study was

inconsistency with Thabet et, al. (2007) that indicated to no gender differences in anxiety disorder.

The studies of Rosenthal and Wilson (2003), Pearce et al, (2003) Momartin et al. (2003), Heptinstall et al, (2004), they revealed that exposure to community violence and psychological distress were related.

In the same vein the studies of Holtz (1998), Thabet et al. (1999), Papageorgiou et al.(2000), Bravo-Mehmedbasić et al. (2003), indicated to torture is the most intense form of trauma leading to intensive psychopathological responses including chronic PTSD. While the studies of Punamäki and Suleiman (1990), Baker (1990), Qouta et al, (1995), Michultka (1998),Punamäki et al, (2001) El Majdalawi, (2002) Thabet et al. (2002), Silove et al, (2002), Qouta et al, (2003), Scholte et al. (2004), Paxton et al, (2004), Benyamin and Solomon (2005), Thabet et, al. (2007), Qouta et al. (2007), they are concluded that exposure to political hardships increased children's psychological symptoms & higher rates of symptoms were associated with higher numbers of traumas experienced.

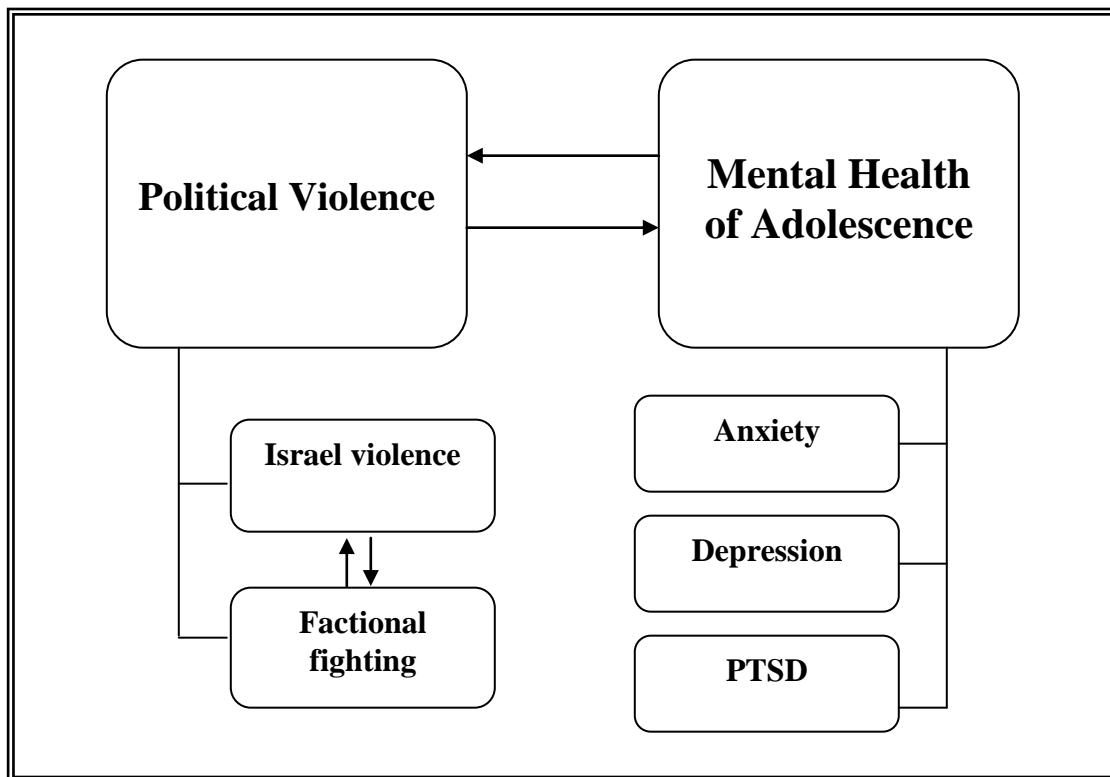
Chapter 3

Theoretical Framework

Chapter 3: Theoretical Framework

In this The researcher reviewed the theoretical framework in three axis; the first is about violence, the second is about anxiety including PTSD, where the third axis is about depression. Also the researcher tried to draw the relations between them as the researcher expected; as shown in the following figure:

Figure 1: the relation between the study variables as the researcher expected



3.1 Violence

3.1.1 Introduction and definitions:

Violence has been declared as a leading public health issue, It is defined as ‘the abusive or unjust exercise of power’. Nonphysical acts like threatening, name-calling, harassment or stalking are also violent acts. (Munni & Malhi 2006).

Definition of violence

World Health Organization (WHO) promotes a broad definition of violence:

The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation. (Geneva, WHO 1999).

The definition encompasses interpersonal violence as well as suicidal behaviour and armed conflict. It also covers a wide range of acts, going beyond physical acts to include threats and intimidation. Besides death and injury, the definition also includes the myriad and often less obvious consequences of violent behaviour, such as psychological harm, deprivation and maldevelopment that compromise the well-being of individuals, families and communities. (Geneva, WHO 1999).

Definition of community violence

Community violence is a complex term that has been used to refer to a wide range of events including riots, sniper attacks, gang wars, drive-by shootings, workplace assaults, terrorist attacks, torture, bombings, war, ethnic cleansing, and widespread sexual, physical, and emotional abuse. (Osofsky 1995).

Community violence is defined for this Action Plan as: violence between people who are not related, and who may or may not know each other (acquaintances and strangers). It generally, but not always, takes place outside the home, in public places. (WHO 2002)

Definition of political violence

Political violence refers to acts of violence committed for political reasons such as riots, the repressive actions of security forces against people opposing this government, battles between hostel dwellers and township residents. (Stavrou 1993).

3.1.2 Types of Violence

In order to develop effective interventions to address violence comprehensively, it is important to have an understanding of the different types of violence. Violence can be categorized in a number of ways. The World Health Organization (2002) has developed the following useful typology that divides violence into three categories, based on the relationship between the perpetrator/s and the victim/s:

1. ***Self-directed violence*** includes suicidal behaviour and self-harm.
2. ***Interpersonal violence*** includes violence inflicted against one individual by another, or by a small group of individuals, and can be categorized as:
 - ***Family and intimate partner violence***; involving violence between family members, and intimate partners, including child abuse and elder abuse. This often takes place in the home.
 - ***Community violence***; involving violence between people who are not related, and who may or may not know each other (acquaintances and strangers). It generally takes place outside the home in public places.
3. ***Collective violence*** includes violence inflicted by large groups such as states, organized political groups, militia groups or terrorist organizations. (WHO 2002).

Research done with victims of violence shows that 60-80% (or more) of people exposed to violent situations, whether directly or indirectly, suffer from symptoms of Post Traumatic Stress Disorder. Research also indicates that just living in a society where the media is filled with images of violence and messages of doom and destruction, can result in people experiencing symptoms of Post Traumatic Stress. (Stavrou 1993)

Children are psychologically more at risk than adults through violent experiences. Follow-up studies of disasters found 80% of children had symptoms of Post Traumatic Stress Disorder one to two years later, compared with 30% of adults. Children's potential for long-term recovery without the support of a significant adult and/or the relevant treatment, is markedly less than that of an adult. Their conceptual and emotional inability properly to understand the violent event, and to have some measure of control over their environment, are factors which mitigate against a swift recovery. (Stavrou 1993).

3.1.3 The most common responses to violent events are:

1. ***Fear***: the most commonly expressed fears are of the security forces, of future attacks especially on the children's homes.
2. ***Emotional changes***: feelings of emotional numbing, powerlessness, of extreme vulnerability and lack of safety. Anxiety, restlessness and irritability. Having no interest in life, feeling guilt or bad to be alive. No energy and feeling tired all of the time. Changing quickly from one mood to another.

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

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

4. ***Difficulties with thinking:*** Constantly thinking about and re-experiencing the traumatic experience. Not being able to concentrate and to remember properly. Children's thoughts are negative and they find it difficult to be creative.
5. ***Social difficulties:*** not wanting to be social with other children, being aggressive with others.
6. ***Eating problems:*** refusal to eat and loss of appetite.
7. ***Somatic complaints:*** mainly in the form of headaches and stomach aches.

(Stavrou 1993).

3.2 Depression

3.2.1 Definitions

Depression is defined as emotional state or mood characterized by one or more of these symptoms: sad mood, low energy, poor concentration, sleep or appetite changes, feelings of worthlessness or hopelessness, and thoughts of suicide (Strickland, 2001).

The term of depression covers a wide range of emotional states that range in severity from normal, everyday moods of sadness, to psychotic episodes with increased risk of suicide.

The current diagnostic system in North America, the Diagnostic and statistical manual of mental disorders (American Psychiatric Association, 1994), divides depression, or mood disorders, into depressive disorders and bipolar disorders. (Davidson, 2000).

3.2.2 Prevalence of depression:

In the National Comorbidity Survey, the lifetime prevalence for depression was 17.1%; the 12-month prevalence was 10.3%. In primary care settings, depression can take many forms, including major depressive disorder and dysthymia. Any depressive disorder can coexist with anxiety (Greco & Zajecka, 2000).

3.2.3 Diagnosis of depression:

There are several possible diagnostic combinations. Diagnosis will depend on the kind, number, and duration of symptoms. Possible diagnoses include (Greco & Zajecka, 2000):

- A full syndromal depressive disorder.

- Coexistence of a depressive disorder, with either or both of the disorders subsyndromal.
(Subsyndromal refers to symptoms that do not meet diagnostic criteria in number or duration yet still cause significant disability).
- Comorbid disorders, including substance abuse.
- Somatic symptoms that may or may not be associated with a comorbid medical illness.

According to DSM-IV-TR, a major depressive disorder occurs without a history of a manic, mixed, or hypomanic episode. A major depressive episode must last at least 2 weeks, and typically a person with a diagnosis of a major depressive episode also experiences at least four symptoms from a list that includes changes in appetite and weight, changes in sleep and activity, lack of energy, feelings of guilt, problems thinking and making decisions, and recurring thoughts of death or suicide (Sadock & Sadock, 2007).

3.2.4 Symptoms & Signs of Depression:

There were some groups of depression's symptoms as the following:

The American psychiatrist Aaron Beck (1921–) designed the Beck Depression Inventory (BDI), which is based on observations of attitudes and symptoms characteristic of depressed patients. The BDI contains 21 categories of symptoms and attitudes, such as sense of failure, dissatisfaction, guilt, sense of punishment, self-accusations, and sleep disturbance. The various *theories of depression* may be grouped generally into biological or psychological types (Marsella, 1994).

Emotional Manifestations:

The term emotional manifestations refers to the changes in the patient's feelings or the changes in his overt behavior directly attributable to his feeling states. There were five symptoms of the emotional manifestations of depression (Beck, 1970) as the following:

- **Dejected Mood:** The characteristic depression in mood is described differently by various clinically-depressed patients.
- **Negative Feelings Toward Self:** Depressed patients often express negative feelings about themselves. These feelings may be related to the general dysphoric feelings just described, but they are different in that they are specifically directed toward the self.
- **Reduction in Gratification:** The loss of gratification is such a pervasive process among depressives that many patients regard it as the central feature of their illness. Loss of gratification appears to start with a few activities and, as the depression progresses.
- **Loss of Emotional Attachments:** involvement in other people or activities usually accompanies loss of satisfaction.
- **Crying Spells:** Increased periods of crying are frequent among depressed patients.
- **Loss of Mirth Response:** Depressed patients frequently volunteer the information that they have lost their sense of humor.

Cognitive Manifestations:

The cognitive manifestations of depression include a number of diverse phenomena (Beck, 1970):

- **Low Self-Evaluation:** is a characteristic feature of depression. Self-devaluation is apparently part of the depressed patient's pattern of viewing himself as deficient in

those attributes that are specifically important to him: ability, performance, intelligence, health, strength, personal attractiveness, popularity, or financial resources.

- **Negative Expectations:** A gloomy outlook and pessimism are closely related to the feelings of hopelessness mentioned previously.
- **Self-Blame and Self-Criticism:** The depressive's perseverating self-blame and self-criticism appear to be related to his egocentric notions of causality and his penchant for criticizing himself for his alleged deficiencies.
- **Indecisiveness:** Difficulty in making decisions, vacillating between alternatives, and changing decisions are depressive characteristics that are usually quite vexing to the patient's family and friends as well as to the patient himself.
- **Distortion of Body Image:** The patient's distorted picture of his physical appearance is often quite marked in depression.

Motivational Manifestations:

Motivational manifestations include consciously experienced strivings, desires, and impulses that are prominent in depressions (Beck, 1970):

- **Paralysis of the Will:** The loss of positive motivation is often a striking feature of depression. The patient may have a major problem in mobilizing himself to perform even the most elemental and vital tasks such as eating, elimination, or taking medication to relieve his distress.
- **Avoidance, Escapist, and Withdrawal Wishes:** The wish to break out of the usual pattern or routine of life is a common manifestation of depression. The clerk wants to get away from his paper work, the student daydreams of faraway places, and the housewife yearns to leave her domestic duties.
- **Suicidal Wishes:** have historically been associated with a depressed state.

- **Increased Dependency:** The term dependency is used here to designate the *desire* to receive help, guidance, or direction rather than the actual process of relying on someone else.

Vegetative and Physical Manifestations:

The physical and vegetative manifestations are considered by some authors to be evidence for a basic autonomic or hypothalamic disturbance that is responsible for the depressive state. These symptoms, contrary to expectation, have a relatively low correlation with each other and with clinical ratings of the depth of depression (Beck, 1970):

- **Loss of Appetite:** is often the first sign of an incipient depression and return of appetite may be the first sign that it is beginning to lift.
- **Sleep Disturbance:** Difficulty in sleeping is one of the most notable symptoms of depression, although it occurs in a large proportion of non-depressed patients as well.
- **Loss of Libido:** Some loss of interest in sex, whether of an auto-erotic or heterosexual nature. Loss of libido correlated most highly with loss of appetite, loss of interest in other people, and depressed mood.
- **Fatigability:** Some patients appear to experience this symptom as a purely physical phenomenon: The limbs feel heavy or the body feels as though it is weighted down.

3.2.5 Types of depression:

Depression is the most common psychological disorder. There are different types of depression. They are mainly distinguished by the severity of symptoms (Bon, 2007).

Following are the common categories in depression:

Major depression: (Major Depressive Disorder) (Uni-polar Depression)

Major Depressive Disorder (also known as Major Depression). A major depressive episode occurs with symptoms that last for most of the day, nearly every day for at least two weeks. A symptom must either be 1 depressed mood or 2 a noticeable decrease in interest or pleasure in all or most activities. At least four (or more) additional symptoms are present (American Psychiatric Association, 1994), (Sadock & Sadock, 2007):

- significant weight loss / weight gain or decrease / increase in appetite.
- difficulty sleeping or increase in sleeping.
- excessive movement or slowing down associated with mental tension (by others).
- fatigue or loss of energy.
- feeling worthless or excessive guilt.
- difficulty thinking, concentrating or making decisions.
- repeatedly thinking about death or suicide, trying to attempt suicide or having a specific plan to commit suicide.

Atypical depression

Atypical Depression characterized by a temporary improvement in mood in reaction to positive events and two (or more) of the following (American Psychiatric Association, 1994):

- significant weight gain or increase in appetite.
- over sleeping.
- heavy feeling in arms or legs.
- long standing pattern of sensitivity to rejection.

Dysthymia: (Bipolar disorder)

Dysthymic Disorder (or also referred to as Dysthymia) – Nearly constant depressed mood for at least 2 years accompanied by at least two (or more) of the following (American Psychiatric Association, 1994):

- decrease or increase in eating.
- difficulty sleeping or increase in sleeping.
- low energy or fatigue.
- low self-esteem.
- difficulty concentrating or making decisions.
- feeling hopeless.

Symptoms do not occur for more than two months at a time. Generally, this type of depression is described as having persistent but less severe depressive symptoms than Major Depression.

Psychotic depression

Psychotic Depression – Major depressive episode with psychotic symptoms such as hallucinations (e.g. hearing voices), delusions (false beliefs) (American Psychiatric Association, 1994).

In psychotic depression, the individual suffers deep despair and sadness and may lose contact with reality and develop delusions, hallucinations, and severe motor and psychological retardation. In this sense, depression may be a symptom of some other psychological disorder, a part or syndrome of related symptoms that appears as secondary to another disorder, or a specific disorder itself (Marsella, 1994).

Manic depression: (Bipolar disorder)

Manic Depression (now known as Bipolar Disorder) – This kind of depression includes periods of mania and depression. Cycling between these two states can be rapid or only mania can be present without any depressive episodes. A manic episode consists of a persistent elevated or irritable mood that is extreme, which lasts for at least one week. At least three (four if only irritable mood) other features are also present (American Psychiatric Association, 1994):

- inflated self-esteem or self-importance.
- decreased need for sleep.
- more talkative than usual or compelled to keep talking.
- experiencing racing thoughts or ideas.
- easily distracted.
- increase in goal-oriented activity (social, work, school, sexual) or excessive movement.
- excessive involvement in potentially risky pleasurable behavior (e.g. over spending, careless sexual activity, unwise business investments).

Symptoms can be severe enough to warrant hospitalization to prevent harm to self or others or include psychotic features (e.g. hallucinations, delusions).

Seasonal affective depression

Some people will show symptoms of depression at the beginning of any season change. Usually it will happen during winter or rainy season. This is mainly because during these time the exposure to sunlight will be limited (Bon, 2007).

Seasonal depression is a type of depressive disorder which is characterized by episodes of major depression which reoccur at a specific time of the year (e.g. fall, winter). In the past

two years, depressive periods occur at least two times without any episodes that occur at a different time (American Psychiatric Association, 1994).

3.3 Anxiety Disorders

3.3.1 Overview and Definitions

Anxiety disorders are among the most prevalent mental disorders in the general population. Nearly 30 million persons are affected in the United States, with women affected nearly twice as frequently as men. Anxiety disorders are associated with significant morbidity and often are chronic and resistant to treatment. (Sadock & Sadock, 2007).

Anxiety is characterized most commonly as a diffuse, unpleasant, vague sense of apprehension, often accompanied by autonomic symptoms such as headache, perspiration, palpitations, tightness in the chest, mild stomach discomfort, and restlessness, indicated by an inability to sit or stand still for long. The particular constellation of symptoms present during anxiety tends to vary among persons (Sadock & Sadock, 2007).

Anxiety disorder defined as unpleasant emotion triggered by anticipation of future events, memories of past events, or ruminations about the self (Strickland, 2001). Anxiety is an unpleasant emotional state, the sources of which are less readily identified. It is frequently accompanied by physiological symptoms that may lead to fatigue or even exhaustion (Goldman, 2000).

Symptoms of Anxiety disorders include physiological responses: a change in heart rate, trembling, dizziness, and tension, which may range widely in severity and origin. People who experience generalized anxiety disorder and panic disorders usually do not recognize a specific reason for their anxiety (Strickland, 2001).

Diagnosis will depend on the kind, number, and duration of symptoms. Possible diagnoses include (Greco & Zajecka, 2000):

- A full syndromal anxiety disorder.
- Coexistence of an anxiety disorder, with either or both of the disorders subsyndromal. (*Subsyndromal* refers to symptoms that do not meet diagnostic criteria in number or duration yet still cause significant disability).
- Comorbid disorders, including substance abuse.
- Somatic symptoms that may or may not be associated with a comorbid medical illness.

3.3.2 Classification of anxiety disorders according to (DSM-IV-TR):

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

Posttraumatic Stress Disorder and Acute Stress Disorder

Posttraumatic stress disorder (PTSD) is a condition marked by the development of symptoms after exposure to traumatic life events. The person reacts to this experience with fear and helplessness, persistently relives the event, and tries to avoid being reminded of it.

Kagan has suggested that children who are behaviorally inhibited may be especially susceptible to anxiety or PTSD after threatening events (Sadock & Sadock, 2007).

PTSD is defined in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) by six different criteria (American Psychiatric Association, 1994).

First, the disorder arises in a person who has been exposed to a traumatic event in which he or she experienced, witnessed, or was confronted with actual or threatened death or serious injury or a threat to the physical integrity of self or others. Furthermore, the response must have involved intense fear, helplessness, or horror. In children, it is allowed that the response may take the form of disorganized or agitated behavior.

Secondly, there must have been at least one of five possible intrusive symptoms occurring as a result of exposure to the trauma, as exhibited in either dream activity or waking life. These include recollections, images, thoughts, or perceptions of the event, recurrent distressing dreams, acting as if the trauma were recurring, and intense psychological or physical distress on exposure to internal or external cues resembling the trauma. Allowance is made for a different set of reactions in children, in whom intrusive symptoms may take the form of repetitive play, frightening dreams without recognizable content, or reenactment of the trauma.

Thirdly, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness must occur as exhibited by at least three of seven symptoms. Although grouped together as one criterion, it is likely that phobic avoidance, numbing and withdrawal do not reflect the same underlying phenomenon.

Fourthly, there must be at least two symptoms indicating the presence of increased arousal (i.e., difficulty sleeping, irritability or anger, difficulty concentrating, hypervigilance, or exaggerated startle response). Symptoms of PTSD should last at least 1 month, and it is necessary that the disturbances cause clinically significant distress or impairment in social, occupational, or other areas of functioning. (Kay & Tasman, 2006).

The diagnosis of PTSD is based on the criteria spelled out in DSM-IV-TR and ICD-10. The diagnostic criteria in DSM-IV-TR are more detailed but also more complicated for routine use in clinical practice because of the need to memorize 17 symptoms grouped in three clusters (symptoms of reexperiencing the trauma, symptoms of avoidance and numbing of general responsiveness, and hyperarousal symptoms), with a minimum number of symptoms from each cluster required for making the diagnosis (Starcevic, 2005).

The lifetime incidence of PTSD is estimated to be 9 to 15% and the lifetime prevalence of PTSD is estimated to be about 8% of the general population, although an additional 5 to 15 % may experience subclinical forms of the disorder (Sadock & Sadock, 2007). Lifetime prevalence in the general population in the United States is 7.8% (Starcevic, 2005).

Comorbidity rates are high among patients with PTSD, with about two thirds having at least two other disorders. Common comorbid conditions include depressive disorders, substance-related disorders, other anxiety disorders, and bipolar disorders. Comorbid disorders make persons more vulnerable to developing PTSD (Sadock & Sadock, 2007).

By definition, a stressor is the prime causative factor in the development of PTSD. Not everyone experiences the disorder after a traumatic event. The response to the traumatic event must involve intense fear or horror. As mentioned, even when faced with overwhelming trauma, most persons do not experience PTSD symptoms. The National Comorbidity Study found that 50% of females had experienced some significant trauma, whereas the reported lifetime prevalence of PTSD was only 6.7%. Similarly, events that may appear mundane or less than catastrophic to most persons can produce PTSD in some. Evidence indicates of a dose response relationship between the degree of trauma and the likelihood of symptoms (Sadock & Sadock, 2007).

Generalized Anxiety Disorder

Anxiety can be conceptualized as a normal and adaptive response to threat that prepares the organism for flight or fight. Persons who seem to be anxious about almost everything, however, are likely to be classified as having generalized anxiety disorder. The text revision of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) defines generalized anxiety disorder as excessive anxiety and worry about several events or activities for most days during at least a 6-month period. The worry is difficult to control and is associated with somatic symptoms, such as muscle tension, irritability, difficulty sleeping, and restlessness. The anxiety is not focused on features of another Axis I disorder, is not caused by substance use or a general medical condition, and does not occur only during a mood or psychiatric disorder. The anxiety is difficult to control, is subjectively distressing, and produces impairment in important areas of a person's life (Sadock & Sadock, 2007).

The National Comorbidity Survey found the 12-month prevalence of generalized anxiety disorder to be 4.3% in females (Goldman, 2000).

Generalized anxiety disorder is probably the disorder that most often coexists with another mental disorder, usually social phobia, specific phobia, panic disorder, or a depressive disorder. Perhaps 50 to 90 percent of patients with generalized anxiety disorder have another mental disorder. The cause of generalized anxiety disorder is not known. As currently defined, generalized anxiety disorder probably affects a heterogeneous group of persons. Perhaps because a certain degree of anxiety is normal and adaptive, differentiating normal anxiety from pathological anxiety and differentiating biological causative factors from psychosocial factors are difficult. Biological and psychological factors probably work together (Sadock & Sadock, 2007).

Chapter 4

Methodology

Chapter 4: Methodology

4.1 Introduction

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

4.2 Study design

This is a descriptive –analytical study, which tries to answer the study questions about assessing effects of political violence on mental health of adolescence in the Gaza governorates. It has been selected because this method would be useful for descriptive analysis of study variables. This type of study measures the level and the prevalence of the phenomena, which applied on a sample of the population in particular time and period. Also, this type of study is easily applicable, economical and cost effective. However this type of study usually gives various results reflecting variation in survey method.

4.3 Population

The population of this study includes all the students in secondary schools (10th class, 11th class, and 12th class) aged 15-18 years old that equal (90708) adolescents; males 43327 (47.77%), females 47381(52.33%). By using IP. INFO program the researcher calculate the sample size.

4.4 Study sample

A cross-sectional stratified cluster random sample survey of 394 adolescents; 203 (51.5%) males and 191 (49.5%) females aged 15-18 years. The researcher chose two schools from each governorate; (one males school and one females school) randomly by using sampling frame. By the same way in each school the researcher chose three classes (10th , 11th, 12th).

Figure 2: Distribution of the sample according to sex and Governorates

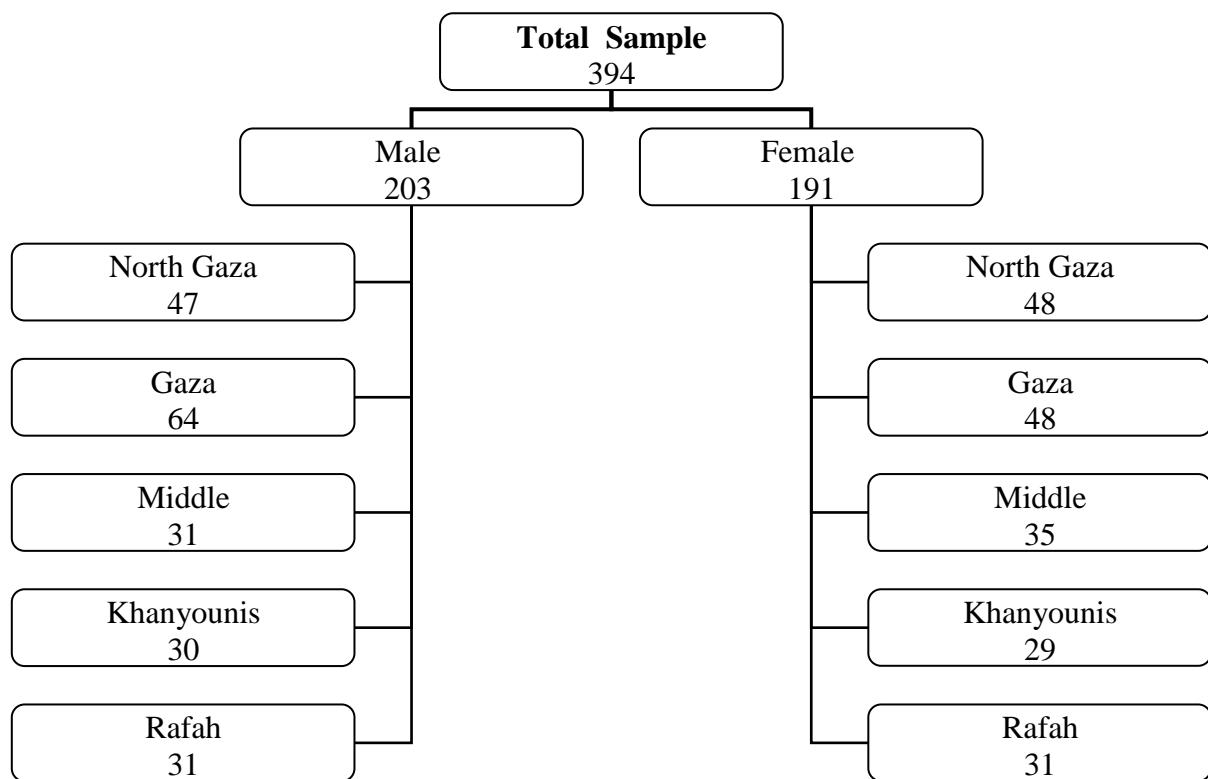
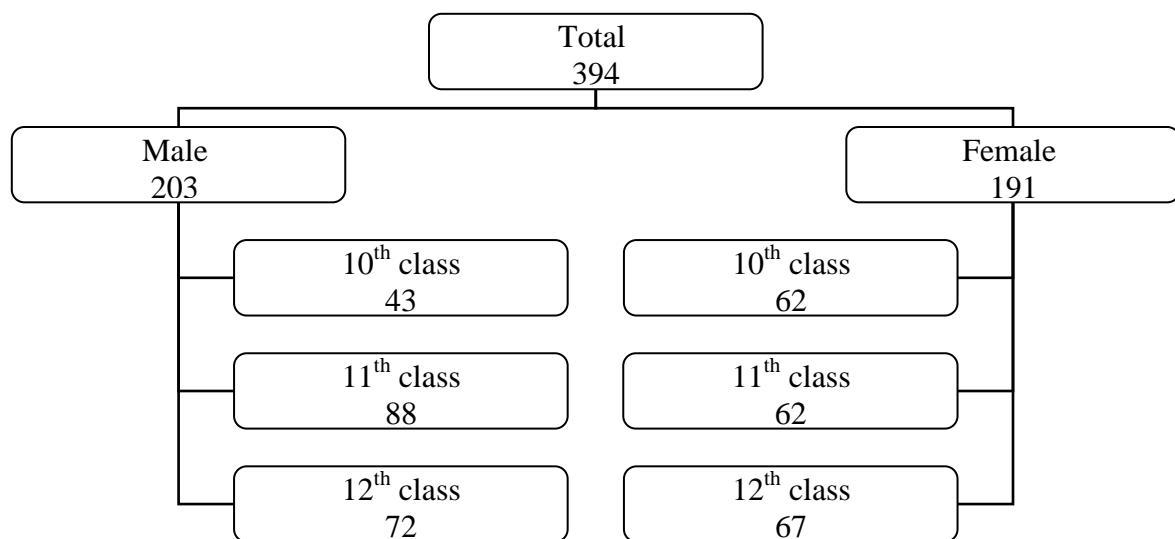


Figure 3: Distribution of the sample according to sex and educational class



4.5 Place of the research

This study carried out in the randomly selected secondary schools that belong to ministry of higher education, Distributed into 5 governorates (North Gaza, Gaza, Middle Area, Khanyounis, and Rafah).

4.6 Ethical considerations

An approval letter was obtained from Helsinki committee in the Ministry of Health to allow the researcher to carry out his study (Annex 1). And another agreement was obtained from the Palestinian ministry of higher education to facilitate data collection procedures (Annex 2).

4.7 Instruments of the study

The researcher used demographic status questionnaire, Gaza Traumatic Events Checklist for Israelis Violence (Thabet et al, 2006), Gaza Traumatic Events Checklist for Factional fighting (Thabet et al, 2006), The Revised Children's Manifest Anxiety Scale (RCMAS) (Reynolds & Richmond, 1978), Child Depression Inventory (CDI), and UCLA PTSD Index for DSM IV (Rodriguez, et al, 1999). That described in detail in the following sections:

4.7.1 Demographic status (developed by the researcher)

Demographic status developed to assess the adolescents age, sex, place of residence, mother educational level, father educational level, mother work, father work, and family income (**annex 3**).

4.7.2 Gaza Traumatic Events Checklist for Israelis Violence (Thabet et al. 2006).

This checklist consists of 28 items covering different types of traumatic events that a child may have been exposed to in the particular circumstances of the regional conflict and Israeli violence in the last 6 months. This checklist covers three domains of trauma. The first domain covers witnessing acts of violence such as the killing of relatives, home demolition, bombardment, and injury of others. The second domain covers hearing experiences such as hearing of the killing or injury of friends or relatives. The third domain covers personal traumatic events such as being shot, injured, or beaten. This checklist can be completed by children aged 6-16 ('yes' or 'no'). For the 31-item scale, Cronbachs's alpha was 0.90 (**annex 4**).

4.7.3 Gaza Traumatic Events Checklist for Factional fighting (Thabet et al. 2006)

This checklist consists of 20 items covering different types of traumatic events that a child or adolescents may have been exposed to in the particular circumstances of the regional conflict between Fatah and Hamas faction fighting including traumatic events resulting from insecurity and the lawless situation in the Gaza Strip, the last factional fighting and war in the area. This checklist can be completed by children aged 6-16 ('yes' or 'no'). For the 18-items scale, Cronbachs's alpha was 0.87 (**annex 5**).

4.7.4 The Revised Children's Manifest Anxiety Scale (RCMAS) (Reynolds and Richmond, 1978) (Arabic version, Thabet 1998):

This is a standardized 37-item self-report questionnaire for children aged 6-19. It measures the presence or absence of anxiety-related symptoms ('yes'/'no' answers) in 28 anxiety items and 9 lie items. A cut-off total score of 19 has been found to predict the presence of

anxiety disorder (Reynolds and Richmond, 1997). Regarding the total anxiety scale reliability, Cronbach's alpha was 0.82 (**annex 6**).

4.7.5 UCLA PTSD Index for DSM IV (Rodriguez, et al. 1999) (translated and validated by Thabet 2008):

The instruments are designed to assess exposure to a wide variety of traumatic events and are suitable to be used to evaluate PTSD symptoms in children and adolescents who have experienced any type of traumatic stress. The Adolescent Version (for adolescents 13 years or older) contains a total of 22 questions. In addition to the first 19 questions, an alternative question (Question 20) has been included to assess for another component of DSM-IV Criterion "D2" (anger/irritability). An alternative question (Question 21) has also been included to assess for another dimension of DSM-IV Criterion "C7" (foreshortened future). Question 22 assesses a common problem reported by traumatized youth, namely a fear that the traumatic event will reoccur (**annex 7**)

4.7.6 Child Depression Inventory (CDI)

The CDI is a standardised self-report questionnaire of depressive symptomatology (Kovacs, 1985). This has been developed for children and young people aged 6-17. The CDI includes 27 items, each scored on a 0-2 scale (from 'not a problem' to 'severe') for the previous two weeks. The total score ranges between 0-54, and a score of 19 and higher has been found to indicate the likelihood of a depressive disorder. The CDI has been adapted for use with Arab children (Gharib, 1985). For the 27-items, Cronbachs's alpha was 0.65 (**annex 8**).

4.8 Data collection:

The researcher collected data through the distribution of questionnaires on governmental schools in the Gaza governorates by the help of some teachers in those schools in the period from 6/2/2008 to 26/2/2008.

4.9 Data entry and analysis

After data collection of the sample the researcher used SPSS computer program for data entry and analysis. While the researcher used other statistical analysis that clarifying the differences between the groups such as frequencies, t- independent test, comparing means, one way A NOVA, and chi-square that also denoted the differences between the groups and within the groups of the study variables.

4.10 Eligibility Criteria

4.10.1 Inclusion Criteria

Adolescents between 15 - 18 years of age who reside in the Gaza Strip and learn in the secondary schools that belong to Palestinian ministry of higher education at (10th class, 11th class , and 12th class) at the time of the study were eligible for the study.

4.10.2 Exclusion Criteria

Adolescents younger than (15 years) and older than (18 years) of age were excluded from the research. In addition to adolescents who not learned in the secondary schools that belong to Palestinian ministry of higher education at (10th class, 11th class , and 12th class) were excluded from the research.

4.11 Limitations

This study was limited by adolescents in Gaza governorates that studied in the three classes of secondary governmental schools by using tools:

- Socioeconomic status questionnaire,
- Gaza Traumatic Events Checklist for Israelis Violence,
- Gaza Traumatic Events Checklist for Factional fighting,
- The Revised Children's Manifest Anxiety Scale (RCMAS),
- Child Depression Inventory (CDI),
- UCLA PTSD Index for DSM IV.

Which associated with the variables of this study (political and traumatic events due to factional fighting, anxiety, depression, PTSD) at the study second semester of academic study year 2007-2008.

Chapter 5

Results

Chapter 5 : Results

5.1 Introduction:

In this chapter the researcher clarified the main results of the study after data collection and analysis by using statistical tools of sample of 394 adolescents. The researcher used SPSS program for data entry and analysis. The researcher used many statistical test like descriptive statistics; frequencies, percentages, means and standard deviation. In addition to differences between study variables using t- independent test and one-way ANOVA test.

5.2 Demographic results of the study sample

The following table shows the demographic results of the study sample, which described the study sample according to sex, Place of residence, Type of residence, number of siblings, mother & father educational level, mother & father work, and monthly income.

The sample consisted of 394 adolescents, 203 were males (51.5%) and 191 were females (48.5%). Adolescents coming from North Gaza were (24.1%), from Gaza (28.4%), from middle area (16.8%), from Khan Younis (15.0 %), and from Rafah (15.7%). According to number of siblings were (28.4%) of adolescents had 4 and less siblings, (45.4%) of adolescents had 5-7 siblings, and (26.1%)of adolescents had 8 and more siblings. According to place of residence, 62.7% of study sample live in cities, 28.4% live in camps, and 8.9% live in villages. According to family monthly income, were (20.1%) of adolescents' had family income less than 600 NIS, (15.0%)family income was from 601-1400 NIS, (12.7 %) of adolescents were from 1401-2000, (19.5%) were from 2001-3000 NIS, (32.7%) were more than 3000 NIS.

Table 1: Demographic characteristics of the study Sample (N = 394)

Sex	N	%
Males	203	51.5
Females	191	48.5
Total	394	100.0
Place of residence	N	%
North Gaza	95	24.1
Gaza	112	28.4
Middle area	66	16.8
Khan Younis	59	15.0
Rafah	62	15.7
Total	394	100.0
Type of residence	N	%
City	247	62.7
Camp	112	28.4
Village	35	8.9
Total	394	100.0
Number of Siblings	N	%
4 and less	112	28.4
5-7 siblings	179	45.4
8 and above	103	26.1
Total	394	100.0
Mother Education	N	%
Illiterate	4	1.0
Primary	15	3.8
Preparatory	46	11.7
Secondary	180	45.7
Diploma	57	14.5
University	92	23.4
Total	394	100.0
Mother Education	N	%
Illiterate	6	1.5
Primary	19	4.8
Preparatory	38	9.6
Secondary	98	24.9
Diploma	36	9.1
University	197	50.0
Total	394	100.0
Mother job	N	%
House wife	328	83.2
Civil employee	66	16.8
Total	394	100.0

Mother job	N	%
Business	57	14.5
Employee	224	56.9
Maker	12	3.0
Worker	75	19.0
Unemployed	26	6.6
Total	394	100.0
Family income by 'NIS'	N	%
600 and less	79	20.1
601-1400	59	15.0
1401-2000	50	12.7
2001-3000	77	19.5
More than 3000 NIS	129	32.7
Total	394	100.0

5.3 The prevalence and frequencies

5.3.1 The frequencies of traumatic events due to Israel violence:

The following frequency table describe the most traumatic events due to Israel violence and its frequency among study sample. The researcher found that 90.4% of study sample watching mutilated bodies in TV, 86.0% hearing shelling of the area by artillery, and 84% hearing the sonic sounds of the jetfighters. While the lowest traumatic events were physical injury due to bombardment of your home 16.5%, deprivation from going to toilet and leave the room at home where you was detained 17.3%, and threatened to death by being used as human shield to arrest your neighbors by the army 17.5%.

Table 2: Frequency of traumatic events due to Israel violence

No	Items	yes	%
1.	Watching mutilated bodies in TV	356	90.4
2.	Hearing shelling of the area by artillery	339	86.0
3.	Hearing the sonic sounds of the jetfighters	331	84.0
4.	Witnessing the signs of shelling on the ground	326	82.7
5.	Hearing the shootings and bombardment	278	70.6
6.	Witnessing assassination of people by rockets	269	68.3
7.	Deprivation from water or electricity during detention at home	214	54.3
8.	Hearing killing of a close relative	191	48.5
9.	Hearing killing of a friend	190	48.2
10.	Witnessing firing by tanks and heavy artillery at neighbors homes	164	41.6
11.	Witnessing of a neighbor home demolition	151	38.3
12.	Being detained at home during incursions or due to factional fighting	142	36.0
13.	Threaten by shooting	134	34.0
14.	Threaten by telephoned to evacuate your home before bombardment	118	29.9
15.	Witnessing firing by tanks and heavy artillery at own home	111	28.2
16.	Witnessing arrest or kidnapping of someone or a friend	108	27.4
17.	Witnessing shooting of a friend	106	26.9
18.	Witnessing of own home demolition	103	26.1
19.	Threaten of family member of being killed	96	24.4
20.	Beating and humiliation by the army	93	23.6
21.	Witnessing killing of a friend	90	22.8
22.	Witnessing shooting of a close relative	88	22.3
23.	Destroying of your personal belongings during incursion	83	21.1
24.	Witnessing killing of a close relative	79	20.1
25.	Threaten of being killed	72	18.3
26.	Threatened to death by being used as human shield to arrest your neighbors by the army	69	17.5
27.	Deprivation from going to toilet and leave the room at home where you was detained	68	17.3
28.	Physical injury due to bombardment of your home	65	16.5

5.3.2 The prevalence of traumatic events due to Israel violence:

The following table shows that 129 of study sample have mild traumatic events due to Israel violence 32.7%, while 172 of study sample have moderate traumatic events due to Israel violence 43.7%. and 93 of study sample have severe traumatic events due to Israel violence 23.6%.

Table 3: The prevalence of traumatic events due to Israel violence

Variables	Frequency		Percent %
	N		
Traumatic events due to Israel violence	Mild	129	32.7
	Moderate	172	43.7
	Severe	93	23.6
Total		394	100.0

(7 and less = mild, 8-14 = moderate, 15 and above severe)

5.3.3 The frequencies of traumatic events due to factional fighting:

The following frequency table describes the traumatic events due to factional fighting and its frequency among study sample. The researcher found that 87.1% of study sample "Hearing the shootings and bombardment due to fighting in the streets", 82.2% "Watching mutilated bodies in TV", and 77.7% "Hearing arrest or kidnapping of someone or a friend". While the lowest traumatic events were "Threaten by shooting or killing" 17.0%, "Shooting by bullets, rocket, or bombs" 17.5%, and "Deprivation from going to toilet and leave the room at home where you was detained" 18.5%.

Table 4: Frequency of traumatic events due to factional fighting

No	Items	yes	%
1.	Hearing the shootings and bombardment due to fighting in the streets	343	87.1
2.	Watching mutilated bodies in TV	324	82.2
3.	Hearing arrest or kidnapping of someone or a friend	306	77.7
4.	Being detained at home	209	53.0
5.	Witnessing of a neighbor home exposing to shooting and shelling	205	52.5
6.	Deprivation from water or electricity during detention at home	201	51.0
7.	Hearing killing of a friend	191	48.5
8.	Hearing killing of a close relative	137	34.8
9.	Being exposed to shooting during the last shooting and confrontations between factions	122	31.0
10.	Witnessing of your home exposing to shooting and shelling	119	30.2
11.	Witnessing shooting of a friend	112	28.4
12.	Beating and humiliation and beating	104	26.4
13.	Threaten of family member of being killed	103	26.1
14.	Witnessing shooting of a close relative	90	22.8
15.	Witnessing killing of a friend	89	22.6
16.	Destroying of your personal belongings during incursion	89	22.6
17.	Witnessing killing of a close relative	75	19.0
18.	Deprivation from going to toilet and leave the room at home where you was detained	73	18.5
19.	Shooting by bullets, rocket, or bombs	69	17.5
20.	Threaten by shooting or killing	67	17.0

5.3.4 The prevalence of traumatic events due to factional fighting:

The following table shows that 120 of study sample have mild traumatic events due to factional fighting 30.5%, while 187 of study sample have moderate traumatic events due to

factional fighting 47.5%. and 87 of study sample have severe traumatic events due to factional fighting 22.1%.

Table 5: the prevalence of traumatic events due to factional fighting

Variables	Frequency		Percent
	N	%	%
Factional fighting	mild	120	30.5
	moderate	187	47.5
	severe	87	22.1
Total		394	100

(4 and less = mild, 5-10 = moderate, 11 and above severe)

5.3.5 The frequencies of anxiety scale items

The following frequency table describe the most Anxiety items and its frequency among study sample. The researcher found that 89.3% of study sample "I get nervous when things do not go the Wright way for me", 73.6% "I worry about what is going to happen", and 71.1% "I often worry about something bad happening to me". While the lowest Anxiety items were "Often I feel sick in my stomach" 18.0%, "I wake up scared some of the time" 23.1%, and "My hands feel sweaty" 24.6%.

Table 6: Frequency of Anxiety items

No	Items	yes	%
1.	I get nervous when things do not go the Wright way for me	352	89.3
2.	I worry about what is going to happen	290	73.6
3.	I often worry about something bad happening to me	280	71.1
4.	My feelings get hurt easily when I am fussed at	251	63.7
5.	My feelings get hurt easily	226	57.4
6.	I worry about what other people think about me	219	55.6
7.	I worry about what other people think about me	214	54.3
8.	I get mad easily	209	53.0
9.	I worry a lot of the time	203	51.5
10.	I am afraid of a lot of things	186	47.2
11.	I worry about what my parents will say to me	185	47.0
12.	Others seem to do things easier than I can	183	46.4
13.	I wiggle in my seat a lot	171	43.4
14.	I am nervous	167	42.4
15.	I feel someone will tell me I do things the wrong way	164	41.6
16.	Often I have trouble getting my breath	156	39.6
17.	Other children are happier than I	148	37.6
18.	I have bad dreams	135	34.3

19.	A lot of people are against me	132	33.5
20.	It is hard to get to sleep at night	128	32.5
21.	I am tired a lot	126	32.0
22.	I have trouble making up my mind	125	31.7
23.	I feel that others do not like the way I do things	119	30.2
24.	I worry when I go to bed at night	112	28.4
25.	I feel alone even when there are people with me	99	25.1
26.	My hands feel sweaty	97	24.6
27.	I wake up scared some of the time	91	23.1
28.	Often I feel sick in my stomach	71	18.0

5.3.6 The prevalence of anxiety levels

The following table shows that 312 of study sample are not anxious 79.2%, while 82 of study sample are anxious 20.8%.

Table 7: The prevalence of anxiety levels

Variables	Frequency		Percent
	N	%	
Anxiety level	Not anxious	312	79.2
	Anxious	82	20.8
Total		394	100.0

5.3.7 The prevalence of depression levels

The following table shows that 272 of study sample are not depressed 69.0%, while 122 of study sample are depressed 31.0%.

Table 8: The prevalence of depression levels

Variables	Frequency		Percent
	N	%	
Depression level	Not depressed	272	69.0
	depressed	122	31.0
Total		394	100.0

5.3.8 The frequencies of PTSD scale items

The following frequency table describe the PTSD items and its frequency among study sample. The table shows that the item "I try to stay away from people, places, or things that make me remember what happened" is the most frequent one (15.7%), then the item "I

have upsetting thoughts, pictures, or sounds of what happened come into my mind when I do not want them to" (14.5%), then the item "When something reminds me of what happened, I get very upset, afraid or sad" (13.7%). While the least frequent items are "I have trouble remembering important parts of what happened" (3.0%), then "I feel alone inside and not close to other people"(4.8%), then " I feel like staying by myself and not being with my friends" (4.8%).

Table 9: Frequency of PTSD items

No	Items	None	Little	Some	Much	Most
		%	%	%	%	%
1.	I try to stay away from people, places, or things that make me remember what happened.	31.7	19.5	16.0	17.0	15.7
2.	I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I do not want them to.	29.7	18.0	20.6	17.3	14.5
3.	When something reminds me of what happened, I get very upset, afraid or sad.	21.1	21.8	25.1	18.3	13.7
4.	I think that I will not live a long life.	33.2	20.1	20.1	13.5	13.2
5.	When something reminds me of what happened, I have strong feelings in my body, like my heart beats fast, my head aches, or my stomach aches.	34.0	20.6	20.6	11.9	12.9
6.	I try not to talk about, think about, or have feelings about what happened.	35.8	22.6	14.7	14.5	12.4
7.	I am afraid that the bad thing will happen again.	22.8	22.1	21.3	21.8	11.9
8.	I watch out for danger or things that I am afraid of.	16.0	25.1	34.0	14.0	10.9
9.	I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me.	27.7	21.3	20.6	19.8	10.7
10.	I think that some part of what happened is my fault.	37.6	15.7	25.1	11.9	9.6
11.	I feel pessimistic or negative about my future.	44.4	17.0	20.8	8.1	9.6
12.	have trouble going to sleep or I wake up often during the night.	49.2	15.7	12.9	13.2	8.9
13.	I feel grouchy, angry or mad.	35.8	24.1	21.3	11.7	7.1
14.	I feel like I am back at the time when the bad thing happened, living through it again.	45.4	17.3	17.3	12.9	7.1
15.	I have trouble concentrating or paying attention.	35.8	22.6	23.6	11.2	6.9
16.	I have dreams about what happened or other bad dreams.	50.5	23.4	13.2	7.6	5.3
17.	I have trouble feeling happiness or love.	45.7	20.3	19.5	9.4	5.1
18.	I have trouble feeling sadness or anger.	46.2	24.6	15.2	8.9	5.1
19.	I have arguments or physical fights.	57.6	19.0	12.2	6.1	5.1
20.	I feel like staying by myself and not being with my friends.	60.7	11.7	17.0	5.8	4.8
21.	I feel alone inside and not close to other people.	59.4	11.4	15.5	8.9	4.8
22.	I have trouble remembering important parts of what happened.	51.3	21.8	14.7	9.1	3.0

5.3.9 The prevalence of PTSD subscales

The following table shows that 227 of study sample fulfill criterion (B) (re-experiencing) 57.6% (mean= 7.12; SD= 4.633), while 89 of study sample fulfill criterion (C) (Avoidance) 22.6% (mean= 9.12; SD= 5.377), and 139 of study sample fulfill criterion (D) (increased arousal) 35.3% (mean= 7.49; SD= 4.184).

Table 10: The prevalence of PTSD subscales levels

PTSD subscales	Frequency	Percent	Mean	Std. Deviation
	N	%		
Criterion (B) Re-experiencing	227	57.6	7.12	4.633
Criterion (C) Avoidance	89	22.6	9.12	5.377
Criterion (D) Increased arousal	139	35.3	7.49	4.184

5.3.10 The prevalence of PTSD levels

The following table shows that 255 of study sample have no PTSD (64.7%), 89 of study sample have partial PTSD (22.6%), while 50 of study sample have full PTSD (12.7) according to DSM-IV.

Table 11: The prevalence of PTSD levels

Variables	Frequency	Percent	
	N	%	
PTSD level	No PTSD	255	64.7
	Partial PTSD	89	22.6
	Full PTSD	50	12.7
Total	394	100.0	

N.B

- **DSM-IV full diagnosis likely = (criteria B, C, D all met)**
- **Partial PTSD likely = (criteria B+C or B+D or C+D were met)**

5.4 The relation between the study variables

5.4.1 The relation between factional fighting and Israel violence:

As shown in following table; 67 of severe traumatic events due to Israel violence "15 scores and above" of study sample were reported severe traumatic events due to factional fighting "11 scores and above" (17%), while 23 of severe traumatic events due to Israel violence of study sample were reported moderate traumatic events due to factional fighting "5- 10 scores" (5.8%), but only 3 of severe traumatic events due to Israel violence of study sample were reported mild traumatic events due to factional fighting "4 scores and less" (0.8%). Whatever 16 of moderate traumatic events due to Israel violence "8 – 14 scores" of study sample were reported severe traumatic events due to factional fighting (4.1%), while 4 of mild traumatic events due to Israel violence "7 scores and less" of study sample were reported severe traumatic events due to factional fighting (1%).

There were significant differences between traumatic events due to Israel violence and traumatic events due to factional fighting among the study sample ($\chi^2 = 235.74$, df= 2; p < 0.001).

Table 12: The relation factional fighting and Israel violence

Variables		Factional fighting				Total		X ²	
		Mild		Moderate				df = 4	
		N	%	N	%	N	%	N	%
Israel violence	mild	79	20.1	46	11.7	4	1.0	129	32.7
	moderate	38	9.6	118	29.9	16	4.1	172	43.7
	severe	3	0.8	23	5.8	67	17.0	93	23.6
Total		120	30.5	187	47.5	87	22.1	394	100.0

*p< 0.05

**p< 0.01

***p< 0.001

As shown in the following table, there were positive significant correlation between traumatic events due to Israel violence and traumatic events due to factional fighting ($r =$

0.787, $p = 0.001$), which means the high incidence of traumatic events due to Israel violence will combined with high incidence of traumatic events due to factional fighting:

Table 13: Correlations between factional fighting and Israel violence

Variables	Factional fighting	P
Israel violence	0.787	0.001 ***

5.4.2 The relation between Israel violence and anxiety levels

As shown in following table; 312 of study sample that are "not anxious", have 68 (21.8%) severe traumatic events due to Israel violence, 131 (42.0%) moderate traumatic events due to Israel violence, and 113 (36.2%) mild traumatic events due to Israel violence. While 82 of study sample that are "anxious", have 25 (30.5%) severe traumatic events due to Israel violence, 41 (50.0%) moderate traumatic events due to Israel violence, and 16 (19.5%) mild traumatic events due to Israel violence. There were a significant differences between traumatic events due to Israel violence and anxiety levels among the study sample ($X^2 = 8.568$; $df = 2$; $p = 0.014$).

Table 14: The relation between Israel violence and anxiety levels

Variables		Anxiety Level				Total		X^2			
		not anxious		anxious							
		N	%	N	%						
Israel violence	mild	113	36.2	16	19.5	129	32.7	* 8.568			
	moderate	131	42.0	41	50.0	172	43.7				
	severe	68	21.8	25	30.5	93	23.6				
Total		312	100	82	100	394	100				

* $p < 0.05$

** $p < 0.01$

*** $p < 0.001$

As shown in the following table, there were positive significant correlation between anxiety and traumatic events due to Israel violence ($r = 0.138$, $p = 0.01$) which means the increase incidence of traumatic events due to Israel violence will lead to increasing of anxiety levels.

Table 15: Correlations between Israel violence and anxiety levels

Variables	Anxiety	P
Israel violence	0.138	0.01 **

5.4.3 The relation between Israel violence and depression levels

As shown in following table; 272 of study sample that are "not depressed", have 56 (20.6%) severe traumatic events due to Israel violence, 117 (43.0%) moderate traumatic events due to Israel violence, and 99 (36.4%) mild traumatic events due to Israel violence. While 122 of study sample that are "depressed", have 37 (30.3%) severe traumatic events due to Israel violence, 55 (45.1%) moderate traumatic events due to Israel violence, and 30 (24.6%) mild traumatic events due to Israel violence. There were a significant differences between traumatic events due to Israel violence and depression level among the study sample ($X^2 = 7.045$; df= 2; p < 0.05).

Table 16: The relation between Israel violence and depression levels

Variables		Depression level				Total		χ^2 df = 2			
		not depressed		depressed							
		N	%	N	%						
Israel violence	mild	99	36.4	30	24.6	129	32.7	* 7.053			
	moderate	117	43.0	55	45.1	172	43.7				
	severe	56	20.6	37	30.3	93	23.6				
Total		272	100.0	122	100.0	394	100.0				

*p< 0.05

**p< 0.01

***p< 0.001

As shown in the following table, there were positive significant correlation between depression and traumatic events due to Israel violence ($r = 0.134$, $p = 0.01$) which means the increase incidence of traumatic events due to Israel violence will lead to increasing of depression levels.

Table 17: Correlations between Israel violence and depression levels

Variable	Depression	P
Israel violence	0.134	0.01 **

5.4.4 The relation between Israel violence and PTSD levels

As shown in following table; 255 of study sample that are "No PTSD", have 58 (22.7%) severe traumatic events due to Israel violence, 104 (40.8%) moderate traumatic events due to Israel violence, and 93 (36.5%) mild traumatic events due to Israel violence. While 89 of study sample that are "partial PTSD", have 19 (21.3%) severe traumatic events due to Israel violence, 44 (49.4%) moderate traumatic events due to Israel violence, and 26 (29.2%) mild traumatic events due to Israel violence. While 50 of study sample that are "Full PTSD", have 16 (32.0%) severe traumatic events due to Israel violence, 24 (48.0%) moderate traumatic events due to Israel violence, and 10 (20.0%) mild traumatic events due to Israel violence. There were significant differences between traumatic events due to Israel violence and depression level among the study sample ($\chi^2 = 7.045$; df= 2; p < 0.05).

Table 18: The relation between Israel violence and PTSD level

Variables		Severity of PTSD						Total		X ²		
		No PTSD		partial PTSD		full PTSD				df = 4		
		N	%	N	%	N	%					
Israel violence	mild	93	36.5	26	29.2	10	20.0	129	32.7	* 7.044		
	moderate	104	40.8	44	49.4	24	48.0	172	43.7			
	severe	58	22.7	19	21.3	16	32.0	93	23.6			
Total		255	100.0	89	100.0	50	100.0	394	100.0			

*p< 0.05

**p< 0.01

***p< 0.001

As shown in the following table, there were positive significant correlation between PTSD and traumatic events due to Israel violence ($r = 0.107$, $p = 0.05$) which means the increase incidence of traumatic events due to Israel violence will lead to increasing of PTSD levels.

Table 19: Correlations between Israel violence and PTSD level

Variables	PTSD	P
Israel violence	0.107	0.05 *

5.4.5 The relation between factional fighting and anxiety levels

As shown in following table; 312 of study sample that are "not anxious", have 62 (19.9%) severe traumatic events due to factional fighting, 145 (46.5%) moderate traumatic events due to factional fighting, and 105 (33.7%) mild traumatic events due to factional fighting. While 82 of study sample that are "anxious", have 25 (30.5%) severe traumatic events due to factional fighting, 42 (51.2%) moderate traumatic events due to factional fighting, and 15 (18.3%) mild traumatic events due to factional fighting. There were a significant differences between traumatic events due to factional fighting and anxiety level among the study sample ($X^2 = 8.652$; df= 2; p < 0.05).

Table 20: The relation between factional fighting and anxiety levels

Variables		Anxiety level				Total		χ^2 df = 2	
		not anxious		anxious					
		N	%	N	%	N	%		
Fractional fighting	mild	105	33.7	15	18.3	120	30.5	* 8.652	
	moderate	145	46.5	42	51.2	187	47.5		
	severe	62	19.9	25	30.5	87	22.1		
Total		312	100.0	82	100.0	394	100.0		

*p< 0.05

**p< 0.01

***p< 0.001

As shown in the following table, there were positive significant correlation between anxiety and traumatic events due to factional fighting ($r = 0.146$, $p = 0.01$) which means the increase incidence of traumatic events due to factional fighting will lead to increasing of anxiety levels.

Table 21: Correlations between factional fighting and anxiety levels

Variables	Anxiety	P
Factional fighting	0.146	0.01 **

5.4.6 The relation between factional fighting and depression levels

As shown in following table; 272 of study sample that are "not depressed", have 51 (18.8%) severe traumatic events due to factional fighting, 127 (46.7%) moderate traumatic events due to factional fighting, and 94 (34.6%) mild traumatic events due to factional fighting. While 122 of study sample that are "depressed", have 36 (29.5%) severe traumatic events due to factional fighting, 60 (49.2%) moderate traumatic events due to factional fighting, and 26 (21.3%) mild traumatic events due to factional fighting. There were a significant differences between traumatic events due to factional fighting and depression level among the study sample ($X^2 = 9.377$; df= 2; p < 0.01).

Table 22: The relation between factional fighting and depression levels

Variables		Depression level				Total		χ^2 df = 2			
		not depressed		depressed							
		N	%	N	%						
Fractional fighting	mild	94	34.6	26	21.3	120	30.5	** 9.377			
	moderate	127	46.7	60	49.2	187	47.5				
	severe	51	18.8	36	29.5	87	22.1				
Total		272	100.0	122	100.0	394	100.0				

*p< 0.05

**p< 0.01

***p< 0.001

As shown in the following table, there were positive significant correlation between depression and traumatic events due to factional fighting ($r = 0.154$, $p = 0.01$) which means the increase incidence of traumatic events due to factional fighting will lead to increasing of depression levels.

Table 23: Correlations between factional fighting and depression level

	Depression	P
Factional fighting	0.154	0.01 **

5.4.7 The relation between factional fighting and PTSD level

As shown in following table; 255 of study sample that are "No PTSD", have 50 (19.6%) severe traumatic events due to factional fighting, 117 (45.9%) moderate traumatic events

due to factional fighting, and 88 (34.5%) mild traumatic events due to factional fighting. While 89 of study sample that are "partial PTSD", have 21 (23.6%) severe traumatic events due to factional fighting, 44 (49.4%) moderate traumatic events due to factional fighting, and 24 (27.0%) mild traumatic events due to Israel violence. While 50 of study sample that are "Full PTSD", have 16 (32.0%) severe traumatic events due to factional fighting, 26 (52.0%) moderate traumatic events due to factional fighting, and 8 (16.0%) mild traumatic events due to Israel violence. There were significant differences between traumatic events due to factional fighting and depression level among the study sample ($X^2 = 8.613$; df= 4; p < 0.05).

Table 24: The relation between factional fighting and PTSD levels

Variables		Severity of PTSD						Total		X^2 df = 4	
		No PTSD		partial PTSD		full PTSD					
		N	%	N	%	N	%	N	%		
Fractional fighting	mild	88	34.5	24	27.0	8	16.0	120	30.5	* 8.613	
	moderate	117	45.9	44	49.4	26	52.0	187	47.5		
	severe	50	19.6	21	23.6	16	32.0	87	22.1		
Total		255	100.0	89	100.0	50	100.0	394	100.0		

*p< 0.05

**p< 0.01

***p< 0.001

As shown in the following table, there were positive significant correlation between PTSD and traumatic events due to factional fighting ($r = 0.113$, $p = 0.01$) which means the increase incidence of traumatic events due to factional fighting will lead to increasing of PTSD levels.

Table 25: Correlations between factional fighting and PTSD level

Variables	PTSD	P
Factional fighting	0.113	0.01 **

5.5 Political violence and demographic variables:

5.5.1 Political violence and sex

In order to test the sex difference between the two types of violence among the study sample the researcher performed t-independent test. As shown in the following table; the result found significant differences in traumatic events due to factional fighting according to sex with an actual probability ($t = 2.65$; $df= 392$, $P=0.008$) in favor to males. But there were no significant differences in traumatic events due to Israel violence according to sex.

Table 26: Independent t-test comparing means of political violence according to sex

Variables	Males N = 203		Females N = 191		T- value df = 392	Significant Level
	Mean	SD	Mean	SD		
Israel violence	11.75	5.967	10.71	5.974	1.73	0.084
Factional fighting	8.32	5.179	7.01	4.589	2.65	0.008 **

* $p < 0.05$

** $p < 0.01$

*** $p < 0.001$

5.5.2 Political violence and the educational classes

One-Way ANOVA analysis was used to study the differences between traumatic events due to Israel violence levels (mild; 0-7 scores, moderate; 8-14 scores, and severe; 15 and above scores) and traumatic events due to factional fighting levels (mild; 0-4 scores, moderate; 5-10, and severe; 11 and above) according to the educational classes. The following table shows that: there were no significant differences between the means traumatic events due to Israel violence levels and traumatic events due to factional fighting levels according to the educational classes (10th class, 11th class, and 12th class).

Table 27: One-way ANOVA comparing types of violence according to educational classes

Variables	Source of variance	Sum of Squares	Df	Mean Square	F- value	Significant Level
Israel violence	Between Groups	6.080	2	3.040	0.084	0.919
	Within Groups	14076.53	391	36.001		
	Total	14082.61	393			
Factional fighting	Between Groups	1.778	2	.889	0.036	0.964
	Within Groups	9587.19	391	24.520		
	Total	9588.97	393			

*p< 0.05

**p< 0.01

***p< 0.001

5.5.3 Political violence and type of residence:

By using One-Way ANOVA analysis, the following table shows that: there were no significant differences between the means of traumatic events due to Israel violence levels and traumatic events due to factional fighting levels according to type of residence (City-Camp-Village).

Table 28: One-way ANOVA comparing types of violence according to type of residence

Variables	Source of variance	Sum of Squares	df	Mean Square	F- value	Significant Level
Israel violence	Between Groups	127.50	2	63.75	1.786	0.169
	Within Groups	13955.11	391	35.69		
	Total	14082.61	393			
Factional fighting	Between Groups	40.79	2	20.39	0.835	0.435
	Within Groups	9548.18	391	24.42		
	Total	9588.97	393			

*p< 0.05

**p< 0.01

***p< 0.001

5.5.4 Political violence and number of siblings:

By using One-Way ANOVA analysis, the following table shows that: there were no significant differences between the means of traumatic events due to Israel violence levels

and traumatic events due to factional fighting levels according to number of sibling (4 and less, 5-7, 8 and more).

Table 29: One-way ANOVA comparing types of violence according to number of siblings

Variables	Source of variance	Sum of Squares	df	Mean Square	F- value	Significant Level
Israel violence	Between Groups	75.92	2	37.96	1.060	0.348
	Within Groups	14006.69	391	35.82		
	Total	14082.61	393			
Factional fighting	Between Groups	86.20	2	43.10	1.773	0.171
	Within Groups	9502.77	391	24.30		
	Total	9588.97	393			

*p< 0.05

**p< 0.01

***p< 0.001

5.5.5 Political violence and mothers education:

By using One-Way ANOVA analysis, the following table shows that: there were no significant differences between the means of traumatic events due to Israel violence levels and traumatic events due to factional fighting levels according to mothers education (illiterate, primary, preparatory, secondary, diploma, and university).

Table 30: One-way ANOVA comparing types of violence according to mothers education

Variables	Source of variance	Sum of Squares	Df	Mean Square	F- value	Significant Level
Israel violence	Between Groups	246.94	5	49.38	1.385	0.229
	Within Groups	13835.67	388	35.65		
	Total	14082.61	393			
Factional fighting	Between Groups	85.63	5	17.12	0.699	0.624
	Within Groups	9503.33	388	24.49		
	Total	9588.97	393			

*p< 0.05

**p< 0.01

***p< 0.001

5.5.6 Political violence and fathers education:

By using One-Way ANOVA analysis, the following table shows that: there were no significant differences between the means of traumatic events due to Israel violence levels and traumatic events due to factional fighting levels according to fathers education (illiterate, primary, preparatory, secondary, diploma, and university).

Table 31: One-way ANOVA comparing types of violence according to fathers education

Variables	Source of variance	Sum of Squares	Df	Mean Square	F- value	Significant Level
Israel violence	Between Groups	291.58	5	58.31	1.641	0.148
	Within Groups	13791.03	388	35.54		
	Total	14082.61	393			
Factional fighting	Between Groups	218.39	5	43.68	1.809	0.110
	Within Groups	9370.57	388	24.15		
	Total	9588.97	393			

*p< 0.05

**p< 0.01

***p< 0.001

5.5.7 Political violence war and mothers work.

By performing t-independent test. As shown in the following table; the result found no significant differences in political and traumatic events due to factional fighting according to mothers work (housewife - employee).

Table 32: Independent t-test comparing means of types of violence according to mothers work

Variables	Housewife N = 203		Employee N = 191		T- value df = 392	Significant Level
	Mean	SD	Mean	SD		
Israel violence	11.35	5.915	10.72	6.345	0.783	0.434
Factional fighting	7.75	4.870	7.33	5.292	0.634	0.526

*p< 0.05

**p< 0.01

***p< 0.001

5.5.8 Political violence and fathers work:

By using One-Way ANOVA analysis, the following table shows that: there were no significant differences between the means of traumatic events due to Israel violence levels and traumatic events due to factional fighting levels according to fathers work (free works, employee, maker, worker, and unemployed).

**Table 33: One-way ANOVA comparing types of violence
according to fathers work**

Variables	Source of variance	Sum of Squares	Df	Mean Square	F- value	Significant Level
Israel violence	Between Groups	141.85	4	35.46	0.990	0.413
	Within Groups	13940.76	389	35.83		
	Total	14082.61	393			
Factional fighting	Between Groups	119.56	4	29.89	1.228	0.298
	Within Groups	9469.41	389	24.34		
	Total	9588.97	393			

*p< 0.05

**p< 0.01

***p< 0.001

5.5.9 Political violence according to monthly income

One-Way ANOVA analysis was used to study the differences between traumatic events due to Israel violence levels according to monthly income (less than 600 NIS, 600-1400, 1401-2000, 2001-3000, and more than 3000). As shown in the following table; the results show that there were significant differences between the means of traumatic events due to Israel violence according to monthly income at levels of significant ($f = 2.734$; $P = 0.029$) toward "less than 600 NIS".

However, the results show that there were no significant differences between the means of traumatic events due to factional fighting according to the monthly income.

Table 34: One-way ANOVA comparing types of violence according to monthly income

Variables	Source of variance	Sum of Squares	Df	Mean Square	F-value	Significant Level
Israel violence	Between Groups	385.023	4	96.256	2.734	0.029 *
	Within Groups	13697.596	389	35.212		
	Total	14082.619	393			
Factional fighting	Between Groups	201.946	4	50.487	2.092	0.081
	Within Groups	9387.028	389	24.131		
	Total	9588.975	393			

*p< 0.05

**p< 0.01

***p< 0.001

Post –hoc analysis according to Scheffee statistical test was done and indicated; the means of traumatic events due to Israel violence according to monthly income (less than 600 NIS, 600-1400, 1401-2000, 2001-3000, and more than 3000); as shown in the following table; there were inverse correlation between traumatic events due to Israel violence and monthly income. In other words if the study sample have monthly income (less than 600 NIS) this will lead to increase of traumatic events due to Israel violence. However, there were no differences observed from the means of traumatic events due to factional fighting according to monthly income, where these means very nearly to each others.

Table 35: Means and standard deviation of political violence according to monthly income

Variable	N	Mean	S.D
less than 600 NS	79	12.75*	6.064
600 - 1400 NS	59	11.03	6.586
1401-2000 NS	50	11.04	5.671
2001-3000 NS	77	9.66	5.540
more than 3000	129	11.46	5.865
Total	394	11.25	5.986

5.6 Mental health and demographic variables:

5.6.1 Mental health and sex

In order to test the sex difference between mental health (anxiety, PTSD, depression) among the study sample, the researcher performed t-independent test. As shown in the following table; the result found significant differences in anxiety levels according to sex with an actual probability ($t = 2.88$; $df= 392$, $P=0.004$) in favor to females. But there were no significant differences in PTSD and depression levels according to sex.

Table 36: Independent t-test comparing means of mental health according to sex

Variables	Males N = 203		Females N = 191		T- value df = 392	Significant Level
	Mean	SD	Mean	SD		
Anxiety Level	11.50	5.750	13.22	6.099	2.88	0.004 **
PTSD Level	28.52	13.760	29.31	16.111	0.52	0.602
Depression Level	13.92	7.866	15.00	8.232	1.32	0.186

* $p < 0.05$

** $p < 0.01$

*** $p < 0.001$

5.6.2 Mental health and the educational classes

One-Way ANOVA analysis was used to study the differences between mental health (anxiety, PTSD, depression) according to the educational classes. The following table shows that: significant differences between the means of anxiety levels ($f = 5.32$; $P= 0.004$), PTSD levels ($f = 5.29$; $P= 0.005$), and depression ($f = 3.27$; $P= 0.039$) according to the educational classes (10th class, 11th class, and 12th class).

Table 37: One-way ANOVA comparing mental health according to educational classes

Variables	Source of variance	Sum of Squares	Df	Mean Square	F- value	Significant Level
Anxiety Level	Between Groups	372.50	2	186.253	5.32	0.004 **
	Within Groups	13669.59	391	34.961		
	Total	14042.10	393			
PTSD Level	Between Groups	2310.59	2	1155.299	5.29	0.005 **
	Within Groups	85320.11	391	218.210		
	Total	87630.71	393			
Depression Level	Between Groups	420.31	2	210.159	3.27	0.039 *
	Within Groups	25071.06	391	64.120		
	Total	25491.38	393			

*p< 0.05

**p< 0.01

***p< 0.001

Post –hoc analysis according to Scheffee statistical test was done and indicated; the means of anxiety, PTSD, and depression levels according to the educational classes (10th class, 11th class, and 12th class); as shown in the following table; there were positive correlation between anxiety, PTSD, and depression levels and educational classes toward 12th class. That means the study sample in 12th class had significantly greater levels of anxiety, PTSD, and depression than other lower classes (10th class).

Table 38: Means and standard deviation of Mental health according to educational classes

Variables		N	Mean	Std. Deviation
Anxiety level	10th	105	10.84	5.420
	11th	150	12.46	6.688
	12th	139	13.33**	5.349
PTSD level	10th	105	25.05	13.279
	11th	150	29.53	16.038
	12th	139	31.14**	14.408
Depression level	10th	105	12.96	7.443
	11th	150	14.40	8.244
	12th	139	15.61*	8.156

5.6.3 Mental health and type of residence

By using One-Way ANOVA analysis, the following table shows that: significant differences between the means of anxiety levels ($f = 4.69$; $P= 0.01$) according to type of residence (city, camp, village). However, the results shown that there were no significant differences between the means of PTSD and depression levels according to type of residence.

Table 39: One-way ANOVA comparing mental health according to type of residence

Variables	Source of variance	Sum of Squares	Df	Mean Square	F- value	Significant Level
Anxiety Level	Between Groups	329.46	2	164.73	4.69	0.010 **
	Within Groups	13712.63	391	35.07		
	Total	14042.10	393			
PTSD Level	Between Groups	1196.25	2	598.12	2.70	0.068
	Within Groups	86434.45	391	221.06		
	Total	87630.71	393			
Depression Level	Between Groups	352.49	2	176.24	2.74	0.066
	Within Groups	25138.88	391	64.29		
	Total	25491.38	393			

*p< 0.05

**p< 0.01

***p< 0.001

Post –hoc analysis according to Scheffee statistical test was done and indicated; the means of anxiety, PTSD, and depression levels according to type of residence (city, camp, village); as shown in the following table; there were positive correlation between anxiety levels and type of residence (city, camp, village) toward the group who live in camp. That means the study sample who live in camp had significantly greater levels of anxiety, than other two group which live in city and village.

Table 40: Means and standard deviation of Mental health according to educational classes

Variables		N	Mean	Std. Deviation
Anxiety level	city	247	11.73	6.098
	camp	112	13.78**	5.803
	village	35	11.94	4.922
PTSD level	city	247	27.57	14.941
	camp	112	31.31	14.899
	village	35	30.65	14.216
Depression level	city	247	13.72	8.130
	camp	112	15.58	7.738
	village	35	15.94	8.094

5.6.4 Mental health and number of siblings

By using One-Way ANOVA analysis, the following table shows that: no significant differences between the means of anxiety, PTSD, and depression levels according to number of siblings.

Table 41: One-way ANOVA comparing mental health according to number of siblings

Variables	Source of variance	Sum of Squares	Df	Mean Square	F- value	Significant Level
Anxiety Level	Between Groups	188.99	2	94.49	2.66	0.071
	Within Groups	13853.11	391	35.43		
	Total	14042.10	393			
PTSD Level	Between Groups	495.98	2	247.99	1.11	0.330
	Within Groups	87134.73	391	222.85		
	Total	87630.71	393			
Depression Level	Between Groups	72.82	2	36.41	0.56	0.572
	Within Groups	25418.55	391	65.00		
	Total	25491.38	393			

*p< 0.05

**p< 0.01

***p< 0.001

5.6.5 Mental health and mothers education

By using One-Way ANOVA analysis, the following table shows that: no significant differences between the means of anxiety, PTSD, and depression levels according to mothers education.

Table 42: One-way ANOVA comparing mental health according to mothers education

Variables	Source of variance	Sum of Squares	Df	Mean Square	F- value	Significant Level
Anxiety Level	Between Groups	372.77	5	74.55	2.11	0.063
	Within Groups	13669.33	388	35.23		
	Total	14042.10	393			
PTSD Level	Between Groups	2222.29	5	444.45	2.01	0.075
	Within Groups	85408.41	388	220.12		
	Total	87630.71	393			
Depression Level	Between Groups	357.58	5	71.51	1.10	0.358
	Within Groups	25133.79	388	64.77		
	Total	25491.38	393			

*p< 0.05

**p< 0.01

***p< 0.001

5.6.6 Mental health and fathers education

By using One-Way ANOVA analysis, the following table shows that: significant differences between the means of anxiety levels ($f = 2.62$; $P= 0.024$), PTSD levels ($f= 2.35$; $P= 0.040$), and depression levels ($f= 2.71$; $P=0.020$) according to fathers education (illiterate, primary, preparatory, secondary, diploma, university).

Table 43: One-way ANOVA comparing mental health according to fathers education

Variables	Source of variance	Sum of Squares	Df	Mean Square	F- value	Significant Level
Anxiety Level	Between Groups	459.86	5	91.97	2.62	0.024 *
	Within Groups	13582.24	388	35.00		
	Total	14042.10	393			
PTSD Level	Between Groups	2578.73	5	515.74	2.35	0.040 *
	Within Groups	85051.98	388	219.20		
	Total	87630.71	393			
Depression Level	Between Groups	862.78	5	172.55	2.71	0.020 *
	Within Groups	24628.59	388	63.47		
	Total	25491.38	393			

*p< 0.05

**p< 0.01

***p< 0.001

Post –hoc analysis according to Scheffee statistical test was done and indicated; the means of anxiety, PTSD, and depression levels according to fathers education (illiterate, primary, preparatory, secondary, diploma, university); as shown in the following table; there were inverse correlation between anxiety levels and fathers education. That means the study sample who have primary education or less had significantly greater levels of anxiety in relation to fathers who have diploma or higher. The table show also inverse correlation between PTSD levels and fathers education. That means the study sample who are illiterate had significantly greater levels of PTSD in relation to fathers who have diploma or higher. The table show also inverse correlation between depression levels and fathers education. That means the study sample who are illiterate had significantly greater levels of depression in relation to fathers who have diploma or higher. In conclusion the study sample who have primary education and less, had more anxiety, PTSD, and depression in relation to fathers who higher educational levels.

Table 44: Means and standard deviation of Mental health according to fathers education

Variables		N	Mean	Std. Deviation
Anxiety level	illiterate	6	14.33	6.088
	primary	19	16.15*	6.405
	preparatory	38	11.65	6.540
	secondary	98	12.95	6.589
	deploma	36	10.83	5.347
	university	197	12.00	5.469
PTSD level	illiterate	6	39.00*	14.993
	primary	19	37.21	16.369
	preparatory	38	28.00	14.090
	secondary	98	28.55	16.250
	deploma	36	24.77	13.234
	university	197	28.90	14.288
Depression level	illiterate	6	18.33*	6.439
	primary	19	17.89	9.097
	preparatory	38	14.63	8.263
	secondary	98	16.00	8.697
	deploma	36	12.36	7.006
	university	197	13.56	7.609

5.6.7 Mental health and mothers work.

By performing t-independent test. As shown in the following table; the result found no significant differences in anxiety, PTSD, and depression levels according to mothers work (housewife - employee).

Table 45: Independent t-test comparing means of types of violence according to mothers work

Variables	Housewife N = 203		Employee N = 191		T- value Df = 392	Significant Level
	Mean	SD	Mean	SD		
Anxiety levels	328	12.57	66	11.15	1.77	0.077
PTSD levels	328	29.36	66	26.65	1.34	0.179
Depression levels	328	14.60	66	13.68	0.84	0.398

*p< 0.05

**p< 0.01

***p< 0.001

5.6.8 Mental health and fathers work

By using One-Way ANOVA analysis, the following table shows that: no significant differences between the means of anxiety, PTSD, and depression according to fathers work.

Table 46: One-way ANOVA comparing mental health according to fathers work

Variables	Source of variance	Sum of Squares	Df	Mean Square	F- value	Significant Level
Anxiety Level	Between Groups	170.97	4	42.74	1.19	0.311
	Within Groups	13871.12	389	35.65		
	Total	14042.10	393			
PTSD Level	Between Groups	1487.33	4	371.83	1.67	0.154
	Within Groups	86143.37	389	221.44		
	Total	87630.71	393			
Depression Level	Between Groups	320.33	4	80.08	1.23	0.294
	Within Groups	25171.04	389	64.70		
	Total	25491.38	393			

*p< 0.05

**p< 0.01

***p< 0.001

5.6.9 Mental health and monthly income

By using One-Way ANOVA analysis, the following table shows that: significant differences between the means of anxiety levels ($f = 2.71$; $P = 0.030$), and depression levels ($f = 3.19$; $p = 0.013$) according to monthly income. However, the results shown that there were no significant differences between the means of PTSD levels according to monthly income.

Table 47: One-way ANOVA comparing mental health according to monthly income

Variables	Source of variance	Sum of Squares	Df	Mean Square	F- value	Significant Level
Anxiety Level	Between Groups	381.45	4	95.36	2.71	0.030 *
	Within Groups	13660.65	389	35.11		
	Total	14042.10	393			
PTSD Level	Between Groups	231.54	4	57.88	0.25	0.905
	Within Groups	87399.16	389	224.67		
	Total	87630.71	393			
Depression Level	Between Groups	809.74	4	202.43	3.19	0.013 *
	Within Groups	24681.63	389	63.44		
	Total	25491.38	393			

*p< 0.05

**p< 0.01

***p< 0.001

Post –hoc analysis according to Scheffee statistical test was done and indicated; the means of anxiety, PTSD, and depression levels according to monthly income (less than 600 NIS, 600-1400, 1401-2000, 2001-3000, more than 3000); as shown in the following table; there were inverse correlation between anxiety levels and monthly income. That means the study sample who have monthly income "601-1400" had significantly greater levels of anxiety in relation to monthly income "1401-2000". The table show also inverse correlation between depression levels and monthly income. That means the study sample who have monthly income "less than 600 NIS" had significantly greater levels of depression in relation to monthly income "more than 3000 NIS". Whoever there was no significant correlation between PTSD level and monthly income.

**Table 48: Means and standard deviation of
Mental health according to monthly income**

Variables		N	Mean	Std. Deviation
Anxiety levels	less than 600 NS	79	13.44	6.531
	600 - 1400 NS	59	13.62*	6.820
	1401-2000 NS	50	10.78	5.357
	2001-3000 NS	77	11.42	5.533
	more than 3000	129	12.21	5.521
PTSD levels	less than 600 NS	79	28.31	16.212
	600 - 1400 NS	59	30.42	15.741
	1401-2000 NS	50	29.56	14.287
	2001-3000 NS	77	28.14	15.065
	more than 3000	129	28.78	14.051
Depression levels	less than 600 NS	79	16.97*	8.461
	600 - 1400 NS	59	15.37	8.590
	1401-2000 NS	50	13.60	7.899
	2001-3000 NS	77	13.37	7.205
	more than 3000	129	13.44	7.813

5.7 Mental health and political violence levels:

5.7.1 Mental health and Israel violence levels:

By using One-Way ANOVA analysis, the following table shows that: significant differences between the means of anxiety levels ($f = 5.05$; $P= 0.007$), PTSD levels ($f= 3.83$; $p= 0.022$) and depression levels ($f= 6.90$; $p= 0.001$) according to traumatic events due to Israel violence level.

Table 49: One-way ANOVA comparing mental health

according to Israel violence levels

Variables	Source of variance	Sum of Squares	Df	Mean Square	F- value	Significant Level
Anxiety Level	Between Groups	354.11	2	177.06	5.05	0.007 **
	Within Groups	13687.98	391	35.00		
	Total	14042.10	393			
PTSD Level	Between Groups	2989.82	2	1494.91	6.90	0.001 ***
	Within Groups	84640.88	391	216.47		
	Total	87630.71	393			
Depression Level	Between Groups	490.68	2	245.34	3.83	0.022 *
	Within Groups	25000.69	391	63.94		
	Total	25491.38	393			

* $p< 0.05$

** $p< 0.01$

*** $p< 0.001$

Post –hoc analysis according to Scheffee statistical test was done and indicated; the means of anxiety, PTSD, and depression levels according to traumatic events due to Israel violence levels (mild, moderate, severe); as shown in the following table; there were positive correlation between anxiety, PTSD, depression levels and traumatic events due to Israel violence levels toward severe traumatic events due to Israel violence. That means the study sample who have exposed to severe traumatic events due to Israel violence had significantly greater levels of anxiety, PTSD, depression in relation to mild traumatic events due to Israel violence.

Table 50: Means and standard deviation of Mental health according to Israel violence

Variables		N	Mean	Std. Deviation
Anxiety level	mild	129	11.02	5.797
	moderate	172	12.76	5.876
	severe	93	13.37**	6.150
PTSD level	mild	129	24.96	13.626
	moderate	172	30.77	14.885
	severe	93	30.92***	15.806
Depression level	mild	129	12.99	7.404
	moderate	172	14.73	7.903
	severe	93	15.92*	8.909

5.7.2 Mental health and factional fighting levels:

By using One-Way ANOVA analysis, the following table shows that: significant differences between the means of anxiety levels ($f = 5.68$; $P = 0.004$), PTSD levels ($f = 6.55$; $p = 0.002$) and depression levels ($f = 3.84$; $p = 0.022$) according to traumatic events due to factional fighting level.

Table 51: One-way ANOVA comparing mental health according to factional fighting levels

Variables	Source of variance	Sum of Squares	Df	Mean Square	F- value	Significant Level
Anxiety Level	Between Groups	396.76	2	198.38	5.68	0.004 **
	Within Groups	13645.34	391	34.89		
	Total	14042.10	393			
PTSD Level	Between Groups	2843.93	2	1421.96	6.55	0.002 **
	Within Groups	84786.77	391	216.84		
	Total	87630.71	393			
Depression Level	Between Groups	491.06	2	245.53	3.84	0.022 *
	Within Groups	25000.32	391	63.93		
	Total	25491.38	393			

* $p < 0.05$

** $p < 0.01$

*** $p < 0.001$

Post –hoc analysis according to Scheffee statistical test was done and indicated; the means of anxiety, PTSD, and depression levels according to traumatic events due to factional fighting levels (mild, moderate, severe); as shown in the following table; there were positive correlation between anxiety, PTSD, depression levels and traumatic events due to factional fighting levels toward severe traumatic events due to factional fighting. That means the study sample who have exposed to severe traumatic events due to factional fighting had significantly greater levels of anxiety, PTSD, depression in relation to mild traumatic events due to factional fighting.

Table 52: Means and standard deviation of Mental health according to factional fighting

Variables		N	Mean	Std. Deviation
Anxiety level	mild	120	10.92	5.708
	moderate	187	12.65	5.835
	severe	87	13.59	6.318
PTSD level	mild	120	25.37	13.883
	moderate	187	29.37	14.674
	severe	87	32.78	15.920
Depression level	mild	120	13.20	7.393
	moderate	187	14.36	7.881
	severe	87	16.32	8.983

Chapter 6

Implications and recommendations

Chapter 6: Implication and recommendations

6.1 Introduction

This chapter introduced the main results that achieved in chapter five and its discussion on the light of the previous studies. Furthermore, it's important here to clarify the results and its relation with other studies that may be helpful in supporting our findings. However, the researcher will put on the hand some of implications and recommendation regarding political, factional fighting and adolescence that are likely to be taken in consideration in the application of the future building. Also, recommendation for further research will be provided on the basis of the results of the current study.

6.2 Main results

- The most traumatic events due to Israel violence was 90.4% of study sample "Watching mutilated bodies in TV", 86.0% "Hearing shelling of the area by artillery", and 84% "Hearing the sonic sounds of the jet fighters". While the lowest traumatic events were "Physical injury due to bombardment of your home" 16.5%, "Deprivation from going to toilet and leave the room at home where you was detained" 17.3%, and "Threatened to death by being used as human shield to arrest your neighbors by the army" 17.5%.
- The prevalence of traumatic events due to Israel violence was: moderate (43.7%), severe (23.6%).
- The most traumatic events due to factional fighting (factional fighting) was "Hearing the shootings and bombardment due to fighting in the streets", 87.1% of study sample, 82.2% "Watching mutilated bodies in TV", and 77.7% "Hearing arrest or kidnapping of someone or a friend". While the lowest traumatic events were "Threaten by shooting or

killing" 17.0%, "Shooting by bullets, rocket, or bombs" 17.5%, and "Deprivation from going to toilet and leave the room at home where you was detained" 18.5%.

- The prevalence of traumatic events due to factional fighting (factional fighting) was: moderate (47.5%). and severe (22.1%).
- The study found 67 of severe Israel violence of study sample were reported severe factional fighting (17%).
- There were a significant differences between Israel violence and factional fighting among the study sample ($X^2= 235.74$, df= 2; p < 0.001).
- The study found there were positive significant correlation between factional fighting and Israel violence ($r = 0.787$, p = 0.001), which means the high incidence of Israel violence will combined with high incidence of factional fighting.
- The prevalence of anxiety levels among study sample was (20.8%).
- The prevalence of depression levels among study sample was (31.0%).
- The prevalence of PTSD levels among study sample was partial PTSD (22.6%), full PTSD (12.7%).
- The prevalence of PTSD subscales was: (57.6%) fulfill criterion (B) (re-experiencing) (mean= 7.12; SD= 4.633), (22.6%) fulfill criterion (C) (Avoidance) (mean= 9.12; SD= 5.377), and (35.3%) fulfill criterion (D) (increased arousal) (mean= 7.49; SD= 4.184).
- The study found 312 of study sample that are "not anxious", have 68 (21.8%) severe Israel violence, while 82 of study sample that are "anxious", have 25 (30.5%) severe Israel violence. There were a significant differences between Israel violence and anxiety levels among the study sample ($X^2= 8.568$; df= 2; p = 0.014).

- There were positive significant correlation between anxiety and Israel violence ($r = 0.138$, $p = 0.01$) which means the increase incidence of Israel violence will lead to increasing of anxiety levels.
- The study found 272 of study sample that are "not depressed", have 56 (20.6%) severe Israel violence. While 122 of study sample that are "depressed", have 37 (30.3%) severe Israel Violence. There were a significant differences between Israel Violence and depression level among the study sample ($X^2 = 7.045$; $df = 2$; $p < 0.05$).
- There were positive significant correlation between depression and Israel Violence ($r = 0.134$, $p = 0.01$) which means the increase incidence of Israel Violence will lead to increasing of depression levels.
- The study found 89 of study sample that are "partial PTSD", have 19 (21.3%) severe Israel Violence. While 50 of study sample that are "Full PTSD", have 16 (32.0%) severe Israel Violence. There were a significant differences between Israel Violence and depression level among the study sample ($X^2 = 7.045$; $df = 2$; $p < 0.05$).
- There were positive significant correlation between PTSD and Israel Violence ($r = 0.107$, $p = 0.05$) which means the increase incidence of Israel Violence will lead to increasing of PTSD levels.
- The study found 82 of study sample that are "anxious", have 25 (30.5%) severe factional fighting. There were a significant differences between factional fighting and anxiety level among the study sample ($X^2 = 8.652$; $df = 2$; $p < 0.05$).
- There were positive significant correlation between anxiety and factional fighting ($r = 0.146$, $p = 0.01$) which means the increase incidence of factional fighting will lead to increasing of anxiety levels.

- The study found 122 of study sample that are "depressed", have 36 (29.5%) severe factional fighting. There were a significant differences between factional fighting and depression level among the study sample ($X^2 = 9.377$; df= 2; p < 0.01).
- There were positive significant correlation between depression and factional fighting (r = 0.154 , p = 0.01) which means the increase incidence of factional fighting will lead to increasing of depression levels.
- The study found 89 of study sample that are "partial PTSD", have 21 (23.6%) severe factional fighting. While 50 of study sample that are "Full PTSD", have 16 (32.0%) severe factional fighting. There were a significant differences between factional fighting and depression level among the study sample ($X^2 = 8.613$; df= 4; p < 0.05).
- There were positive significant correlation between PTSD and factional fighting (r = 0.113 , p = 0.01) which means the increase incidence of factional fighting will lead to increasing of PTSD levels.
- The study found significant differences in factional fighting according to sex with an actual probability (t = 2.65; df= 392, P=0.008) in favor to males. But there were no significant differences in Israel Violence according to sex.
- There were no significant differences between the means Israel Violence levels and factional fighting levels according to the educational classes (10th class, 11th class, and 12th class).
- There were no significant differences between the means of Israel Violence levels and factional fighting levels according to type of residence (City-Camp-Village).
- There were no significant differences between the means of Israel Violence levels and factional fighting levels according to number of sibling (4 and less, 5-7, 8 and more).

- There were no significant differences between the means of Israel Violence levels and factional fighting levels according to mothers education (illiterate, primary, preparatory, secondary, diploma, and university).
- There were no significant differences between the means of Israel Violence levels and factional fighting levels according to fathers education (illiterate, primary, preparatory, secondary, diploma, and university).
- There were no significant differences in political and factional fighting according to mothers work (housewife - employee).
- There were no significant differences between the means of Israel Violence levels and factional fighting levels according to fathers work (free works, employee, maker, worker, and unemployed).
- The study found significant differences between the means of Israel Violence according to monthly income at levels of significant ($f = 2.734$; $P = 0.029$) toward "less than 600 NIS". However, the results shown no significant differences between the means of factional fighting according to the monthly income.
- There were inverse correlation between Israel Violence and monthly income. That means the low monthly income were had highest level of Israel Violence.
- The study found significant differences in anxiety levels according to sex with an actual probability ($t = 2.88$; $df= 392$, $P=0.004$) in favor to females. But there were no significant differences in PTSD and depression levels according to sex.
- The study found significant differences between the means of anxiety levels ($f = 5.32$; $P= 0.004$), PTSD levels ($f = 5.29$; $P= 0.005$), and depression ($f = 3.27$; $P= 0.039$) according to the educational classes (10th class, 11th class, and 12th class).

- There were positive correlation between anxiety, PTSD, and depression levels and educational classes toward 12th class. That means the study sample in 12th class had significantly greater levels of anxiety, PTSD, and depression than other lower classes.
- The study found significant differences between the means of anxiety levels ($f = 4.69$; $P= 0.01$) according to type of residence (city, camp, village). However, the results shown that there were no significant differences between the means of PTSD and depression levels according to type of residence.
- There were positive correlation between anxiety levels and type of residence (city, camp, village) toward the group who live in camp. That means the study sample who live in camp had significantly greater levels of anxiety, than other two group which live in city and village.
- There were no significant differences between the means of anxiety, PTSD, and depression levels according to number of siblings.
- There were no significant differences between the means of anxiety, PTSD, and depression levels according to mothers education.
- The study found significant differences between the means of anxiety levels ($f = 2.62$; $P= 0.024$), PTSD levels ($f= 2.35$; $P= 0.040$), and depression levels ($f= 2.71$; $P=0.020$) according to fathers education.
- There were positive correlation between anxiety levels and fathers education toward the group who has primary education. That means the study sample who have primary education had significantly greater levels of anxiety in relation to fathers who have diploma. The study found also positive correlation between PTSD levels and fathers education toward the group who are illiterate. That means the study sample who are illiterate had significantly greater levels of PTSD in relation to fathers who have

diploma. The study found also positive correlation between depression levels and fathers education toward the group who are illiterate. That means the study sample who are illiterate had significantly greater levels of depression in relation to fathers who have diploma. In conclusion the study sample who have primary education and less, had more anxiety, PTSD, and depression in relation to fathers who higher educational levels.

- There were no significant differences in anxiety, PTSD, and depression levels according to mothers work (housewife - employee).
- There were no significant differences between the means of anxiety, PTSD, and depression according to fathers work.
- The study found significant differences between the means of anxiety levels ($f = 2.71$; $P= 0.030$), and depression levels ($f= 3.19$; $p= 0.013$) according to monthly income. However, the results shown that there were no significant differences between the means of PTSD levels according to monthly income.
- There were inverse correlation between anxiety levels and monthly income toward monthly income "601-1400". That means the study sample who have monthly income "601-1400" had significantly greater levels of anxiety in relation to monthly income "1401-2000". inverse correlation between depression levels and monthly income toward monthly income "less than 600 NIS". That means the study sample who have monthly income "less than 600 NIS" had significantly greater levels of depression in relation to monthly income "more than 3000 NIS". Whoever there was no significant correlation between PTSD level and monthly income.

- The study found significant differences between the means of anxiety levels ($f = 5.05$; $P= 0.007$), PTSD levels ($f= 3.83$; $p= 0.022$) and depression levels ($f= 6.90$; $p= 0.001$) according to Israel Violence level.
- There were positive correlation between anxiety, PTSD, depression levels and Israel Violence levels toward severe Israel Violence. That means the study sample who have exposed to severe Israel Violence had significantly greater levels of anxiety, PTSD, depression in relation to mild Israel Violence.
- The study found significant differences between the means of anxiety levels ($f = 5.68$; $P= 0.004$), PTSD levels ($f= 6.55$; $p= 0.002$) and depression levels ($f= 3.84$; $p= 0.022$) according to factional fighting level.
- There were positive correlation between anxiety, PTSD, depression levels and factional fighting levels toward severe factional fighting. That means the study sample who have exposed to severe factional fighting had significantly greater levels of anxiety, PTSD, depression in relation to mild factional fighting.

6.3 Discussion

The most prevalent traumatic event due to Israel violence (Israel Violence) that affects the study sample was "Watching mutilated bodies in TV" 90.4%. The researcher hypothesized that these finding related to continuous browsing of martyrs and injured in the television by the media that attracted all ages to follow these events. Furthermore, the daily news exhibit different media that presented to the audience without monitoring. Also, this reflects the importance of the media and its affect on our community; since all of us listen and watch TV programs especially daily news. The second most traumatic events due to Israel violence that affect the study sample was "Hearing shelling of the area by artillery"(86.0%). The researcher hypothesized that these finding related to that artillery occurred suddenly and randomly and nobody knows what the consequences of such rights shelling.

The studies of Thabet et, al. (2007) and El Majdalawi, (2002) found that the most common traumatic events children reported was watching mutilated bodies and wounded people on TV 98.5%, 96.9% respectively. That appeared to be consistent with our current results.

The most prevalent traumatic events due to factional fighting (factional fighting) that affect study sample was "Hearing the shootings and bombardment due to fighting in the streets" (87.1%), then "Watching mutilated bodies in TV" (82.2%). That appeared to be consistent with the most prevalent traumatic events due to Israel violence (Israel Violence) with slight variations in order.

The prevalence of traumatic events due to Israel violence (Israel Violence)was: moderate (43.7%), severe (23.6%). While the prevalence of traumatic events due to factional fighting (factional fighting) was: moderate (47.5%). And severe (22.1%).

The prevalence of political and factional fighting (mild, moderate, severe) appeared to be consistent with each others.

The study found there were positive significant correlation between factional fighting and Israel Violence ($r = 0.787$, $p = 0.001$), which means the high incidence of Israel Violence will combined with high incidence of factional fighting. That appeared to be consistent with the previous result.

While the study of El Majdalawi, (2002) found 72.4% of study sample exposed to moderate trauma and 7.9% of the study sample exposed to severe trauma. That appeared to be inconsistent with the our current study result.

This study found that (17.0%) of the sample had severe political and factional fighting. In addition there were positive significant correlation between factional fighting and Israel Violence which means the high incidence of Israel Violence will combined with high incidence of factional fighting.

In agree of LeBlanc (2002) which revealed to positive correlation between family violence exposure neighborhood violence exposure.

The researcher sees that the adolescence who expose to Israel Violence are prone to expose to factional fighting. Palestinian people which live in the same circumstances and area which expose to the same levels of political as watching mutilated bodies in TV and factional fighting as Hearing the shootings and bombardment due to fighting in the streets.

The prevalence of anxiety was (20.8%). This prevalence appear to be consistent with the studies of Thabet and Vostains (1998) (21.5%) and Papageorgiou et al. (2000) (23.0%). But appear to be inconsistent with the studies of Thabet et al. (2007) (33.9%), Holtz (1998) (41.4%), and Scholte et al. (2004) (51.8%).

The prevalence of depression was (31.0%). This prevalence appear less than the studies of Alexander (2007) (35.0%), Eisenman et al, (2003) (36.0%), Scholte et al, (2004) (38.5%), Mollica et al. (1999) (39.2%), Elbedour et al, (2007) (40.0%), Papageorgiou et al, (2000) (47.0%), but more than the study of Roussos et al, (2005) (13.9%)

The prevalence of PTSD levels among study sample was: partial to full PTSD (35.3%).

This prevalence appear less than the studies of Silove et al. (1997) (37.0%), Thabet et al., (2000) (40.6%), Thabet et al. (1999), (41.0%), Qouta et al, (2003) (54%), Thabet et, al. (2007) (65.%), Michultka (1998) (68.0%), Elbedour et al, (2007) (68.9%), El Majdalawi, (2002) (71.2%), but more the studies of Eisenman et al, (2003) (18.0%), Scholte et al, (2004) (20.4%), Mollica et al. (1999) (26.3%), Papageorgiou et al, (2000) (28.0%).

The study found those who are suffering from anxiety have been exposed to severe Israel Violence by (30.5%) and severe factional fighting by (30.5). in addition there were positive significant correlation between anxiety and Israel Violence, also there were positive significant correlation between anxiety and factional fighting, which means the increase incidence of Israel Violence and factional fighting will lead to increasing of anxiety levels.

The previous results appeared to be consistent with the study of Punamäki and Suleiman (1990) that found exposure to political hardships increased children's psychological symptoms as general, also the study of Holtz (1998) which revealed that torture survivors had a statistically significant higher proportion of elevated anxiety scores than did the nontortured, while the study of Scholte et al, (2004) that found higher rates of symptoms were associated with higher numbers of traumas experienced.

The study found those who are suffering from depression have been exposed to severe Israel Violence by (30.3%), and severe factional fighting by (29.5%). In addition there were positive significant correlation between depression and Israel Violence , also there were

positive significant correlation between depression and factional fighting. which means the increase incidence of Israel Violence, and factional fighting will lead to increasing of depression levels.

The previous results appeared to be consistent with the study of Eisenman et al, (2003) that pointed to of those exposed to Israel Violence, (36%) had symptoms of depression. While the study of Scholte et al, (2004) found that higher rates of symptoms were associated with higher numbers of traumas experienced. Also Qouta et al, (2007) and Paxton et al, (2004) exposure to violence was significantly associated with depressive symptoms.

The study found those who are suffering from "partial PTSD to full PTSD" have been exposed to severe Israel Violence by (21.3%), (32.0%) consecutively. Also those who are suffering from "partial PTSD to full PTSD", have been exposed to severe factional fighting by (23.6%), (32.0%) consecutively. In addition there were positive significant correlation between PTSD and Israel Violence, also there were positive significant correlation between PTSD and factional fighting. which means the increase incidence of Israel Violence and factional fighting will lead to increasing of PTSD levels.

The previous results appeared to be consistent with the study of Bravo-Mehmedbasić et al. (2003) that indicated torture is the most intense form of trauma leading to intensive psychopathological responses including chronic PTSD. Also Paxton et al, (2004), Punamäki et al, (2001) and Thabet et al, (2002) found that exposure to violence was significantly associated with PTSD symptoms. While study of Michultka (1998) and Thabet et al. (1999) found that higher numbers of war experiences predicted PTSD severity. While Scholte et al, (2004) conclude as general that higher rates of symptoms were associated with higher numbers of traumas experienced. Also the study of Qouta et al,

(2007) indicated that adolescents' PTSD symptoms were most likely if they had been exposed to high levels of traumatic and stressful experiences.

The researcher belief that the increase political and factional fighting among the adolescence of the study sample will lead to feel disturbance and emotional unstable due to the conflict.

There were significant differences in factional fighting according to sex, in favor to males.

But there were no significant differences in Israel Violence according to sex.

The average mean indicated that males exposed to traumatic events due to factional fighting (factional fighting) more than females. The researcher attribute that for the social habits in our society that reflect the dominant male and who more exposed to different types of trauma; who shared in different types of aggression events, and violence. Even though there were no significant differences in Israel Violence according to sex , the average mean indicated that males exposed to traumatic events due to Israel violence (Israel Violence) more than females.

The previous result consistent with the study of Garbarino and Kostelny (1996) that found under conditions of high accumulated risk, boys evidenced more problems than girls.

The study found no significant differences between the means of Israel Violence levels and factional fighting levels according to the educational classes, type of residence, number of sibling, mothers education, fathers education, mothers work, and father work.

Researcher attributes this to the fact that exposure to violence, whether political or factional fighting does not change by previous demographic factors changing, furthermore exposure to violence does not change depending on the educational level of a adolescents, and the level of violence does not differ depending on the type of residence because the traumatic events whether political or factional fighting occurring in the anywhere. In addition, the

exposure to violence does not change depending on the number of adolescents' sibling, and does not differ depending on the educational level of the mother or the father, and does not varies according to the mother work or the father work.

The study found significant differences between the means of Israel Violence according to monthly income significant toward "less than 600 NIS". However, the results shown no significant differences between the means of factional fighting according to the monthly income.

Which revealed inverse correlation between Israel Violence and monthly income. The adolescence with low monthly income were had highest level of Israel Violence and the high monthly income were associated with lowest level of Israel Violence.

In agree with Thabet et, al. (2007) that revealed that Children coming from families with monthly income less than 271 \$ reported more traumatic events.

The study found significant differences in anxiety levels according to sex in favor to females. But there were no significant differences in PTSD and depression levels according to sex.

This result was consistence with the studies of Silove et al. (1997), Garbarino and Kostelny (1996), and Qouta et al, (2003) that found that anxiety scores were associated with female gender. While the study was inconsitence with Thabet et, al. (2007) that indicated to no gender differences in anxiety disorder.

The researcher sees that the female adolescents are more emotionally than males which lead to state of tension and anxiety among them, while the depression and PTSD were not affected by the role of sex. Which means the Palestinian people were use isolation of affect (self defense mechanism) against the political and factional fighting which inhibit the

incidence pathological cases of depression and PTSD , in other hand depression and PTSD were at the same levels among both sexes.

The study found significant differences between the means of anxiety, PTSD, and depression levels according to the educational classes (10th class, 11th class, and 12th class).

Which revealed positive correlation between anxiety, PTSD, and depression levels and educational classes toward 12th class. That means the study sample in 12th class had significantly greater levels of anxiety, PTSD, and depression than other lower classes.

This result is inconsistent with the study of Garbarino and Kostelny (1996) that revealed younger children exhibited more problems than older children.

Researcher sees that the greater the education class or age, whenever greater human interactions with the environment around it and traumatic events which increases the mental health problems

The study found significant differences between the means of anxiety levels according to type of residence (city, camp, village). However, the results show no significant differences between the means of PTSD and depression levels according to type of residence.

Which revealed positive correlation between anxiety levels and type of residence (city, camp, village) toward the group who live in camp. That means the study sample who live in camp had significantly greater levels of anxiety, than other two group which live in city and village.

This result inconsistency with the study of Quota (1992) that revealed the level of anxiety have increased among the citizens compared to camp refugee, re-settled refugees, and town Refugee.

The researcher sees that the camps and their high population density, the nature of the crowded housing, lack of services provided, and the diversity of their inhabitants as well as

being subjected to Israel Violence and communal violence, which constitutes an additional burden and traumatic events occurred that may lead to increasing the pressure and tension

There were no significant differences between the means of anxiety, PTSD, and depression levels according to number of siblings, mothers education, mothers work, and fathers work.

This result seem to be inconsistence with the study of Qouta et al, (2003) that found The child's gender and age, mother's education and PTSD symptoms were significant,

The study found significant differences between the means of anxiety levels, PTSD levels, and depression levels according to fathers education.

There were positive correlation between anxiety, PTSD, depression levels and fathers education toward the group who has primary education or less. That means the study sample who have primary education and less, had more anxiety, PTSD, and depression in relation to fathers who higher educational levels.

The researcher hypothesized that; it is well known that the mother used more affection and emotional interactions with their children in spite of the different levels of education have, while men used more than a way of upbringing that linked positively to the education levels. The greater the level of father education, would be better able to control their emotions and use healthy social rearing methods used

The study found significant differences between the means of anxiety levels, and depression levels according to monthly income. However, the results show that there were no significant differences between the means of PTSD levels according to monthly income.

There were inverse correlation between anxiety, depression levels and monthly income toward monthly income "601-1400" and less. That means the study sample who have monthly income "601-1400" and less had significantly greater levels of anxiety and

depression than the higher monthly income. Whoever there was no significant correlation between PTSD level and monthly income.

the Thabet et, al. (2007) that revealed that Children coming from families with monthly income less than 271 \$ reported more traumatic events.

Based on the previous two results the researcher hypothesized that lack of monthly income consider an integral part of the stressors that face family, and it consider a source of tension. In addition to their inability to meet the basic requirements of the family under difficult economic conditions, all of this may lead to frustration and depression.

There were positive correlation between anxiety, PTSD, depression levels and Israel Violence levels (mild, moderate, severe) toward severe Israel Violence. That means the study sample who have exposed to severe Israel Violence had significantly greater levels of anxiety, PTSD, depression in relation to mild Israel Violence.

There were positive correlation between anxiety, PTSD, depression levels and factional fighting levels (mild, moderate, severe) toward severe factional fighting. That means the study sample who have exposed to severe factional fighting had significantly greater levels of anxiety, PTSD, depression in relation to mild factional fighting.

This results are consistent with the studies of Rosenthal and Wilson (2003), Pearce et al, (2003) Momartin et al. (2003), Heptinstall et al, (2004), they revealed that exposure to factional fighting and psychological distress were related.

In the same vein the studies of Holtz (1998), Thabet et al. (1999), Papageorgiou et al.(2000), Bravo-Mehmedbasić et al. (2003), indicated to torture is the most intense form of trauma leading to intensive psychopathological responses including chronic PTSD.

While the studies of Punamäki and Suleiman (1990), Baker (1990), Qouta et al, (1995), Michultka (1998), Punamäki et al, (2001) El Majdalawi, (2002) Thabet et al. (2002), Silove

et al, (2002), Qouta et al, (2003), Scholte et al. (2004), Paxton et al, (2004), Benyamin and Solomon (2005), Thabet et, al. (2007), Qouta et al. (2007), they are concluded that exposure to political hardships increased children's psychological symptoms & higher rates of symptoms were associated with higher numbers of traumas experienced.

6.4 Recommendations

- Therapeutic programmes – including counseling for victims of violence or for those at risk, support groups, and behavioural therapy for depression and other psychiatric disorders.
- Family therapy programmes – these programmes are aimed at improving communications and interactions between family members, as well as teaching problem-solving skills to assist parents and children in confronting the various traumatic events.
- Home visitation programmes – these programmes include regular visits from a nurse or other health professional to the homes of families in special need of support and guidance. Interventions can include counselling, training and referrals to specialists or other agencies.
- Public education campaigns using the media to target entire communities or educational campaigns for specific settings such as schools, workplaces, and health care and other institutions.
- Extracurricular activities for young people, such as sports, drama, art and music.
- Training for police, health and education professionals, and employers to make them better able to identify and respond to the different types of violence.

- Community policing to create partnerships between police and a variety of groups at community level.
- Coordinated community interventions – involving many sectors and geared toward improving services and programmes.

6.5 Suggested research studies.

- Effects of self-directed violence on the mental health.
- Effects of interpersonal violence on mental health.
- Effects of collective violence on mental health.
- Identifying the risk and protective factors that link with the violence exposure.
- Factors that promote resilience or positive outcome after exposure to violent events should continue.

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Annex 1

Helsinki Approval Letter

Palestinian National Authority
Ministry of Health
Helsinki Committee



السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

Date: 5/3/2008

التاريخ: ٢٠٠٨ / ٣ / ٥

Name: Ahmed El-Kahlout

الاسم: أحمد الكحلوت

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

نفيدكم علماً بأن اللجنة قد ناقشت مقترن دراستكم حول:

Effects of community and political violence on mental health of adolescence in the Gaza Governorates.

In its meeting on _____ and decided the following :-

To approve the above mentioned research study

و ذلك في جلستها المنعقدة لشهر مارس ٢٠٠٨
قررت ما يلي :

الموافقة على البحث المذكور عاليه



Signature

التوقيع

Acting Chairperson



Conditions:-

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

Annex 2
Ministry of Higher Education Approval Letter

Palestinian National Authority
Ministry of Education & Higher Education
Deputy Minister Office



السلطة الوطنية الفلسطينية
وزارة التربية والتعليم العالي
مكتب الوكيل

الرقم : و ت غ / مذكرة داخلية ٢٤١
التاريخ : 2008/2/5

السادة / مديرى التربية والتعليم - محافظات غزة
حفظهم الله ،،،
السلام عليكم ورحمة الله وبركاته ٦٦٦

الموضوع : تسهيل مهمة بحث

يقوم الباحث / أحمد محمد الكھنوت ، والمسجل لدرجة الماجستير في الصحة العامة بجامعة القدس - أبو ديس، بعمل بحث بعنوان:

The Effect of Community and Political Violence on Mental Health of Adolescents in the Gaza Governorates

لامانع من قيام الباحث من تطبيق أدوات بحثه وهي: استبانة الحالة الاجتماعية والاقتصادية - استبانة العنف السياسي - استبانة الاقتتال الداخلي - مقياس القلق - مقياس كرب ما بعد الصدمة - مقياس الاكتئاب . CDI

وذلك على عينة عشوائية من طلبة الصفوف العاشر والحادي عشر والثاني عشر في المدارس الحكومية بمحافظات غزة، وذلك حسب الأصول .

ونتظر انتقال (الإجازة) ... سهلا

د. محمد أبو شقير
وكيل وزارة التربية والتعليم العالي



ر. ج. بـ
نسخة : الملف

Annex 3

Socio-economic status Questionnaire

عزيزي الطالب/ عزيزتي الطالبة:

يقوم الباحث بإعداد رسالة ماجستير في الصحة النفسية المجتمعية بعنوان "العنف الاجتماعي والسياسي وتأثيرهما على الصحة النفسية لدى المراهقين في محافظات غزة"، ويرجو الباحث منك أن تستجيب على فقرات الاستبيانة التالية بالكامل، علماً بأن جميع الإجابات صحيحة ما دامت تعبر عن وضعك ورأيك الشخصي، وأن البيانات التي ستم جمعها لن تستخدم إلا لأغراض البحث العلمي فقط:

أولاً: استبيان الحالة الاجتماعية الاقتصادية

1. العمر :

2. الصف : العاشر الحادي عشر الثاني عشر

3. الجنس : ذكر أنثى

4. مكان السكن : شمال غزة غرب غزة الوسطى

رفح مخانيونس

5. نوع السكن مدينة قرية مخيم

6. عدد الأخوة :

7. تعليم الأم :

إبتدائي ثانوي أمي
 دبلوم بعد الثانوية جامعي إعدادي

8. تعليم الأب :

إبتدائي ثانوي أمي
 دبلوم بعد الثانوية جامعي إعدادي

9. عمل الأم :

موظفة عاملة أخرى حدد

10. عمل الأب :

موظف صانع تاجر
 آخر حدد عامل

11. مقدار الدخل الشهري للأسرة:

أقل من 600 شيكل من 1401-2000 شيكل من 3001-2001 شيكل
 أكثر من 3000 شيكل

4Annex

Gaza Traumatic Events Checklist for Israelis Violence

ثانياً: مقياس الخبرات الصادمة بسبب الاحتلال:

أمامك مجموعة من البنود التي توضح أنواع الخبرات الصادمة (الأحداث المؤلمة) التي قد يتعرض لها أي إنسان في الظروف الصعبة مثل الاحتلال، والحروب، والاجتياحات المتكررة، والتي قد تشمل بعض ما تعرضت له خلال فترة الأربع عشر شهراً الماضية، نرجو أن تضع علامة (X) في الحانة الموجودة أمام السؤال:

الرقم	الحدث أو الخبرة الصادمة	نعم	لا
.1	سماعك لاستشهاد صديق لك		
.2	سماعك لاستشهاد أب أو أخ أو أخت أو قريب لك		
.3	سماعك للقصف المدفعي للمناطق المختلفة من قطاع غزة		
.4	سماعك لأصوات الطائرات الحربية عند اختراقها لجاوز الصوت		
.5	سماعك لاعتقال أو حطف أحد الأشخاص		
.6	مشاهدة استشهاد صديق لك أمامك		
.7	مشاهدة استشهاد أب أو أخ أو أخت أو قريب لك أمامك		
.8	مشاهدة إصابة صديق لك أمامك بالرصاص		
.9	مشاهدة إصابة أب أو أخ أو أخت أو قريب لك أمامك بالرصاص		
.10	مشاهدة اعتقال أو حطف أحد أمامك		
.11	مشاهدة بيتك وهو يهدم، ويدمر من القصف أو الحرافات		
.12	مشاهدة بيت جيرانكم وهو يهدم ، ويدمر من القصف أو الحرافات		
.13	مشاهدة بيوت الجيران وهي تقصف بالمدفعية الثقيلة والرشاشات، و الطائرات.		
.14	مشاهدة بيتك وهو يقصف بالمدفعية الثقيلة، والرشاشات، والشاشات، و الطائرات		
.15	مشاهدة صور الجرحى والأشلاء والشهداء في التلفزيون		
.16	مشاهدة عمليات الإغتيالات لرجال المقاومة من قبل الطائرات أو القصف المدفعي		
.17	مشاهدة الآثار الناتجة عن القصف المدفعي على قطاع غزة		
.18	تعرضك للإصابة الجسدية نتيجة لقصف متلك		
.19	تعرضك للاحتجاز في البيت		
.20	تعرضك للضرب والإهانة		
.21	تعرضك للحرمان من الماء والأكل والكهرباء		
.22	تعرضك أو تعرض عائلتك للتهديد بالتلفيفون لقصف بيتك وهدمه		
.23	تعرضك لإطلاق النار بقصد التخويف		
.24	تعرض إغراضك الشخصية للتدمير والتكسير والنهب		
.25	تعرضك للتهديد شخصياً بالقتل		
.26	تعرضك للتهديد بقتل أحد أفراد الأسرة		
.27	تعرضك للخطر الشديد باستخدام كدرع بشرى للقبض على جار لكم		
.28	تعرضك للحرمان من استخدام دورة المياه ومنعك من الخروج من الغرفة التي حجزت فيها		

5Annex

Gaza Traumatic Events Checklist for Factional War

ثالثاً: مقياس الخبرات الصادمة في غزة الناتجة عن الاقتتال الداخلي
 أمامك مجموعة من البنود التي توضح أنواع الخبرات الصادمة (الأحداث المؤلمة) التي قد يتعرض لها أي إنسان في الظروف الصعبة مثل الإحداث الأخيرة في قطاع غزة، والتي قد تشمل بعض ما تعرضت له خلال فترة السنة أشهر، نرجو أن تضع علامة (X) في الخانة الموجودة أمام السؤال :

الرقم	الحدث أو الخبرة الصادمة	نعم	لا
.01	سماعك لاستشهاد صديق لك نتيجة الاشتباكات في الإحداث الأخيرة في قطاع غزة		
.02	سماعك لاستشهاد أبو أخت أو أخي أو أخت أو قريب لك نتيجة الاشتباكات في الإحداث الأخيرة في قطاع غزة		
.03	سماعك للرصاص والقصف نتيجة الاشتباكات في الإحداث الأخيرة في قطاع غزة		
.04	سماعك لاعتقال أو حطف أحد الأشخاص		
.05	مشاهدة استشهاد صديق لك أمامك في الإحداث الأخيرة في قطاع غزة		
.06	مشاهدة استشهاد أبو أخت أو أخي أو أخت أو قريب لك أمامك		
.07	مشاهدة إصابة صديق لك أمامك بالرصاص		
.08	مشاهدة إصابة أبو أخت أو أخي أو أخت أو قريب لك أمامك بالرصاص		
.09	مشاهدة بيوت الجيران وهي تتعرض لإطلاق النار و القصف		
.10	مشاهدة بيتك وهو يتعرض لإطلاق النار و القصف		
.11	مشاهدة صور الجريحي والأشلاء والشهداء الناتج عن الاقتتال الداخلي		
.12	تعرضك للإصابة بشظية قبليه أو الرصاص		
.13	تعرضك للاحتجاز في البيت نتيجة الاشتباكات في الإحداث الأخيرة في قطاع غزة		
.14	تعرضك لإطلاق النار أثناء تبادل إطلاق النار العشوائي في المواجهات الناتجة عن الإحداث الأخيرة		
.15	تعرضك للضرب والإهانة في المواجهات نتيجة الاشتباكات في الإحداث الأخيرة في قطاع غزة		
.16	تعرضك للحرمان من الماء والأكل والكهرباء		
.17	تعرضك لأغراضك الشخصية للتدمير والتكسير والنهب		
.18	منعك من استخدام الحمام والخروج من الغرفة التي حجزت فيها		
.19	تمديدك شخصياً بالقتل		
.20	تمديدك بقتل أحد أفراد الأسرة		

Annex 6

The Revised Children's Manifest Anxiety Scale (RCMAS)

رابعاً: وفي هذا الجزء أرجو منك وضع علامة (X) تحت العمود مقابل كل عبارة بما يتفق مع رأيك:

لا	نعم	العبارات	م
		أشعر بأنني غير قادر على اتخاذ قرار	.01
		أشعر بالقلق عندما لا تسير الأمور كما أريد	.02
		الآخرين يعملا الحاجات بسهولة أكثر من بعض الأحيان أعلى من ضيق في التنفس	.03
		آنا فلقان معظم الوقت	.04
		أنا وأخاف من حاجات كثيرة	.05
		من السهولة إغضابي	.06
		أشعر بالقلق لما سيقوله لي والدي	.07
		بأحس بأن الآخرين لا يحبون الطريقة التي أفعل بها الأشياء اليومية.	.08
		أنا بأحد صعوبة في الذهاب للنوم في الليل	.09
		أنا بأقلق على الذي يفكرون الناس عني	.10
		آنا دائمًا أشعر بأنني وحيد عندما أكون مع الناس	.11
		أشعر عادة بوجع في المعدة	.12
		من السهل جرح مشاعري وإسلامي	.13
		أيدي بترق دائما	.14
		أنا دائمًا تعنان	.15
		أنا فلقان على بدوه يحصل في المستقبل	.16
		الأطفال الآخرين ميسقطين أكثر مني	.17
		أنا بأحلام أحالم مش كويسيه	.18
		من السهولة جرح مشاعري عندما أكون فلقان	.19
		أنا باشعر بان أحد ما سوف يخبرني بأنني أعمل الأشياء وبشكل غلط.	.20
		بأصحى من الترم مرعوب بعض الأحيان	.21
		أنا بأقلق عندما أذهب إلى فراشي للنوم	.22
		بأشعر بالقلق لما يعتقد الآخرين عنى	.23
		بأنململ في مقعدتي باستمرار	.24
		أنا فلقان وعصبي	.25
		بأحس بأن ناس كثير ضدي	.26
		أنا دائمًا فلقان على أشياء سيئة ممكن تحدث لي	.27
			.28

Annex 7

UCLA PTSD Index for DSM IV

عزيزي: أمامك مجموعة من الأسئلة التي تقيس ردود الفعل على الأحداث الصعبة في أوقات الاجتياحات والأغلاق، الاقتتال الداخلي في خلال الشهر الماضي التي قد يتعرض لها من هم في سنك. برجاء وضع دائرة حول الإجابة الصحيحة

خامساً: وفي هذا الجزء أرجو منك وضع علامة (X) تحت العمود مقابل كل عبارة بما يتفق مع رأيك:

الرقم	البنود	النوع	لا	قليلًا	أحياناً	كثيراً	غالباً
.01	أتربق دائمًا شيء خطير ممكِن يحدث أو أشياء أخرى أحاف منها						
.02	عندما يذكُري أحد بالحدث الذي واجهته ، أصاب بالقلق ، والتوتر، والحزن .						
.03	تتناهى أفكار ، أصوات ، صور ، لما حدث لي بدون رغبة مني في استرجاعها						
.04	أشعر بالغضب الشديد ، التهيج .						
.05	أعاني من أحلام مزعجة تتعلق بما تعرضت له .						
.06	أشعر بأن ما حدث لي سيحدث مرة أخرى الآن ، كما لو أنني أعيش في نفس الحدث مرة أخرى الآن						
.07	أحب أن أكون لوحدي وليس مع أصدقائي .						
.08	أحس بأنني وحيد ولست قريباً من أحد						
.09	أحاول بآلاً أتحدث ، أفكِر ، أشعر بما حدث لي .						
.10	أعاني من صعوبات في الشعور بالسعادة ، أو حب الآخرين .						
.11	أعاني من صعوبات في الشعور بالحزن والغضب .						
.12	أشعر بأنني أهيج بسرعة ، أو أتفزز بحد سطح صوت عالي ، أو أحد يفاجئني بسرعة						
.13	لدي صعوبة في الذهاب للنوم ، وأصحوا كثيراً في الليل.						
.14	أشعر بان ما حدث لي هو غلطني أنا .						
.15	لدي صعوبات في تذكر الأحداث التي تعرضت لها .						
.16	عندى صعوبة في التركيز والانتباه .						
.17	أتجنب الأشخاص ، الأماكن ، الأشياء التي تذكرني بالحدث الصادم						
.18	عندما يذكُري أحدهم بما حدث ، أشعر بمشاعر في جسمي ، وسرعة في ضربات القلب ، وجع في المعدة ، صداع .						
.19	أعتقد بأنني لن أعيش لفترة طويلة ، وسيكون عمري قصير .						
.20	أجادل كثيراً و أتعارك جسدياً مع الآخرين .						
.21	أشعر بالتشاؤم والسلبية تجاه مستقبلني .						
.22	أحاف من أن أشياء سيئة سوف تحدث لي .						

Annex 8

Child Depression Inventory (CDI)

سادساً: وفي هذا الجزء يوجد مجموعات من العبارات التي تصف المشاعر والأفكار بحيث تضم كل مجموعة ثلاثة عبارات وعليك أن تختار العبارة الأكثر وصفاً لحالتك من كل مجموعة في الأسبوعين الأخيرين، وذلك بوضع علامة (X) أمام العبارة:

<p>إنيأشعر بالحزن أحياناً.</p> <p>إنيأشعر بالحزن في أوقات كثيرة.</p> <p>إنيأشعر بالحزن طوال الوقت.</p>	<p>.01</p>
<p>كل ما يخصني لا يسير سيراً حسناً.</p> <p>أنا لست متأكداً من أن الأشياء والظروف تسير سيراً حسناً.</p> <p>الأشياء والظروف سوف تسير سيراً حسناً بالنسبة لي.</p>	<p>.02</p>
<p>أنا أعمل أغلب الأشياء بطريقة جيدة.</p> <p>أنا أعمل أشياء كثيرة بطريقة خطأ.</p> <p>أنا أعمل كل شيء بطريقة خطأ.</p>	<p>.03</p>
<p>توجد أشياء كثيرة تسلبني.</p> <p>بعض الأشياء وال حاجات تسلبني</p> <p>لا يوجد شيء يسلبني.</p>	<p>.04</p>
<p>في كل الأوقات أنا سيء.</p> <p>في أوقات كثيرة أكون سيئ.</p> <p>أحياناً أكون سيئ.</p>	<p>.05</p>
<p>أحياناً أفكرا في أشياء سيئة (غير مستحبة) تحدث لي.</p> <p>أنا فاق ومشغول من بعض الأشياء السيئة أو غير المستحبة تحدث لي.</p> <p>أنا متأكد من أشياء سيئة أو غير مستحبة سوف تحدث لي.</p>	<p>.06</p>
<p>أنا أكره نفسي.</p> <p>أنا لا أحب نفسي</p> <p>أنا أحب نفسي.</p>	<p>.07</p>
<p>كل الأشياء السيئة أو غير المستحبة تحدث بسببي أنا.</p> <p>كثير من الأشياء السيئة أو غير المستحبة تحدث بسببي أنا.</p> <p>لا تحدث الأشياء السيئة أو غير المستحبة دائمًا بسببي أنا.</p>	<p>.08</p>
<p>أنا لا أفكر في أن أقتل نفسي.</p> <p>أنا أفكر في قتل نفسي ولكن لن أفعل ذلك.</p> <p>أنا أريد أن أقتل نفسي.</p>	<p>.09</p>
<p>يومياً أشعر باني أريد أن أبكي.</p> <p>في أوقات كثيرة أشعر أني أريد أن أبكي.</p> <p>أحياناً أشعر أني أريد أن أبكي.</p>	<p>.10</p>
<p>توجد أشياء تصايفني دائمًا.</p> <p>توجد أشياء تصايفني أوقات كثيرة.</p> <p>توجد أشياء تصايفني أحياناً.</p>	<p>.11</p>
<p>أنا أحب أن أكون مع الناس.</p> <p>أنا لا أحب أن أكون مع الناس في أوقات كثيرة.</p> <p>أنا لا أريد أن أكون مع الناس أبداً.</p>	<p>.12</p>
<p>أنا لا استطيع أن أقرر أو أحدد رأيي في الأشياء.</p> <p>من الصعب علي أن أقرر أو أحدد رأيي في الأشياء.</p> <p>أنا أقرر أو أحدد رأيي في الأشياء بسهولة.</p>	<p>.13</p>
<p>أنا شكلي حسن.</p> <p>يوجد بعض الأشياء في شكلي غير حسنة.</p>	<p>.14</p>

أنا شكاي غير حسن.		
يجب علي أن أدفع نفسي طوال الوقت حتى أكمل واجبات المدرسة. يجب علي أن أدفع نفسي أكثر من مرة حتى أكمل واجبات المدرسة. وواجبات المدرسة ليست مشكلة كبيرة بالنسبة لي.		15
كل ليلة يصعب علي النوم. في ليالي كثيرة يصعب علي النوم. أنا أنام جيدا.		16
أشعر أحياناً أني مجهد أو متعب. أشعر في أوقات كثيرة أني مجهد أو متعب. أشعر طوال الوقت بالإجهاد أو التعب.		17
في أغلى الأيام لا تكون لدي شهية للطعام. في أيام كثيرة لا تكون لدي شهية للطعام. أنا أكل بطريقة جيدة.		18
أنا غير قلق من أي آلام أو أوجاع. في مرات كثيرة أكون فلماً من بعض الآلام والأوجاع. طوال الوقت أكون فلماً من الآلام والأوجاع.		19
أنا لا أشعر بالوحدة. في أوقات كثيرة أشعر بالوحدة. طوال الوقت أشعر بالوحدة.		20
لم أشعر بالمتعة في المدرسة أبداً. أحياناً أشعر بالمتعة في المدرسة. في أوقات كثيرة أشعر بالمتعة في المدرسة.		21
لدي أصدقاء كثيرون. لدي بعض الأصدقاء ولكن أتمنى أن يكون لدي أصدقاء أكثر. أنا ليس لدي صديق واحد.		22
عملي-شغلي-المدرسي جيد. عملي المدرسي ليس جيداً كما كان من قبل. عملي المدرسي سيئ جداً في مواد كنت دائماً جيد فيها.		23
أنا لا يمكن أن أكون جيداً مثل باقي زملائي. لو أردت فإني أستطيع أن أكون جيداً مثل باقي زملائي. أنا جيد مثل باقي زملائي.		24
في الحقيقة لا أحد يحبني. أنا لست متأكداً من أن أحد يحبني. أنا متأكد من أن بعض الأشخاص يحبونني.		25
أنا عادة أعمل ما يطلب مني. في أغليبية الأوقات أنا لا أعمل ما يطلب مني. طوال عمري لم أعمل ما يطلب مني.		26
أنا أنسجم مع الناس. في أوقات كثيرة أجد نفسي متورطاً في مشاجرات. طوال الوقت أنا أنورط في مشاجرات.		27

Annexes 9

DSM-IV diagnostic criteria for major depressive episode (American Psychiatric Association, 1994):

- A. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either depressed mood or loss of interest or pleasure. Note: Do not include symptoms that are clearly due to a general medical condition or to mood-incongruent delusions or hallucinations.
 - 1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (eg, feels sad or empty) or observation made by others (e.g, appears tearful). Note: In children and adolescents, can be irritable mood.
 - 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
 - 3. Significant weight loss when not dieting or weight gain (e.g, a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
 - 4. Insomnia or hypersomnia nearly every day.
 - 5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
 - 6. Fatigue or loss of energy nearly every day.
 - 7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
 - 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
 - 9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- B. The symptoms do not meet criteria for a mixed episode.
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to the direct physiologic effects of a substance (eg, a drug of abuse, a medication) or a general medical condition (eg, hypothyroidism).
- E. The symptoms are not better accounted for by bereavement (ie, after the loss of a loved one, the symptoms persist for longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation).

Annexes 10

DSM-IV-TR Diagnostic Criteria for Posttraumatic Stress Disorder :

- A. The person has been exposed to a traumatic event in which both of the following were present:
 - 1. the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 - 2. the person's response involved intense fear, helplessness, or horror.
- B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
 - 1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
 - 2. recurrent distressing dreams of the event.
 - 3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).
 - 4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
 - 5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
 - 1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - 2. efforts to avoid activities, places, or people that arouse recollections of the trauma
 - 3. inability to recall an important aspect of the trauma
 - 4. markedly diminished interest or participation in significant activities
 - 5. feeling of detachment or estrangement from others
 - 6. restricted range of affect (e.g., unable to have loving feelings)
 - 7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
 - 1. difficulty falling or staying asleep
 - 2. irritability or outbursts of anger
 - 3. difficulty concentrating
 - 4. hypervigilance
 - 5. exaggerated startle response
- E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Annexes 11

DSM-IV-TR Diagnostic Criteria for Generalized Anxiety Disorder:

Generalized anxiety disorder, according to DSM-IV-TR, is characterized by a pattern of frequent, persistent worry and anxiety that is out of proportion to the impact of the event or circumstance that is the focus of the worry. The distinction between generalized anxiety disorder and normal anxiety is emphasized by the use of the words "excessive" and "difficult to control" in the criteria and by the specification that the symptoms cause significant impairment or distress (**American Psychiatric Association, 2000**):

- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
- B. The person finds it difficult to control the worry.
- C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months).
 - 1. restlessness or feeling keyed up or on edge
 - 2. being easily fatigued
 - 3. difficulty concentrating or mind going blank
 - 4. irritability
 - 5. muscle tension
 - 6. sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
- D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a panic attack (as in panic disorder), being embarrassed in public (as in social phobia), being contaminated (as in obsessive-compulsive disorder), being away from home or close relatives (as in separation anxiety disorder), gaining weight (as in anorexia nervosa), having multiple physical complaints (as in somatization disorder), or having a serious illness (as in hypochondriasis), and the anxiety and worry do not occur exclusively during posttraumatic stress disorder.
- E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder.