وزارة الصحة

كلية الصحة العامة
School of Public Health
القدس- فلسطين

جامعة القدس

Deanship of Graduates Studies

Al-Quds University

The Impact of Parenting Support on Post Traumatic Stress Disorder Among Palestinian Children in Gaza Strip

Submitted by

Ibrahim Hassan Hashem Abu-Nada

Master Thesis

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The Impact of Parenting Support on Post Traumatic Stress Disorder Among Palestinian Children in Gaza Strip

A thesis

Submitted in Partial Fulfillment of the Requirements for the Degree of Master in Community Mental Health

Through
Al-Quds University

By

Ibrahim Hassan Abu-Nada

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Submitted:

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CMH

Deanship of Graduates Studies

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Al-Quds University

September 2003

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 .....

Ibrahim Hassan Abu Nada

Date:

Dedication

In the memory of my parents, whom their souls give me the courage for improvement and antecedence

and to the memory of all martyrs of

Palestine and Al - Aqsa Intifada

Acknowled

Acknowledgment

I would like to express my acknowledgment and sincere gratitude to those who helped me in putting this essay into practice.

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Abstract

When the children are exposed to traumatic events they might develop a lot of physical and psychological symptoms that need immediate intervention in order to prevent further adverse consequences of the traumatic events, the first and the immediate useful intervention can play an important role is the parenting support to their traumatized children. The overall aim of this study is to assess the impact of parenting support on post-traumatic stress disorder among Palestinian children in the Gaza strip. Descriptive cross-sectional study was carried out on a sample of 450 Palestinian children aged from 12 - 16 years (Primary school) living in Gaza Strip were assessed during the second scholar trimester using structured self-report questionnaire for the possible types of traumatic event, questionnaire for possible post traumatic stress disorder symptoms, and questionnaire for perceiving parenting support. The results indicated that, the Palestinian children are exposed to different types of war traumatic events, (girls 22.7%, boys 12.6%), many of them are vulnerable to develop post traumatic stress disorders reactions, (girls 41.1%, boys 36.8%), parenting support is very vital and important factor to be provided by the parents to their traumatized children at the time of traumatic events. These may highlight the problem as a public in nature that need community–based intervention programs integrated to school health and health education programs. Also these results are similar to those identified by other studies regionally and worldwide.

ملخص الدراسة

هدفت هذه الدراسة إلي اختبار مدى تأثير التدعيم الوالدى على ظهور أعراض ما بعد التعرض للخبرة الصادمة علي طلاب وطالبات المرحلة الإعدادية في قطاع غزة.

الأهداف الخاصة :

- دراسة أهم الخبرات الصادمة التي يتعرض لها الأطفال
- دراسة تأثير الصدمة علي الأطفال
- دراسة الأعراض التي تظهر على الأطفال بعد تعرضهم للإحداث الصادمة
- دراسة العلاقة بين الصدمة و أعراض ما بعد الخبرة الصادمة
- دراسة العلاقة بين التدعيم الوالدى للأطفال وأثره علي ظهور أعراض ما بعد الخبرة الصادمة

منهجية الدراسة :

هذه الدراسة هي دراسة وصفية تحليلية درست تلاميذ المرحلة الإعدادية بصورة مقطعية

عينة الدراسة:

تكونت العينة النهائية من 434 طالب وطالبة تم اختيارهم بصورة عشوائية متعددة المراحل من ستة مدارس إعدادية موزعة علي ثلاث مناطق من قطاع غزة وهى بيت حانون، م.جباليا ، الرمال.

كيفية جمع المعلومات :

جمعت المعلومات بطريقة مباشرة من الطلاب بواسطة إستبانة تم تصميمها لجمع المعلومات الاجتماعية والشخصية ولقد تم فحص صدق وثبات الاستبانة من الناحية العلمية والعملية من قبل محكمين بالإضافة إلي تطبيقها علي عينة أولية.

النتائج :

أظهرت الدراسة أن الأطفال يتعرضون إلي العديد من أنواع الخبرات الصادمة (22.7 % بنات ، 12.6 % أولاد) وأن الكثير منهم يطورون أعراض ما بعد الخبرة الصادمة (41.1% بنات ، 36.6% أولاد) ، كما أظهرت وبشكل إيجابي أن التدعيم الوالدى يقلل من ظهور أعراض ما بعد الخبرة الصادمة.

التوصيات :

- من أهم التوصيات التي خرجت بها هذه الدراسة ما يلي:
- تشجيع الوالدين بأن يهتموا بأبنائهم أثناء وبعد التعرض للإحداث الصادمة
- أن يشجع الوالدين الأبناء لتفريغ مشاعرهم وعدم كبتها
- التركيز علي توعية الوالدين وتعريفهم بالاضطرابات النفسية والأعراض النفسية
- العمل علي زيادة التوعية والتثقيف المجتمعي
- فتح المجال أمام الاهتمام لمعالجة الحالات التي طورت أعراض ما بعد الخبرة الصادمة
- زيارة أماكن الأحداث للتدخل في الأزمات والحد من عدد الإصابات بالإضرابات النفسية
- تكثيف العمل بين المؤسسات الطبية والمختصة والعمل معا من خلال برامج موحدة لمساعدة المتضررين

توصيات بحثية :

- القيام بدراسة لمعرفة مدى إمكانية تقديم تدعيم والدى بواسطة والدين تعرضوا لخبرات صادمة
- القيام بمسح شامل لتحديد مدى انتشار اضطراب ما بعد الخبرة الصادمة
- القيام بدراسة مستوى التحصيل الدراسي لدى الأطفال الذين يعانون من خبرات صادمة
- القيام بدراسة متابعة التغيرات والآثار الناجمة عن التعرض لخبرات صادمة لدى الأطفال

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List of abbreviations

PTSD	Post traumatic stress disorder
DSM – III – R	Diagnostic and Statistical Manual of Mental Disorders, (third edition).
DSM - IV	Diagnostic and Statistical Manual of Mental Disorders, (Forth edition).
GTEC	Gaza Traumatic Events Checklist
CPTSD -RI	Child Post Traumatic Stress Disorder Reactions Index
PPS	Perceiving Parenting Scale
ICD 10	International Classification of Diseases, 10^{th} revision.(WHO)
PCBS	Palestinian Central Bureau of Statistics
NGO	Non governmental organization
UNRWA	United Nation Relief and Work Agency
WHO	World Health Organization
SPSS	Statistical Package for Social Sciences
SD	Stander deviations
P	Level of statistical significance
R	In correlation coefficient (Spearman and Pearson tests)
T	Value of t – test

like sleep disturbances, lack of academic achievement, behavioral disturbances, anxiety, depression, and most importantly of post-traumatic stress disorder reactions (Thabet et al, 2000).

Parents are considered the figure of protection, power, source of safety and security to the children. Mental health professionals exhibited more concern about developmental risk factors for children victims of political violence and war. Family and parent-child attachment considered an important factor in providing a protective shield for children's psychological well being in dangerous conditions (Freud & Burlingham, 1943; Garbaino et al, 1991).

However, can parents fulfill their protecting role if violence and war negatively affect both themselves and their children?

Al - Aqsa Intifada (2000), is manifested by some notable differences in comparison with the first intifada (1987), the manifestation of the current intifada includes; eruption of the intifada after the assignment of Oslo peace treaty between the PLO and Israeli government, excessive military measures were used by Israelis. The Israelis used high technology aircraft and helicopters to bombard Palestinian military headquarters, workshops, and homes.

Parents and their children were exposed to the same traumatic events, stressful situations and under the death threatening. However, most of the fathers in this intifada are unemployed, which makes them unable to provide the main basic human needs for their children, (PCBs, 2001). The mothers are also under extreme distress, and in spite of all that distress they have the moral responsibility to provide a shelter for their traumatized children.

Local and international researcher published a huge number of research studies focusing on the post - traumatic stress disorder as a reaction to the political violence, and the importance of parenting support and caring of their children during the stressful situation and traumatic events. In the Palestinian case, it is evident that both parents themselves are exposed to the same traumatic experience as well as their children.

In this study, it was hypothesized that; fathers are using more strict discipline methods of rearing and control, especially with boys; and mothers show more warmth and affection, especially for girls. Certain traumatic events such as loss, injury, arrest, or humiliation of family member is associated with children's perception of their mothers and fathers parenting support, this perception might by positive in certain situation and some times negative in other situations.

Parent – child relationship

Parent – child relationship, is considered very important source in providing a protective shield for children's psychological well – being in dangerous situations, perceived parental behavior emerged as an important factor in mediating children's stress responses, those whose parents manifested positive emotions toward them, and who enjoyed good parental communication employed more activity – focused and effective coping methods (Bat – Zion & Levy – Shif, 1993). One of the important mediating factors that have been focused on was, the displacement of the family from its community and supporting network (Kuterovac et al, 1994), and socio economic adversity, particularly among refugees (Hodes, 1998).

The transgeneration impact of Holocaust trauma on survivors' children provides further information about traumatic experiences and parenting. Last (1989) showed that, mothers and fathers parenting attitudes towards their sons and daughters varied according to the severity of their Holocaust experiences. The more the fathers had been exposed to traumatic events, the more their sons perceived them as lacking in nurturing attitude, in positive affectionate involvement and in paternal control. On the other hand, the more mothers had been exposed to traumatic events, the less the boys perceived them as using harsh control, parents are the closest objects to the children and have direct physical contact with them, the parent intervention and support might decrease the symptoms of post - traumatic stress disorder reactions, (Quota et al,1995).

1.2 Justification of the study

Post - traumatic stress disorder (PTSD), is one of the psychiatric disorders developed as reaction of the individual victims that exposed to traumatic events regardless of the victim's age group or gender. Exposure to traumatic events has been well established as a cause of post - traumatic stress disorder and other type of psychopathology among children and adults.

From our practical experience in the community mental health clinics we have notes that, children are developed different of physical and psychological reactions after exposure to traumatic events, these symptoms wasn't known before the exposure to the traumatic events, and are specific for PTSD that indicated their affection, e.g. re-experiencing symptoms, avoidance symptoms, hyperarouasl, and hypervigilance symptoms. The parents came to the clinic very confused and worry about these new

changes in there children behaviours they asked many questions about the ways of intervention in order to overcome these reactions and symptoms, we believed that these symptoms might be decline or reduced if the child perceived support from his surrounding environment especially their parents. So we have decided to study this phenomena in order to detect the prevalence of post traumatic stress disorder and does the parenting support play a major part in decreasing the symptoms of post traumatic stress disorder among the traumatized Palestinian children.

1.3 Study purpose

The purpose of this study is to assess the impact of parenting support on post - traumatic stress disorder among Palestinian children living in the Gaza Strip and to find the best possible positive effective parenting behaviors and attitudes that parents need to practice with their traumatized children.

1.4 General objective

To study the impact of parenting support on post - traumatic stress disorder among Palestinian children in the Gaza strip.

1.5 Specific objectives

1- To study the prevalence of post traumatic stress disorder\

2- To study the effects of trauma on children.

3- To study the association between parenting support and post - traumatic stress disorder on children.

4 -. To detect the most common traumatic events experienced by the children.

5 - To study the relationship between trauma and post - traumatic stress disorder among children.

1.6 Research questions

The study addresses the following questions.

1 - What are the types of the traumatic event experienced by the children?

2 – What are the levels of traumatic events the children have exposed to?

3 – What is the relationship between exposure to traumatic events and the demographical residency?

4 – What are the most common post traumatic stress disorders reactions expressed by the children?

5 – What is the relationship between parenting support and demographical data (place of residency, age, sex).

6 - What is the relationship between the parenting supports and parental education and occupational statues

7 – what is the relationship between parenting support and traumatic events and post traumatic stress disorder reactions?

8 – What is the prevalence of post traumatic stress disorders?

9 – What is the relationship between the post traumatic stress disorder reactions and demographical area of residency?

1.7 Background

In this chapter, we review the socioeconomic and demographic characteristics of the Gaza Strip, the population characteristics such as; population density, crude birth rate, fertility rate, and sex ratio will be also mentioned. Further more this chapter will focus on the existing psychological well-being of children.

1.8 Geographical and demographic background

1.8.1 Geographic background

Palestine was a part of the original homeland of human being and the land of Palestine witnessed the evolution of the main monotheistic religion, and many ancient civilizations. Palestine had also a central role in the ancient international trades across the history. This important role was earned by its important geographical situation between the three continents Asia, Africa, and Europe, (Safi 1995).

Palestine is situated on the Eastern Mediterranean cost between the longitudinal 34 15 and 35 40 to the east of Grenache. The latitudes is 29 30 and 33 15 to the north of the equator, it has a long cost on Mediterranean Sea (224Km). To the east it shares borders with Jordan and Syria, to north with Lebanon, and to the south with Egypt (Saleh, HA 1985).

In 1948 the state of Israel was established on the cost of the Arab lands. Israel controlled 78% of Palestine leaving 22% of its land for Palestinians.

In 1967 Israel occupied the remaining 22% of the Palestinian territories. In 1993 a peace accord was signed between PLO and the Israeli government leaving the civil control of the Palestinian people on the hands of the Palestinian National Authority.

1.8.2 The Gaza Strip

The Gaza Strips is part of the historical Palestine, and constitute part of the Palestinian National Authority Territories; it is a narrow area of land, 46km in length, and 5-12 km in width, with an area of 362km2. Egypt borders it on the south; Israel borders it on north and east, and by the Mediterranean Sea on west, Gaza Strip has a subtropical climate, with distinct seasons, the area is flat and sandy,(altitude 0 - 40 meters). The average rainfall is 150 - 350mm per year. (MoH 1999).

The Gaza Strip has five administrative governorates, which are, Rafah governorates, Khan-Yunis governorates, Central governate, Gaza city governorates, Northern governorate. Gaza Strip is consisted of 5 cities, 7 villages, and 8 refuge camps.

1.8.3 Population

Since the war of 1948, and the establishment of Israel State, many hundreds of thousands of people were uprooted from their homeland and become refugees. Some of them are living in the Diaspora and others are living in refugee camps in the West Bank and Gaza Strip, uprooting classified the Palestinian population into three categories, urban population, rural population, and refugee population. Thirty eight percent of the Palestinian population resides in urban areas. Large segments of the population in Gaza are refugees, more than two thirds of the population in Gaza is composed of registered refugees, as compared to one third in the West Bank.

Gaza general populations are (1,196,59,1) 52% are children under 18 years – old (MoH, 2001).

There are eight refugee camps in the Gaza Strip; very high numbers of people are living within a small area. A case in point is Jabalia Camp in Gaza a registered refugee population of nearly 96,000 populations living in an area of 4 square km, (El - Telbani, 1999).

Jabalia camp is located in the northern region of the Gaza strip (Northern Governate). The Majority of Jabalia male people are simple workers in Israel; fewer minorities are employees in the governmental, non-governmental institution, and UNRWA.

Jabalia camp was the flame of the first intifada when it is started in 1987, were hundred of people were killed, injured and detained. (El - Telbani, N, 1999).

The houses of the camp are build of Asbest and recently the people started to rebuild their homes by Batons, the streets of the camp are paved.

During the Al Aqsa Intifada Jabalia camp was exposed to repeated night incursions, invasions by Israeli army forces, which leads to killing of many civilian, and injury of many others, a number of houses and workshops were demolished or destroyed.

Bet - Hanon; is located also in the northern resign of Gaza strip (northern governate). The general number of population of Bet Hanon village is about 20,791(PCBs, 1997).

During the period of the Israeli occupation it was consider as a village, but after the coming of the Palestinian National Authority it was considered as a city. Bet Hanon is famous by farmers, citrus garden. Their streets are not paved. Water, electricity, and sewage system supply bet Hanon. The majority of the residences are depending on agriculture, but the minorities are working as worker in Israel or employee in the governmental and non-governmental institutions.

During Al Aqsa intifada Bet Hanon was exposed to repeated Israeli aggressions, incursions and invasions for several times, many people were killed, many are injured and many are detained. Hundred mails of hectares were bulldozing by the Israeli army forces. (Al Mezan center for human rights, 2002).

Al - Remal region; is located in Gaza City (Gaza governate), it is subdivided into three parts, (West, north and south Remal). The majority of the people are working as employee in governmental and non- - governmental institutions. It is consider modernized place in comparison with other places in Gaza. There streets are paved, water, electricity, sewage system are supply El - Remal area.

During Al Aqsa intifada Al - Remal city was exposed to several day and night raids by aircraft and helicopters to destroy military headquarters, homes, workshops, and to make targeting assassination of activists.

Chapter 2

Literature Review

2.1 Introduction

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

Since the beginning of the Al Aqsa Intifada, children have been exposed to various traumatic events, often reported by media across the world, particular events experienced e.g. bombardment of homes and military quarters, shooting, killing, arresting. How can parents fulfill their protecting role if violence and war traumatic events are negatively affects both parents themselves and their traumatized children?

2.2 Definition of stress

The term stress is used in a number of quite different ways. Thus it can used to describe unpleasant situations or events, which are considered to be stressfully. Alternatively, it may be used to describe the behavioral and physiological responses, which occur when an individual is confronted by an unpleasant situation or stressor. Selye, (1965).

2.2.1 Stress as response

Selye, (1965 - 1974), who viewed stress as the organism's response to environment demands. He maintained the stress response is an inherent mechanism, which occurs whenever demands are placed on the organism.

Selye described a three - stage process to as General Adaptive Syndrome, (GAS), which is a general physiological reaction to all forms of stress, followed by a resistance stage, which represent a functional recovery to a level superior to the pre - stress state, and final stage is exhaustion.

2.2.2 Stress as a stimulus

A stimulus-based approach to stress is concerned with identification of aspects of the environment, which have an adverse effect on the individual, (Cohen, 1979).

2.2.3 Stress as a perceived threat

This type of stress is combined both, stimulus and response elements .The best-known proponent of this approach is Lazarus (1976,1980,1984, &1999). Who maintains that stress occurs when there are demands on an individual that he or she cannot cope with or adjust to, thus stress is not associated with a specific stimulus or specific response, but rather arises when individuals perceives and evaluate situation as threatening.

2.3 Definition of trauma

There has been a recent intensification of interest in finding what constitutes a traumatic experience during childhood (Terr 1984; Eth and Pynoos 1985).

Many definitions have been given to the types of traumatic events that adults and children are exposed to and which may result in posttraumatic stress disorder.

Freud 1967; S Freud, 1920; Furman 1986), also Freud, (1910) suggests that "hysterical symptoms" are the remnant and the meaning symbols of certain traumatic experience.

(Frederick, 1977) defined disasters as "any hurricane, tornado, storms, and flood, high wind drives water, tidal snow storm and any other catastrophes.

Trauma can be defined as a sudden, dangerous, uncontrollable, and irregular event. Such as stimulus may result in behavioral or emotional reactions, which may become prolonged (Rachman, 1980).

A widely agreed definition of trauma refers to an external event that is intense, sudden, and that overwhelming the child's capacity to cope or master the trauma at the time (A. James (1989) defined trauma as " an emotional shock that creates substantial, lasting damage to an individual's psychological development, its overwhelming, uncontrollable experiences that psychologically impact victims by creating in them feeling of helplessness, vulnerability, loss of safety, and loss of control (James, 1989).

The American psychiatric Association (APA, 1994), has defined trauma as an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. If an individual has experienced, witnessed, or been confronted with such events, his responses may include intense fear, helplessness, or

horror. In children, this may be expressed instead through disorganized or agitated behaviours (DSM – IV, 1994).

2.4 Post traumatic stress disorder(PTSD)

The American Psychiatric Association (APA), was influenced by Horowitz (1975, 1976, 1979) work on the phenomenology of trauma - related reactions. Posttraumatic stress disorders was recognized by DSM III (APA, 1980), as collection of symptoms such as intrusive re - experiencing of the trauma, avoidant behaviors and increased physiological arousal. These criteria were revised in subsequent edition of the classification (DSM - III - R: APA, 1987; DSM - IV; APA, 1994) (Annex 5).

Internationally, the international classification of diseases (ICD), had recognized two reactions stress; an acute reaction to stress, which was transient, lasting only a few hours or days; and an adjustment reaction, which lasted slightly longer, in the tenth revision of ICD in (1992).

World health organization (WHO), defined post - traumatic stress disorder along similar lines to the American DSM, albeit placing slightly different emphases on some of the symptoms.

Post - traumatic stress disorder develops in persons who have experienced emotional or physical stress that would be extremely traumatic for virtually any person such traumas include combat experience, natural catastrophes, assault rape, and disasters such as building firs. (Thabet,1996).

Definitions of post - traumatic stress disorder according to (DSM - IV),

Is an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone? PTSD was introduced to DSM - IV as result of the description of this syndrome in veterans of the Vietnam War.

Other old names of PTSD were known as "solder hearts" shell shock.

PTSD was seen in World War II in the survivors of the united state atomic bombing of Japan.

2.4.1 History of post traumatic stress disorder in children

Post traumatic stress disorder, (PTSD), is a psychiatric disorder that can occur following the experience or witnessing, exposed to, life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged, and these symptoms can be severe enough and last long enough to significantly impair the person's daily life. (Berliner,1997).

PTSD is complicated by the fact that it frequently is co - morbid with other disorders such as depression, substance abuse, anxiety, and other problems of physical and mental health.(Kulka et al, 1990) Post traumatic stress disorder is also associated with impairment of the person's ability to function in social or family life, including occupational instability, marital problems and divorces, family discord, and difficulties in parenting.

Post traumatic stress disorder is not a new disorder, there are written accounts of similar symptoms that go back to ancient times, and there is clear documentation in the

historical medical literature. PTSD-like disorder was known as "Da Costa's Syndrome." There are particularly good descriptions of posttraumatic stress symptoms in the medical literature on combat veterans of World War II and on Holocaust survivors.

Careful research and documentation of post – traumatic stress disorder began in earnest after the Vietnam War.

Post traumatic stress disorder (PTSD) has subsequently been observed in all veteran populations that have been studied, including World War II, Korean conflict, and Persian Gulf populations, and in United Nations peacekeeping forces deployed to other war zones around the world. There are remarkably similar findings of post – traumatic stress disorder, in military veterans in other countries. For example, Australian Vietnam veterans experience many of the same symptoms that American Vietnam veteran's experience.

Post traumatic stress disorder, is not only a problem for veterans, however. Although there are unique cultural- and gender-based aspects of the disorder, it occurs in men and women, adults and children, Western and non-Western cultural groups, and all socioeconomic strata. A national study of American civilians conducted in 1995 estimated that the lifetime prevalence of post – traumatic stress disorder (PTSD) was 5% in men and 10% in women.(Ithinte,1996).

2.4.2 Development of PTSD

Most people who are exposed to a traumatic, stressful event experience some of the symptoms of post traumatic stress disorder, in the days and weeks following exposure. Available data suggest that about 8% of men and 20% of women go on to develop post traumatic stress disorder, and roughly 30% of these individuals develop a chronic form that persists throughout their lifetimes. (Erickson et al, 1999).

2.4.3 People at risk

When an individual is exposed to life threatening traumatic event or circumstances that is out of his usual range, he become victims of this events and might develop psychological problems that might cause change in his life, those individuals could be;

1. Those who experience greater stressor magnitude and intensity, unpredictability, uncontrollability, sexual (as opposed to nonsexual) victimization, real or perceived responsibility, and betrayal

2. Those with prior vulnerability factors such as genetics, early age of onset and longer-lasting childhood trauma, lack of functional social support, and concurrent stressful life events

3. Those who report greater perceived threat or danger, suffering, upset, terror, and horror or fear

4. Those with a social environment that produces shame, guilt, stigmatization, or self-hatred

2.4.4 Consequences of PTSD

PTSD is associated with a number of distinctive neurobiological and physiological and biological changes. PTSD may be associated with stable neurobiological alterations in both the central and autonomic nervous systems, such as altered brainwave activity, decreased volume of the hippocampus, and abnormal activation of the amygdalate. Both the hippocampus and the amygdalate are involved in the processing and integration of memory. The amygdalate has also been found to be involved in coordinating the body's fear response. (Almqvist et al,1999).

Psycho physiological alterations associated with PTSD include hyper-arousal of the sympathetic nervous system, increased sensitivity of the startle reflex, and sleep abnormalities.

People with PTSD tend to have abnormal levels of key hormones involved in the body's response to stress. Thyroid function also seems to be enhanced in people with PTSD. Some studies have shown that cortical levels in those with PTSD are lower than normal and epinephrine and nor epinephrine levels are higher than normal. People with PTSD also continue to produce higher than normal levels of natural opiates after the trauma has passed. An important finding is that the neurohormonal changes seen in PTSD are distinct from, and actually opposite to, those seen in major depression. The distinctive profile associated with PTSD is also seen in individuals who have both PTSD and depression, (Sack et al, 1993).

2.4.5 Categorizing of PTSD

After the exposure to unusual traumatic event, the reactions of post traumatic stress disorder are started to arise on the victim, it is manifested by four main groups of behaviours and attitude that are expressed by the victims.

These groups of symptoms are

1 - Re- experiencing symptoms

2 - A voidance symptoms

3 - Hyperarousal symptoms

4 - Associated features

2.4.6 Reexperiencing symptoms

Here, the traumatic event remains a dominating psychological experience that evokes panic, terror, grief, or despair which manifested in daytime fantasies, traumatic nightmares, and psychotic reenactments known as PTSD flashbacks which is uncommon in children (Friedman, 1996). These flashbacks are so strong that the individual thinks that he or she is actually experiencing the trauma again. When a person has a severe flashback, he or she is in a dissociative state (APA, 1997). When this occurs, the individual may actually start to act out the incident as if he or she was experiencing the traumatic event again.

2.4.7 Avoidance symptoms

Avoidance symptoms are characterized by emotional constriction or numbing -- a need to avoid feelings, thoughts, and situations reminiscent of the trauma, a loss of normal emotional responses, or both (Long, 1997). These symptoms reflect the behavioral, cognitive, and emotional strategies used by PTSD patients in attempt to reduce their psychological response to the traumatic stimuli (Friedman, 1996).

Patients try to avoid all situations that might serve as stimuli for the traumatic event. When taken to the extreme, this may superficially resemble agoraphobia because the PTSD patient is afraid to leave the house for fear of confronting reminders of the traumatic event (Friedman, 1996). Dissociation and psychogenic amnesia are included among avoidant/numbing symptoms by which individuals cut off conscious experience of trauma based memories and feelings

Because PTSD patients cannot tolerate string emotions of any kind, they perceive only the cognitive aspects of psychological experience and not the emotional aspects. This "psychic numbing" acts as an emotional anesthesia and makes meaningful interpersonal relationships extremely difficult (Friedman, 1996; Long, 1997).

2.4.8 Hyperarousal symptoms

Individuals with PTSD often act as though they were constantly threatened by the trauma that caused their illness (Long, 1997). These symptoms most closely resemble those seen in panic and generalized anxiety disorder (Friedman, 1996). Although some symptoms such as insomnia and irritability are generic anxiety symptoms,

hypervigilance and startle are more unique. The hypervigilance in PTSD may sometimes become so intense that it appears to simply be paranoia. The startle reaction of PTSD patients also has neurobiological implications for more on the neurobiological causation of PTSD.

2.4.9 Associated features

The person with PTSD may attempt to rid themselves of painful flashbacks, loneliness, and panic attacks by abusing alcohol and other drugs. These serve the purpose of blunting the patient's emotions and helping them to forget their trauma. Related, a PTSD patient may also show poor control over his or her impulses, increasing the risk of suicide (APA,1997).

2.5 Middle East studies

The Middle East is considered one of the most troubled areas in the world; it was and stills an area of war and conflict.

In a very interesting studies of the Middle East, on 2220 Lebanese children found that on average, a Lebanese child has experienced five to sex different types of war related traumatic events during his or her life, and some events were experienced several times. Exposure to shelling or combat, displacement, extreme poverty and witnessing violent acts were the most common traumatic experience faced by Lebanese children. In contrast, involvement in military activities, being a victim of violent acts, and suffering from serious physical injuries were less common experience. In addition, the number and types of traumatic experiences varied significantly by age, gender, socioeconomic status and region of residence (Maksoud, 1992).

In another study in Lebanon, (Maksoud, Lawrence, 1992). In study of 224 Lebanese children found that, the number and type of children's war trauma varied meaningfully in number and type by their age, gender, father's occupational status, and mother's educational level. The number of war trauma were experienced by a child was positively related to PTSD symptom's and various types of war traumas were differentially related to PTSD, mental health symptoms, and adaptation outcomes. For example, children who were exposed to multiple war, were bereaved, became victims of violent acts, witnessed violent acts, and were exposed to shelling or combat exhibited more PTSD symptoms. Children who were separated from parents reported more depressive symptoms and children who experience bereavement and were not displaced reported more painful behavior. Lastly, children who were separated from parents and who witnessed violent acts reported more proscoial behavior.

In Palestinian study (Thabet et al 1999) in his study of 234palestinian children found that, the rate of children who reported moderate to severe PTSD reactions at follow-up had decreased from 40.6% (N=102) to 10.0% (N=74). 49 children (20.9%), were rated above the cut-off for mental health problems on the Rutter A2 (parent) Scales, and 74 children (31.8%) were above the cut-off on the Rutter B2 (teacher) Scales. The total scores on all three measures had significantly decreased during the one-year period. The total CPTS-RI score at follow-up was best predicted by the number of traumatic experiences recalled at the first assessment.

But in interesting study conducted in Palestine by Thabet et al, (2002). On 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 - report measures of post traumatic stress, anxiety and fears, he found that, significantly more children exposed to bombardment and home demolition reported symptoms of PTSD and fear than controls group, by contrast, children exposed to other events, mainly through the media and adults, reported more anticipatory anxiety and cognitive expression of distress than children who were directly exposed.

In one of the studies of the Middle East, 2o Kurdish children aged 6 – 16 years were assessed. Four (20%) fulfilled PTSD criteria according to DSM III – R, but these subsided at follow – up (Ahmed, 1992). The same researcher assessed a different sample of 45 Kurdish children of Anfal families, five years after the uprising operation and relocation in two camps in North of Iraq. Eighty seven percent 87% of children reported PTSD (Ahmed et al, 2000). Children's trauma scores were positively correlated with posttraumatic stress disorder.

The first Gulf War between Iraq and Iran led to great loss in human and properties in both sides. A large number of families fled from both countries to find save place for themselves and their children. Those children who exposed to organized violence during war and persecution, which put them at risk of developing chronic PTSD.

The second Gulf war affected a large number of children especially Kuwaiti children, who experienced a large number of traumatic events ranging from witnessing killing of others to being hurt themselves, Nader et al (1993) assessed Kuwaiti children following the Gulf crisis, and found that 70% reported moderate to sever PTSD reactions. In anther sample of Kuwaiti children and adolescent after the Iraqi invasion,

prevalence rates were 48.1% for mild 40.6% for moderate, and 11.4% for sever or very sever posttraumatic stress disorder (Abdin et al, 1994).

In Palestinian studies, (Qouta et al,1995). In study of 108 Palestinian children found that, exposure to political traumatic experiences increases children's psychological suffering, neuroticism and increases children's active participation in national struggle. But this activity does not save children from suffering from psychological symptoms when the exposure to traumas is overwhelming.

In another significant study for, Garbarino et al (1996), in his study of 150 Palestinian children and their mothers living in cities and villages in the West Bank, he founds that; boys were more vulnerable to risks than girls. Moreover, boys were especially susceptible to multiple risks. Older children were better able to use cognitive processes to seek resources outside the family and to find refuge and take action than younger children. Further more, older children were more likely to have had a longer period of normal times before facing the extended crisis of political violence.

2.6 International studies of children escaping armed conflict

Croatia and Bosnia were areas of ethnic cleansing; findings have arisen from a number of studies following the war in Croatia and Bosnia. In 1992, Bosnian Serb and Serbian forces launched a campaign of ethnic cleansing against Muslim and Croat civilians in Bosnian – Herzegovina. Military and paramilitary forces, along with local unit, attack non – Serbs in their homes, thought villages and cities across Bosnia. In a study of Bosnian adolescents, posttraumatic stress disorder reactions were weakly

children's perception of negative stressful

present in 19%, moderately present in 52.4%and severely in 28.6% of the adolescent (Ajdukovic, 1998).

In study Orla, (2003), of 160 children 8- year- old of Northern Ireland found that, children's perception of negative stressful events related to the political conflict in northern Ireland showed that over times 1 and 2 girls perceived three events as considerably more stressful than boys also the children's perception of stressful events are related to a host of social factors. Personal, social and situational factors differently determine children perception of negative life experiences.

In another study of children from Bosnian – Herzegovina, Smith et al (2001), estimated that up to 58% were likely cases, with psychiatric disturbances at 18-22%. During the 1994 siege in Sarajevo, children were assessed, 41% of who had clinically significant PTSD reactions (Allwood et al, 2002).

Orlee, et al,(2000). In study of 217 children found that, developing PTSD following the disaster was significantly associated with being female. With pre- disaster factors of learning and psychological difficulties in the child and violence at the home, severity of exposure to the disasters, survivors subjectively appraisal of the experience, adjustment in the early post disaster period, and life events and social support subsequently, when all these factors were considered together, measures of the degree of exposure to the disaster and of subjective appraisal of life threat, those survivors who developed PTSD, its duration and severity were best predicted not by objective and subjective disasters – related factors, but by pre-disaster vulnerability factors of social, physical, and psychological difficulties in childhood.

Derek, et al (2000) in study on 216 teenagers had survived a shipping disaster and 87 young people as matched controls were interviewed found that, the survivors showed raised rates of diagnosis in a range of anxiety and affective disorders during the follow-up period. The highest rates were among the survivors who had developed post traumatic stress disorder, and those survivors who had not were generally similar to the controls. Onset of anxiety and affective disorders varied between being indefinitely close to the disaster to years later. Differences in rates of disorder between the survivor and control groups had lessened by the time of follow-up but were still apparent, due to continuing distress among the survivors still suffering from PTSD, and to a lesser extent among those who had recovered from PTSD.

Paul, L. (2000). In his survey sample on 31 Bosnian refugee children in 1996 at the International Clinic of Boston Medical Center found that, only one family expressed interest in psychosocial services of any kind. Large numbers of Bosnian refugees are likely to have experienced traumatic war violence and are at risk of behavioral symptoms. The Refugee Health Assessment (RHA), affords opportunities to screen for behavioral problems but not to intervene. Primary care providers and other clinicians should be aware of likely recurrences of symptoms in high-risk children.

In study conducted in Russia, Vladislav, (1998), in study of 156 subjects, (42%) fulfilled partial criteria and 87 (25%) fulfilled full DSM-IV criteria for post traumatic stress disorder. They found that, Russian juvenile delinquents represent a severely traumatized population, mainly due to high levels of violence exposure. Those with full post traumatic stress disorder are the most severely traumatized and have highest rates of psychopathology, as compared to those with no or partial PTSD, and they

require the most clinical attention and rehabilitation. Both exposures to violence and levels of post traumatic stress are related to personality traits, which influence degree of exposure and individual perception of stress. The latter should be considered in individualized approaches to rehabilitation.

In a useful study, Betty et al, (1999) in the study of 3,218 students found that more than 40% of the students reported knowing someone injured and more than one-third reported knowing someone killed in the blast. Post traumatic stress symptoms at 7 weeks significantly correlated with gender, exposure through knowing someone injured or killed, and bomb-related television viewing.

Pfefferbaum, (1999). Found that, PTSD has been described in children exposed to a variety of traumatic experience1s.Partial symptomatology and co-morbidity are common. A variety of factors influence response to trauma and affect recovery. They include characteristics of the stressor and exposure to it; individual factors such as gender, age and developmental level, and psychiatric history; family characteristics; and cultural factors. Since the condition is likely to occur after disaster situations, much of the literature describes the child's response to disaster and interventions tend to include efforts within schools and/or communities. A number of clinical approaches have been used to treat the condition. While assessment has been studied extensively, the longitudinal courses of PTSD and treatment effectiveness have not been biological correlates of the condition also warrant greater attention.

In another study of Pfefferbaum, et al (1999) of 3,220 students found that, more than one third of the sample knew someone killed in the explosion. Bereaved youths were more likely than non bereaved peers to report immediate symptoms of arousal and

fear, changes in their home and school environment, and posttraumatic stress symptoms.

Retrospective measures of initial arousal and fear predicted posttraumatic stress symptoms at 7 weeks. The results support the literature addressing the role of initial response in post - traumatic stress symptom development. The study raises concern about the impact of television, and traumatized youths' reactivity to it.

But, Paul, et al, (1999) in study of one 170 children confirmed that, 39, (22.9%) fulfilled the DSM-IV criteria for PTSD. There were significant differences between children with and without PTSD on each individual component of the screening battery. Various criteria for caseness were evaluated and at 6 weeks post trauma the screen identified up to 90% of children diagnosed with PTSD and 73% with borderline conditions. A sample of 36 children was re - assessed 8 months post trauma and all children with persistent PTSD were correctly identified by initial screen scores.

In another Bosnian study, Richard et al,(1997). In a study of 364 Bosnian Children found that, the children were exposed to virtually all of the surveyed war-related experiences. The majority had faced separations from family, bereavement, close contact with war and combat, and extreme deprivation. The prevalence and severity of experiences were not significantly related to a child's gender, wealth, or age, but were related to their region of residence, with children from the region of Sarajevo having the highest prevalence of experiences. Almost 94% of the children met Diagnostic and Statistical Manual of Mental Disorders, 4th ed., criteria for posttraumatic stress disorder. 90.6% and 95.5% of the children reported significant life activity affecting sadness and anxiety,

2.7.1c Authoritative parents

They are both demanding and responsive. "They monitor and impart clear standards for their children's conduct. They are assertive, but not intrusive and restrictive. Their disciplinary methods are supportive, rather than punitive. They want their children to be assertive as well as socially responsible, and self-regulated as well as cooperative" (Baumrind, 1991, p. 62).

2.7.1d Uninvolved parents

They are low in both responsiveness and demandingness in extreme cases; this parenting style might encompass rejecting–neglecting and neglectful parents, although most parents of this type fall within the normal range.

2.8 Parental mental health and child mental health

This special relationship between the child and his parents includes the continuous parenting supply of love, kind, protection, and help. These are very important roles for the child during his early years, without it the society will not possess well and healthy individuals.

The effects of family relation on the child life started as early as possible between the child and his mother, then it develops to include the father and the rest of the family members (sibling), this relation go forward with the child till his adolescence, then it diminished when the child become well matured,(Alsaied, 1979).

2.8.1 Parenting issues

The parenting treatment methods in side the families are differing. Some Parents adopt the reciprocal dialogue with their child, respecting his opinion, listening to him, encouraging him to express his feelings, so he grew up with traits of independence, and self-confidence. Other families are adopting the authoritative styles, which lead to personality disturbances and loss of self-confidence, the impaired and inconstant dealing with the children will produce disturbed children (Winner, 1994). There are two main aspects are controlling the relationship between the parents and their children, firstly, firstly, aspects are concern the children them selves, and secondly, aspects are concern the parents them selves and they are

1 - Either parents or one of them considers the parenthood as a burden they cannot stand in front or tolerate.

2 - One or both parents see the child as source of attention and carefulness.

3 - Some parents are proud that they parents and have family and children, but in contrary some parents look to the parent hood and the family as an obstacle to be active out side the home and to be socially active.(Fahmi, 1996).

The parents are affected by their child hood owns experience with their parents and they are reflecting this experience in their dealing with their children, but other parents are their children avoiding the bad experience that they have perceived during the period of childhood. (Fahmi, 1994).

Some mothers provide a lot of kindness toward their children when they are feels bereaved from parenting kindness. Also those bereaved mothers from her husband kindness provide a lot of her kindness toward her male son, (Fahmi, 1994).

The fathers whom are grew up in miserable situation, introverted, submissive, usually tries to express this bereaved life during his childhood period by different means of aggression, offensiveness, and authoritarian style in his work or family surrounding. (Fahmi, 1994).

We note that parenting depends on multi conscious and unconscious factors, like their instinct, cultural background, self - experience, the marital status.

The parenting emotional growth and psychological stability are consider the main factors in dealing with their children and not only their educational level or cultural background consider enough to deals with children.(Rajih,1970).

2.8.2 children Issues

No doubt that, children are affected and infected by their surrounding environment.

The children are playing an active role in growing their parents as the parent's role in growing their children (Renold, 1968).

1 - The child himself: the nervous child imposes nervous behavior on his parents, and the quite child imposes the quietness on his parent's behavior.

2 - The child influencing his parents to adopt certain style in dealing with him, e.g. the passive quietness of the child might push the parents to create energizing means in order to aware him, in contrast, the hyperactive child might push his parents to look for inhabitant means.

3 - The reaction of the child toward his parent styles might support the same style to be practiced or to be stopped. e.g. the smile of the child as a reaction to certain behavior might encourage the parent to repeat the same behavior, but the shouting and crying might make the parents to stoop that behavior (Hussein, 1987).

4 - Some parenting might be influenced by the birth order of the child, his gender, age, individual characteristics, personality trait (Nader, 1994).

In study Jenni. et al, (2003), of 527 mothers and fathers found that, parental mental health problems can compromise a mother's and father's parenting abilities and represent a threat to their children adjustment. The different types of parental mental – health problems initiate specific paths between parental and child mental – health problems. Also the results suggest that, opposite – sex parenting is important to children's adjustment during the years of early adolescence.

But, Bifulco et al, (2002), in study of 276 mothers – offspring pairs found that, offspring of vulnerable mothers had a fourfold higher rate of early disorder than those in the comparison series. They were twice as likely as those in the comparison series to have experienced childhood adversity comprising either sever neglect, physical or social abuse before age 17.physical abuse, in particular, perpetrated either by mother or father/ surrogate father was significantly raised in the vulnerable group.

In different study, Debra et al, (2001), in a study of 850 twin families, aged 8-17 years had found that, Parental depression is not comorbid or associated with a different spousal disorder is associated with a significantly elevated level of depression and overanxious disorder symptoms and a significantly increased risk for overanxious disorder. While, parental alcoholism that is not comorbid or associated with a maternal

quality of partner's relationship with the child. The pattern of associations between the adult's life course experiences meant that children were at risk for a double dose of less affectionate relationship in families in which parents had experienced early adversities.

Murphy et al, (1997), in study of 583 UK students and US found that, three-factors (care, denial of psychological autonomy and encouragement of behavioural freedom) solution was found to be more satisfactory than a two-factor solution. Using the three-factor solution, group differences that were not apparent with the two-factor solution were identified and it was found that the parenting behaviours associated with depression could be more accurately identified.

Martha (1998), in study on 105 mothers of different socioeconomic strata in Hermosill, found that, demographic variables affected both family dysfunction and harsh parenting in different ways. These exogenous variables had an indirect influence on child punishment selecting punitive behavior via the promotion of family dysfunction and/or the mother's authoritarian parenting style. Given the emphasis in the field on family dysfunction as a risk factor for maltreatment - especially substance use and marital violence - we were surprised to discover that family dysfunction did not directly predict the mother's harsh parenting. The problems of the adults were clearly related to the mother's adoption of corporal punishment, but only through the mediating construct of her general authoritarian parenting style.

Also he found that, the lower the occupational status of the father the higher the dysfunction in the family. The higher status the father's occupation, the harsher the mother's parenting, less educated mothers relied more often on authoritarian parenting.

The relationship between education and parenting style expressed the importance of information, training, and knowledge on the development of a positive parental disposition toward children and their education. On the other hand, maternal occupation had no significant effect on parenting style.

But, David, (1999), in study of 1025 New Zealand children, found that, there are consistent tendencies for increasing maternal age to be associated with declining risks of educational underachievement, juvenile crime, substance misuse, and mental health problems. Children with teenage mothers had risks of later adverse outcomes that were higher than the risks for offspring of mothers aged over 30. Subsequent analyses revealed that, the associations between maternal ages, later educations and psychosocial outcomes, were large, but not wholly, that explained by associations between maternal age, the child-rearing practices and home environments experienced by children. In general, increasing maternal age tended to be associated with more nurturing, supportive, and stable home environments. In turn, these linkages between maternal and childhood environment explained most of the association between maternal age and later outcomes.

Were, Ann (2000), in his sample study on 8,441 member of the National Child Development Study found that, A childhood experience of single parenthood and an experience of care predicted adult psychological distress in men but not in women, restructured parenting was not a risk factor for maladjustment at age 16. Rather, a childhood experience of care or social disadvantage was significantly related to psychosocial problems at age 16. Psychological distress at age 33 was associated with maladjustment at age 16. A childhood experience of care was associated with a

tendency to adult psychological distress in men, as was growing up with a single parent.

In one of the fruitful study, Jennifer,(2000), in study on 56 undergraduate's students found that 92%of students with authoritative parenting style are securely attached that only attachment styles predictor intimacy patterns.

Those students who were securely attached to their parent scored significantly higher on test of personal intimacy. 70% of those participants with an authoritative parenting style were securely attachment while only 12.5% of those with an authoritarian parenting style were securely attached and 0%of those with a permissive parenting style were securely attached.

But, Deborah (2000), in study of 50 children from intact families found that the high level of maternal acceptance during adolescence forecasted lower level of early adult internalizing problems, additionally, higher level of maternal firm control during adolescence were associated with more secure early adult romantic attachment and, surprisingly, lower level of educational achievement. There were no main effects for fathers, but parental -parenting behavior interacted with maternal parenting behavior to predict two early adult outcomes. The most secure attachment in early adulthood was associated with higher level of both parental firm control and maternal acceptance.

Helen, (2000), in study of 134 Australian parents found that parental generativity was related to father's societal generativity, but not to mothers. However, particular child care activity that promoted children social -- emotional developments were related to

the fathers societal generativity, wears activities that promoted children's academic -- intellectual development were related to mother's societal generativity.

Lisa, et al, (2000), in a sample of 50 adolescent--mother dyads had found that, depressed adolescents have difficulty shifting out of depressive states is consistent with the preliminary findings in adult samples. Difficulty in transitioning from bouts of depressive and aggressive affect may be a significant risk for ongoing depression because of the adverse impact of negative affects on one's ability to constructively engage in conflict resolution or interpersonal problem solving. In turn, poorer conflict resolution and problem solving may lead to continued interpersonal difficulties, resulting in an ongoing risk for depressive disorder.

Kender et al (1997), in his study of 828 twin families found that, parenting bonding instrument (PBI), yielded three factors: warmth (W), protectiveness (P) and authoritarianism (A). W was most strongly predicted by parental personality and psychopathology, parental marital quality, and child temperament. P and A were both most strongly predicted by parental educational level and religious fundamentalism. In addition, P was predicted by neurotic/anxious traits in both parent and child. For a number of variables that predicted W, the strength of the association was stronger when twins were reporting than when parents were reporting.

Lichtnstein (1998), in study of 97 mothers as earned secure, continuous secure, and insecure, found that, home observations of parenting and maternal self-reports of daily stress measure were obtained, Planned comparisons revealed that the diathesis-stress incoherent present state of mind model most accurately predicted parenting. Thus, under high stress, the earned secures parented equivalently to the continuous secures

and more positively than the insecure, under low stress no group differences were obtained. These findings indicate that in a normative sample earned secures break the intergenerational cycle and exhibit resilient parenting even under high stress conditions.

But in another study findings, Seiffge et al, (1998), in study of 198 adolescents and their mothers and fathers participated in a 4-year longitudinal study, found that, mothers and fathers showed high agreement, especially about their daughters, whereas parents and adolescents showed little agreement. Agreement was higher for internalizing than for externalizing behaviors. In general, adolescents reported more symptomatology than their parents did. However, mothers' ratings of their children's behaviours were significantly correlated with adolescents' self-ratings, but fathers' ratings were not. Statistical tests of correlations showed that mothers experiencing stress caused by marital problems perceived more problem behaviours in their children. Fathers' perceptions were relatively unaffected by personal adjustment. However, poor marital adjustment perceived by both parents showed a significant negative relation to adolescent externalizing problem behaviour.

In another study, Laura (1998), in study of 107 students found that, identity development did serve as a mediating, or protective factor between poverty and adjustment. While poverty was not directly associated with negative psychological outcomes, it was negatively associated with identity, which in turn was clearly linked to well-being and adjustment while perceived parental treatment was not related to economic hardship; it was clearly associated with psychological well-being in this

sample. Maintaining a supportive relationship with parents remains important for adolescents in this environment. While both factors were influential in predicting psychological adjustment, they were associated in different ways. Perceived parental treatment was not affected by the contextual variable of economic hardship.

Jolanda et al, (1998), in study of 137 families referred to out patient mental health services found that, both the mother–child and the mother–father relationship were related to child problem behaviours. However, whereas the mother–child relationship was consistently more related to externalizing behaviour, the mother–father relationship was particularly related to internalizing behaviour also the findings suggested that, a protective influence of the parent–child relationship having one or two positive parent–child relationships was associated with less problem behaviour.

Linda (1999), in his study sample of 45 bereaved families with children aged 2 to 16 have found that parentally bereaved children and surviving parents showed higher than expected levels of psychiatric difficulties. Boys were more affected than girls, and bereaved mothers had more mental health difficulties than bereaved fathers. Levels of psychiatric disturbance in children were higher when parents showed probable psychiatric disorder. Service provision related to the age of the children and the manner of parental death. Children under 5 years of age were less likely to be offered services than older children were even though their parents desired it. Children were significantly more likely to be offered services when the parent had committed suicide or when the death was expected. Children least likely to receive service support were those who were not in touch with services before parental death.

Service provision was not significantly related to parental wishes or to level of psychiatric disturbance in parents or children. There is a role for general practitioners and primary care workers in identifying psychologically distressed surviving parents whose children may be psychiatric disturbed, and referring them to appropriate services.

Howard, (2001). In study of 419 female care givers found that the group of mothers (sample) reported more depression, more frequents use of harsh parenting practice and more child internalizing and externalizing behavior problems than those who were not victimized, Also the study found that women who had experienced both child and adult abuse suffered more maternal health ill - effects than women abused as child or as an adult.

2.9 Parenting and PTSD

The domestic violence and family loose has its adverse effects on the family structure and existence; it can lead to family breakdown, loss of support networks, and other adversities, the following studies are focused on the parenting role and the PTSD.

Maureen, (2002), in study samples of children, living in Sarajevo during the Bosnian war, found that, times of war, both violent and nonviolent trauma may have grave effects on children's adjustment. They found that political actions such as embargoes (e.g., withholding fuel and food) might be as harmful to children as exposure to military violence. He also found that in light of limited resources during times of war, children might be best served by efforts to reduce the compounded effects of multiple traumas. For example, reducing exposure to indirect violence, such as graphic media

coverage of war atrocities, and providing comfort from fears of starvation and freezing, may be functionally as helpful to children's adjustment as reducing their direct exposure to violence.

Tytti, (2002), in study sample of A normal population consist of 990 twelve-year-old Finnish children and their mothers' (843) and fathers (573) was used. He found those children in the Active empathy and indifference groups experienced more positive parenting. Discrepancies in family members' perceptions of child distress and mothering and fathering were especially characteristic of the emotional over involvement group. Typical for the avoidance group was a within-family agreement on poor parenting and severe child distress. Children's response patterns as regards parental low mood are related to family dynamics. The study suggests that discrepancies in parents and children's perceptions of parenting and child distress can be meaningful in understanding family interactions and child development and well being.

Laor et al, (2001), in study of 81 Israeli families and their children after the SCUD missiels attack found that, there was a significant decrease in severity in most symptom domains and an increase in avoidant symptoms in the children. Greater severity of symptoms was associated with being displaced, living in a family with inadequate cohesion, and having a mother with poor psychological functioning. The association between the symptoms of children and mothers was stronger among the younger children. Posttraumatic symptoms increased in one-third of the children and decreased in one-third over the last 30 months of the study. Severe post - traumatic symptoms were reported in 8% of the children. Despite a continuous decrease in

symptom severity, risk factors identified shortly after the Gulf War continued to exert their influence on children 5 years after the traumatic exposure

In another study, Johnson et al (2001), in a study of 593 biological parents found that maladaptive parental behavior substantially mediated a significant association between parental and offspring psychiatric symptoms. Parents with psychiatric disorders had higher levels of maladaptive behavior in the household than did parents without psychiatric disorders. Maladaptive parental behavior, in turn, was associated with increased offspring risk for psychiatric disorders during adolescence and early adulthood. Most of the youths that experienced high levels of maladaptive parental behavior during childhood had psychiatric disorders during adolescence or early adulthood, whether or not their parents had psychiatric disorders. In contrast, the offspring of parents with psychiatric disorders were not at increased risk for psychiatric disorders unless there was a history of maladaptive parental behavior. Maladaptive parental behavior is associated with increased risk for the development of psychiatric disorders among the offspring of parents with and without psychiatric disorders. Maladaptive parental behavior appears to be an important mediator of the association between parental and offspring psychiatric symptoms.

Daniel (2001), in another study of 484 adolescents had found that, dangerously violent adolescents reported higher levels of exposure to violence and victimization than did matched controls. Dangerously violent females were more likely to score in the clinical range of depression, anxiety, posttraumatic stress, anger, and dissociation than were control females and violent males; they also had significantly higher levels of suicide potential. Students who have been known to commit violent acts should be

adequately assessed for violence exposure and symptoms of psychological trauma, with special attention given to the suicide potential of violent females.

Erin et al (2001), in study sample of 816 fifteen-year-old children, found that, maternal anxiety disorder significantly predicted the presence of anxiety disorders in children; the association between paternal anxiety disorder and child anxiety disorder was not significant. There was no evidence that perceived parenting played a mediating role in the association between mother and child anxiety disorders. These results replicate earlier studies' findings of elevated rates of anxiety disorders among the offspring of anxious parents, but only when the child's mother is the anxious parent.

In pioneer study conducted in Palestine; Thabet et al, (2001). In study of 286 Palestinian children aged 9 - 18 years old and their mothers in the Gaza strip, had found that; the number of traumatic events experienced by children during Al – Aqsa Intifada was 4 furthermore boys were significantly more exposed to high traumas than girls, the most common type of traumatic event was seeing victims picture on television. Also he found that mothers with mental health problems were mothers of children with PTSD.

Laura, (2000), in study of 337 School-age children found that children from violent households were no more likely to report an extra familial traumatic stressor than children from nonviolent homes. Among the children reporting a traumatic event, 24.6% met the diagnostic criteria for PTSD. Both type I and type II trauma can result in PTSD in about one quarter of children. Children with posttraumatic stress symptoms

had many other forms of co -morbid psychopathology, indicating a global and diffuse impact of trauma on children.

In a study conducted in Palestine, Punmaki et al (1997), in study of 108 Palestinian children found that, the more the children were exposed to traumatic events the more they perceived both their parents as strictly disciplining, rejecting &hostile and their mother as treating them more negatively than the girls did. Affectionate parenting, such as intimacy and love was not associated with traumatic events; traumatic events increased perceived parenting rejection and hostility only among the boys and perceived strict disciplining among the girls.

But in another results on the same sample Punmaki et al (1997), in study of 108

Palestinian children found that, the exposure to traumatic events increased psychological adjustment problems in children of 11 - 12 years of age via two mediating paths, first the more the traumatic events children had experienced the more negative parenting they experienced and poorer they perceived parenting, the more they suffered from high neuroticism and low self esteem, secondly, the more traumatic events children had exposed, the more political activity they showed, and the more active they were, the more they suffered from psychological adjustment problems .Good perceived parenting protected children psychological adjustment by making them less vulnerable in two ways, First, traumatic events decrease the children intellectual, creativity, cognitive resources, and loss of resources predicted many psychological adjustment problems in model of excluding perceived parenting, Secondly, political activity increase psychological adjustment in the same model, but not in the model including good parent.

Judith (1992), in study of 248 young adults and children found that, certain parenting style are transmitted across generating and intervening in personality and drug use domain can increase the likhood, that parents will form close attachment relationship with their own children.

2.10 Conclusion

From the previous mentioned studies we can conclude that, the traumatic events are different from one country to another, where, some countries are exposed to civil war actions, natural disasters, domestic violence, also the time of the traumatic events is different from country to an other, where in certain places the traumatic events might finish within few days or week, but in other places the traumatic events might be ongoing and continues for years as the case of Palestine. But in each situation the individuals who become victims to the traumatic events usually develop different psychological problems mainly post traumatic stress disorder reactions, the previous studies also focused on the psychological problems developed by the victims and arises very important results which indicated the real adverse consequences that the victims experienced during and after their exposure to traumatic events.

When his family and his community support the traumatized children, his capability to cope with and to overcome his psychological problems became highly significant, mainly when the parents provide well parenting support to their traumatized children.

As indicated above, some of the findings are conflicting, and most of the relevant studies undertaken to date are methodologically compromised in various ways, e.g.

through the selection of small and non-representative samples, and the use of non-standardized measurers (Malmquist, 1986; Stuber et al, 1991; Michele, 1995; Ahmed et al, 2000).

Most of the epidemiological studies do not address the underlying mechanisms, i.e. the interaction between, and environmental risk factors such as parental response or mental illness, developmental and child – related factors such as cognitive appraisal of the event and coping strategies, and how this lead to the development and maintenance of psychopathology.

Several studies have, investigated the roles of family or peer relation, school factors, social factors, and indicate a multifactor etiology for PTSD (Yehuda & Mcfarlance, 1995; Berliner, 1997).

It is very interesting to know more about the impact of parenting support on children, and how it decrease the symptoms of Post traumatic stress disorder, noting that in the Palestinian political situation the parents as will as their children are exposed to the traumatic events, the parents themselves are also vulnerable to develop post traumatic stress disorder reactions which might adversely affect the capability of the parents to provide parenting support to their traumatized children, also it is very interesting to understand what are the best parenting behaviors lead to good children response and decrease the post traumatic stress disorder reactions.

Also it is so important and interesting to identify some data related Al – Aqsa Intifada, such as; prevalence of post traumatic stress disorder, in order to understand the incidence of new cases and how to overcome this problem in the future.

Also it is very important point to which traumatic events that commonly cause post traumatic stress disorder.

Finally it is very vital to study and understand exactly the influence of parenting educational level, occupation status on their parenting behaviors and attitudes.

Chapter 3

Methodology

3.1 Study design

This is a cross-sectional study, which tries to answer the study questions about this specific problem. We adopted the selection the cross-sectional design because this type of studies is useful for descriptive purposes. The cross-sectional studies are also known as prevalence studies since it measures the prevalence of health determinants, which are carried out in a population at a part of time or over a short period of time (Beaglehole, 1993). Cross-sectional studies are relatively easy and economical to perform, which is needed in the present study due to limited time and resources.

The time factor plays an important role in choosing a cross - sectional study design, the political situation of the resign could adversely affects the proper follow-up studies children in any other longitudinal design such as cohort studies. So, it was necessarily to conduct the study in short period of time. On the other hand cross-sectional studies of health determinants often give widely varying results usually reflecting variation in survey methods as well as true differences between populations (Beaglehole, 1993).

3.2 Sample population

The population frame for this study consisted of male and female pupils in the primary schools living in Gaza (Bet-Hanon Village, Jabalia Refugee Camp, El-Remal), only in the UNRWA schools between the ages of 12 - 16 years old.

450 Palestinian children living in Gaza strip (aged 12 - 16 years old), (primary school), were selected for the study. 75 boys and 75 girls from, (Bet-Hanon) Village, 75 boys and 75 girls from, (Jabalia Refugee camp), 75 boys and 75 girls from (El-Remal city).

3.3 Sampling

The sample selected was consisted of 450 Palestinian children, 150 children from Bet Hanon village, 150 from Gaza city, and 150 from Jabalia refugee camp.

The selection of the children was determined to meet the purpose of the study. Pupils were selected from the primary UNRWA schools. Noting that, (there is no governmental primary schools in the villages and camps). The researcher took into consideration to select all subjects anonymously and to ensure confidentiality of data through ignoring the personal details.

The sample selection was multistage random selection, the first is cluster random selection included, all the UNARWA schools in Jabalia Refuge camps, El-Remal area, and Bet-Hanon village, all were filling the criteria of our study and were involved in the sample.

The second stage was stratified cluster selection of classes, were one class was selected from each grade in the school, which means one from the7th, 8th and 9th grads.

The third stage was a random selection of pupils where inside the class, were the researcher-selected pupils by systematic seat order; one right pupil from every seat was given a participation invitation by the researcher. The researcher tries to avoid the influence of the class teachers in selection of pupils to ensure anonymity and convenience of sampling.

According to the first stage of sampling, cluster random selection of 12 UNRWA schools was done, six UNRWA schools from Jabalia Refuge camp, four UNRWA schools from El - Remal, and two UNRWA schools from Bet–Hanon area, schools of the UNRWA in each resign were given numbers separately, two schools from each area were selected and involved in the study.

3.3.1 Including criteria

Pupils where included in the study according to the following criteria:

1 - Pupils who study in UNRWA schools.

2 - Pupils between the ages of 12-16 years.

3.3.2 Excluding criteria

There were no significant excluding criteria except for

1 – Mentally retarded children.

2 - Children with obvious psychiatric problems.

3.3.3 Response Rate

The researcher expected a moderate response rate in this study. Expectation were based on, First is the political instability of the region, Secondly is the expectation of pupils parents to get materialistic assistance's, where a respectable percent of people expect to have some kind of services from official or NGOs, and the fact that they knew that there will be no materialistic reward will reduce their expectation and thus

reduced the response rate by their children. But these expectation were un realistic because the response rate was 96.4%. The researcher reflects this significant high response rate to the direct intervention of the schools headmasters, teachers, who encouraged and motivated the pupils to participate actively in responding the questionnaires.

3.4 Period of the study

The study was conducted on February 2003 in the second trimester of the scholastic year 2002-2003. Data collection had done after getting the Helsinki committee permission.(Annex 6).

3.5 Place of the study

The study was conducted at the classrooms of the UNRWA primary schools. The researcher was attended at each school, the researcher gave detailed information about the study purpose, objectives, and give the needed reassurance for the protection of the confidentiality of the given personal data and to replay the questions asked by the children, then, the random selection process of the children was done, where, every right child of each classroom seat was invited to participate in the study, 30 children from each class was given a written consent form to his parents to gain their agreement to participate in the study

3.6 Data collection

Questionnaires were tested for content validity, they were distributed to panel of experts consisted of 7 professionals, were it was general agreement around 85 % of them agreed on the questions of the questionnaires.

Data was collected in spring 2003 during Al-Aqsa Intifada. Samples of 450 Palestinian children living in Gaza strip aged 12-16 years were participated in the study. Written informed consent form was obtained from the parents of the children, the data was collected at schools. The consent form was distributed on the children at school in one day, and in the second day the children who obtain parent consent were invited to participate in answering the questionnaires.

3.7 Choice of instruments

In order to conduct a research study, and to get good and fruitful results, one of the most important roles to achieve that mission is to use the most suitable instrument.

Several features should be taken in consideration when choosing an instrument; mainly, the acceptability, applicability, procedural adequacy, reliability, and validity.

The researcher has read many different measurements that were applied on research studies inside and out side of Palestine. In this current study the researcher used the measurement that were designed and reformed to meet the goals of the study.

1 - The Demographical & Socio - Economic status (DSES).

2 - The Gaza Traumatic Event Checklist (GTEC).

3 –Child Post Traumatic Stress Index (CPTSI).

4 - Perceived-Parenting Support Scale (PPS).

3.7.1 The Personal and Demographical questionnaire

It includes demographic data such as, age, sex, place of residency, paternal and maternal educational level, and type of works…etc.

The Socio-economic questionnaire contains information about the family source of assistance and monthly income. (Annex 8).

3.7.2 The Gaza Traumatic Event Checklist

It is a checklist in which 19 events that commonly occurs during times of political and military violence in Gaza Strip. The original checklist was based on previous checklist used in Gaza strip (Thabet et al 2001).(Annex 9).

Few items were not present in the first Intifada checklist of 1987, and added to the checklist of the current Al - Aqsa Intifada, these items are 3, 4, 5, 7, 12, 16, 17, were added by professionals working in the field of community mental health, and was rated by children as a dichotomy, "No" or "Yes" (Table 4).

The checklist was rating the children level of exposure to traumatic events, the children who reporting 4 events or less, were classified as "low exposure", those children who reported 5-10 events were classified as "moderate exposure", and those children who reported 11 events or more classified as " sever exposure ".

3.7.3 Child Post Traumatic Stress Disorder reaction Index (CPTS-RI).

This is a self-rated scale tailored closely to the symptom definitions of the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) (American Psychiatric Association, 1994). The original (CPTS-RI).is composed of 17 items self reported scale designed to score symptoms of post traumatic stress disorder reactions of children aged 6 – 16 years. Inter – rater reliability for this instrument when administered by a clinician has been reported to be high, with a Cohen k of 0.87 for agreement between items. The CPTSD–RI has been translated into Arabic and validated for this culture, in this study, the spilt half reliability of the scale was 0.72 and Chronbach was 0.74.

17 DSM-IV symptoms. Items of (CPTSD–RI), can be categorized as follows:

Items 1-4, 17: represents criteria B (intrusive re-experiencing).

Items 5-11: represents criteria C (avoidance and numbness).

Items 12-16: represents criteria D (hyperarousal reactions). (Basoglu, et al 2001)

This Index was developed to measure the two most characteristics aspects of post traumatic psychopathology, namely the strengths of unpleasant, intrusive thoughts and the energy spent in trying to block them out of conciseness. Items are rated as "never" (0)," sometimes" (1), and "often" (2).

We estimated a cut - off point for the presence of post traumatic stress disorder reactions according to DSM IV diagnostic criteria, in which four of the following conditions have to be presented in the traumatized children. (Annex 10).

A - The children has been exposed to traumatic events with a period not less than one month, in which both of the following have been presented, direct confronting an events and the person's response to the traumatic events, involve intense fear, helplessness or horror.

B -The traumatic event is persistently re - experienced in one or more of ways such as

(1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

(3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.

(4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) such as.

(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 sleep

(2) Irritability or outbursts of anger

(3) Difficulty concentrating

(4) Hypervigilance

(5) Exaggerated startle response

3.7.4 Perceived-Parenting Support Scale (PPS)

The original questionnaire was prepared by Dr. Adel Abdullah Mohammed from Al Zagazig University in Egypt, the original parenting scale was 73 items including the most common parental behaviors that the fathers are providing to their children, the scale items were minimized to 50 item after 80% panel of experts agreement, the scale was rated by (Yes - sometimes-no) every item is range between zero degree (no), to (2) degrees except those items (4-9-12-13-15-20-21-25-30-34-39-40-43-44-47-48) which follow the opposite of this scaling. The degree of this scale is ranged between 0 - 100

degree, 50 degree is consider the mean for these degrees. This scale was designed to be applied by the parents. In this current study the researcher converted the same 50 parenting scale items to be applied by the children in order to detect the impact of perceiving parenting support. (Annex 11).

The validity of parenting support scale in this study was, Alpha chronbach was 0.75 and Split half was 0.76.

3.8 Piloting

On Feb. 2003, the pilot study was applied, in which 75 pupils were selected from Salah El - Din primary school that was selected randomly from 12 primary schools.

It served as a pre - test of the questionnaires and the whole study, response rate of subjects was estimated and examination of the field and all preparation was done, minor modification of the questionnaire was needed, these modifications had no effects on the results and on the main structure of the study, for that pilot study was included in the sample subjects.

There was no need for dramatic modifications of the questionnaires in which, the pupils misunderstood some words meaning and asked about the meaning of these words in the questionnaires, in item 6, 11, 12, 40, 44, they were unfamiliar with the meaning of some words, which later was modified and replaced by more simple and familiar words.

This study was carried out in winter 2003 in the second scholars' trimester. The questionnaires were distributed at schools. The researcher provides a full explanation

and details to the children and teachers at each selected class about the questionnaires in order to guarantee a good and effective participation of the children.

Alpha chronbach for the pilot study was 0.802 and half split was 0.795.

3.9 Ethical consideration and procedure

The ethical consideration and procedures are very important conditions in applying the research or performing any medical procedures, all of the ethical procedures have to be followed perfectly without ignoring any of them at all, they have to be implemented by hundred percent because any careless implementation will lead to unwanted adversity and incomplete perfect results, some of these important ethical procedures are,

The first ethical consideration was obtaining an official letter of approval to conduct the study was from the Helsinki committee, which is the ethical committee in Gaza Strip, an official letter was obtained from the UNRWA Education Department in order to conduct the study in UNRWA schools, every child in the study was given an explanatory letter about the study, this form includes the purpose of the research, confidentiality of information, the researcher explained to all children that, participation is optional and emphasis confidentiality, ethical concept, respect for trust, and respect for people have been considered, a written consent form from parent children to participate in the study was obtained.(Annex 6)

3.10 Limitation of the study

There were a number of limitations to the study

1) Possible mediating family and social factors were not examined.

2) Cultural factors may have affected the validity of the instruments

3) Lack of investigation of potential mediating factors, particularly related to the impact of trauma on parents.

3.11 Statistical analysis

The collected data was processed and analyzed under the supervision of the academic supervisor and the statisticians.

Data was entered by the statistical Package for Social Sciences (SPSS) software version 10.

This statistical program has a variety of options that is optimal for use in thus studies. Were data can be entered, labeled, coded and recorded as different variables, and tested in many kinds of statistical tests that are available in this program; including pragmatic and non- pragmatic tests.

Frequency distribution and descriptive statistics were used to presents the data.

Statistical significance of the results was established when the P value was less than 5% (p 0.05)

Categorical data were compared by Chi Square. Two groups of normally distributed continuous variables were compared by t–test, while those not normally distributed by non-pragmatic U – test.

Averages and standard deviation for some variables were calculated and presented.

One-way ANOVA were used for nonparametric analyses of differences with three or more independent groups.

Relevant associations were investigated with Pearson product – moment correlations if normally distributed, and Spearman Rank correlation if not normally distributed.

Internal consistency of the questionnaires was indexed by means of Chronbach (Alpha values). Validity was assessed using Pearson product – moment correlations.

T – test used to compare two groups of normally distributed continuous variables.

Chapter 4

Results

In this chapter we will present the main findings of the study, including the socio demographic characteristics of the study sample, clarifying the associations and relations between dependent and independent variables using the statistical test and the appropriate method for each finding.

4.1 Socio -demographic characteristics of the study population

The study sample consisted of 434 children (primary school)

Table 1
Socio demographic characteristics
(No = 434 children)

Variables	Male		Female	
age	No.	%	No.	%
12	31	14.7	44	19.8
13	54	25.6	62	27.9
14	74	35.1	68	30.6
15	45	21.3	46	20.8
16	8	3.3	2	0.9
Place of residency				
El – Remal City	71	33.5	72	32.4
Bet – Hanon Village	71	33.5	72	32.4
Jabalia Camp	70	33	78	35.2
Social assistance				
Governmental	29	14.7	19	8.6
UNRWA	60	27.3	74	33.3
No assistances	65	28.3	64	41.1
Others	63	29.7	60	17
Paternal education				
Illiterate	9	4.2	5	2.3
Elementary	20	9.4	22	9.9
Primary	44	20.8	35	15.8
Secondary	55	23.6	72	32.4
Diploma	28	13.2	18	8.1
University	37	17.5	55	24.8
High degree	24	11.3	15	6.7
Paternal job				
Unemployed	49	23.3	62	25.6
Simple worker	35	16.5	30	15

Handcrafts possessor	20	9.4	13	7.6
Employee	70	33	65	31.1
Farmer	2	0.9	3	1.2
Merchant	20	9.4	20	9.3
Other	16	7.5	29	10.4
Maternal education				
Illiterate	17	8	6	2.7
Elementary	26	12.3	20	9
Primary	37	17.5	45	20.3
Secondary	77	36.3	98	44.1
Diploma	14	6.6	13	5.9
University	34	16	36	16.2
High degree	7	3.3	4	1.8
Maternal job				
House wife	182	85.8	196	88.3
Simple worker	8	3.8	3	1.4
Employee	22	10.4	19	8.6
Other	-	-	4	1.7

The age of the children range between 12 - 16 years old, mean 13.64 year, SD = 1.07 year.

The sample of the children was consisted of 434 children, four hundred and thirty four children,

In the study 212 male children were selected, their ages are ranged between 12 – 16 years old, 12 years, 31 (14.7%)children, 13 years 54 (25.6%) children, 14 years, 74 (35%) children, 15 years, 45 (21.3%) children, and 16 years, 8 (3.3%) children.

Also, 222 female children were selected; their ages are ranged between 12 – 16 years old, 12 years, 44 (19.8%) children, 13 years, 62 (27.9%) children, 14 years, 68 (30.6%) children, 15 years, 46 (20.8%) children, and 16 years, 8 (0.9%) children.

The sample housing type is 73% are living in home builds from Baton, 22.4% living in Asbest, and 3.9% are living in neither Baton nor Asbest.

The sample study revealed that 29 (14.7%) male children, 19 (8.6%) female children are depending on governmental assistances, (ministry of social affaire's), 60 (27.3%) male children, 74 (33.3%)female children, of the families depending on UNRWA assistances, 65 (28.3%), male children, 64 (41.1%) female children families are not received any assistances at all, 63(29.7%) male children, 60 (17%) female children, of the families don't depend on certain assistances.

Paternal educational level, rang from illiterate level, in which 9 (29.7%) male children fathers, 5 (29.7%) female children fathers are illiterate, 20 (9.4%) male children fathers, 22 (9.9%) female children fathers are elementary school level, 44(20.8%) male children fathers, 35(15.8%) female children fathers are primary school, 55 (23.6%) male children fathers, 72 (32.4%) female children fathers are secondary school level, 28 (13.2%) male children fathers, 18 (8.1%) female children are diploma level, 37 (17.5%) male children fathers, 55 (24.8%) female children fathers are university level, 24 (11.3%) male children fathers, 15 (6.8%) female children fathers are high degree level.

Paternal occupational statues, revealed that, 49 (23.3%) male children fathers, 62 (25.6%) female children fathers are unemployed, 35 (16.5%) male children fathers, 30 (15%) female children are simple workers, 20 (9.4%) male children fathers, 13 (7.6%)

female children fathers are handcrafts posses, 70 (33%) male children fathers, 65 (31.1%) female children fathers are employees, 2 (0.9%) male children fathers, 3 (1.2%) female children fathers are farmers, 20 (9.4%) male children fathers, 20(9.2) female children fathers are merchant, 16 (7.5%) male children fathers, 29 (10.4%) female children fathers are others (no specific job).

Maternal educational level, rang from illiterate maternal educational level, in which 17 (8%) male children mothers, 6 (2.7%) female children mothers are illiterate, 26(12.3%) male children mothers, 20 (9%) female children mothers are elementary school level, 37 (17.5%) male children mothers, 45 (20.3%) female children mothers are Primary school, 77 (36.3%) male children mothers, 98 (44.1%) female children mothers are secondary school level, 14 (6.6%) male children mothers, 13 (5.9%) female children mothers are diploma level, 34 (16%) male children mothers, 36 (16.2%) female children mothers are university level, 7 (3.3%) male children mothers, 4 (1.8%) female children mothers are high degree level.

Maternal occupational statues, revealed that, 182 (85.8%) male children mothers, 196 (88.3%) female children mothers are house wife, 8 (3.8%) male children mothers, 3 (1.4%) female children mothers are simple workers, 22 (10.4%) male children mothers, 19 (8.6%) female children mothers are employee, 4 (1.7%) female children mothers others (no specific job).

Table 2
Types of traumatic events
(No = 434 children)

Seri No.	**Traumatic event**	No.	%
1	Watching picture of injured persons and martyr in the TV	419	96.5
2	Watching home demolishing in TV	408	94
3	Witnessing the bombardment by aircraft	398	91.7
4	Witnessing targeted assignation by aircraft	299	69.9
5	Hearing of invasion	295	68
6	Hearing of the killing of a friend	195	45
7	Witnessing of bombardment of people homes	195	44.9
8	Witnessing the shooting of a friend	134	30.9
9	Witnessing the demolishing of your friend home	110	25.3
10	Witnessing the killing of your close relative	109	25.1
11	Witnessing the invasion of your or neighbor homes	107	24.7
12	Does your land destroyed	107	24.7
13	Witnessing the killing of close family member	79	18.2
14	Witnessing a killing of a friend	72	16.6
15	Hearing of killing of a close relative	71	16.4
16	Witnessing the bombardment your home	70	16.1
17	Watching the invasion	44	10.1
18	Witnessing the demolishing of your home	44	10.1
19	Being shot by bullets	27	6.2

Table 2 shows that, the most common five traumatic events that reported by the children were ordered as, watching TV picture of injured people and martyr, 419 children, (96%), watching home demolishing in TV 408 children (94%) witnessing the bombardment by aircraft, 398 children (91.7%) witnessing targeted assassination by aircraft 299 children (69.9%) hearing of incursion and 295 children (68%) in contrast

the most less common five traumatic events that experienced by the children of the study were: being shot by bullets 27 children (6.2%) witnessing the demolishing of one own home 44 children(10.1%), watching the incursion 44 children (10.1%), witnessing the bombardment of one own home 70 children (16.1%), hearing of killing of a close relative 71 children (16.4%).

Table 3
Level of exposure to traumatic events
(No = 434 children)

Traumatic events	**Male**		**Female**	
	No.	%	No.	%
Mild expo.	22	10.0	52	23.4
Moderate expo.	142	67.3	142	64.0
Severe expo.	48	22.7	28	12.6
Total	212	100.0	222	100.9

Graph 1
Level of exposure to traumatic events
(No = 434 children)

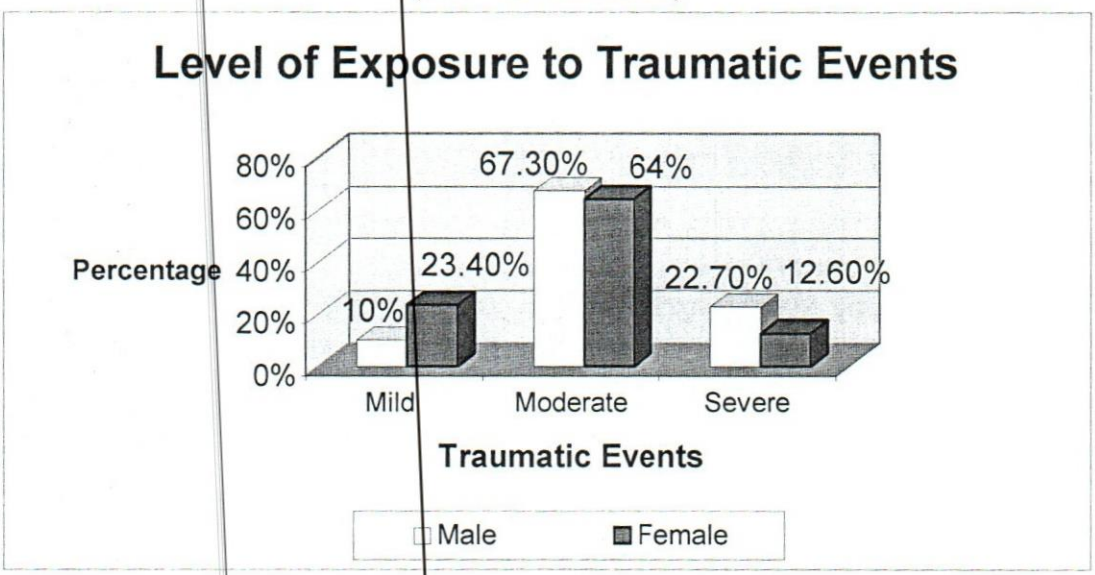

Table 3 shows that, 22 male children (10.0%) were exposed to mild traumatic (less than 4 traumatic events) 142 children (67.3) were exposed to moderate traumatic events (5 – 10 traumatic events), 48 children (22.7%) were exposed to sever traumatic events, (more than 10 traumatic events). Also it shows that, 62 female children (23.4%), were exposed to mild traumatic level (less than 4 traumatic events), 142 children (64.0%), were exposed to moderate traumatic level (5 – 10 traumatic events), 48 children (12.6%), were exposed to sever traumatic level, (more than 10 traumatic events).

Table 4
Gender differences and exposure to traumatic events
(N- 434 children)

Sex	**Mean**	**S.D**	**t**	**p.value**
Male	8.69	2.93	3.44	0.01
Female	7.69	3.14		

Table 4 shows that, males children are exposed more to traumatic events than the female children, in which, the male children mean was 8.69 and S.D = 2.93, but the female children mean = 7.69, and SD = 3.14, which means presence of differences loyal to the boys more than girls, t = 3.44, p.value = 0.01.

Table 5
Traumatic level according to the place of residency
(N= 434 children)

Residency	Traumatic level	No.	%
El – Remal	Mild exposure	34	24.0
	Moderate exposure	87	61.2
	Severe exposure	22	14.8
Bet – Hanon	Mild exposure	10	7.0
	Moderate exposure	90	63.0
	Severe exposure	43	30.0
Jabalia Camp	Mild exposure	22	14.8
	Moderate exposure	108	73.0
	Sever exposure	18	12.2

Graph 2
Traumatic level according to the place of residency

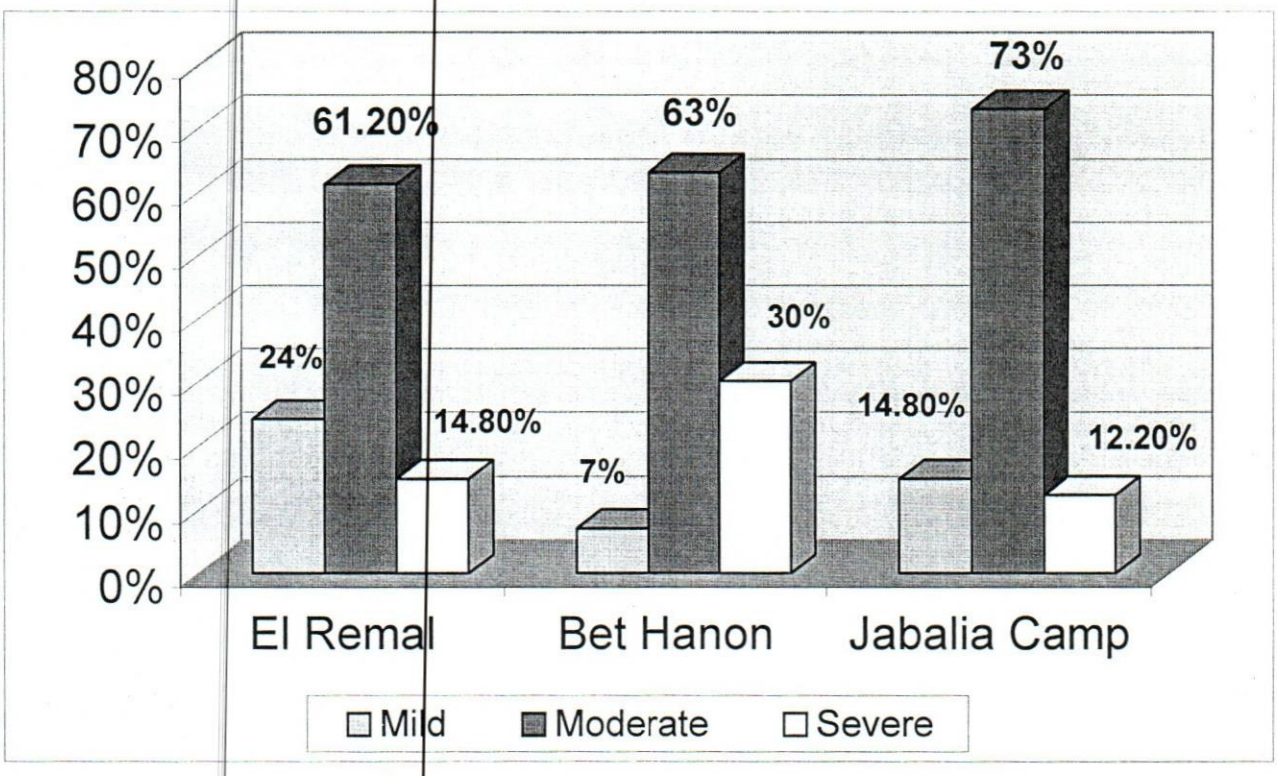

Table 5 shows that, 34 (24.0%) children were exposed to mild traumatic events, 87 (61.2%) children were exposed to moderate traumatic events, and 22 (14.8%) children were exposed to severe traumatic events. But in Bet – Hanon area, 10 (7%) children were exposed to mild traumatic events, 90 (63%) children were exposed to moderate traumatic events, and 43 (30%) children were exposed to sever traumatic events, and in Jabalia refuge camp, 22 (14.9%) children were exposed to mild traumatic events, 108 (73.0%) children were exposed to moderate traumatic events, and 18 (12.2%) children were exposed to sever traumatic event, which means that, Bet – Hanon is exposed to severe traumatic events more than Jabalia camp and El – Remal area.

Table 6

Relationship between the exposure to traumatic events and the place of residency

Place of residency	**Mean**	**SD**
Jabalia camp	7.79	2.49
Bet – Hanon	9.63	3.13
El – Remal	7.22	3.04

Table 6 shows that, there is a significant statistical differences between place of residency and the exposure to traumatic events, in which, the mean for jabalia camp is 7.79 and SD = 2.49, but the mean for Bet – Hanon is 9.63 and SD = 3.13, while, the mean for El – Remal city was 7.22 and SD = 3.04 , which means that, Bet – Hanon is exposed to traumatic events more than Jabalia and El – Remal area, F value = 26.926 which is significant at p – value 0.01.

Table 7

Child post - traumatic stress disorder reactions according to DSM IV scale

(No = 434 children)

No.	Items	Sometimes	Always	Never
-	Have you had painful images memories or thoughts of the event?	67.3	14	18.7
-	Have you had distressing dreams of the event?	59.7	13.6	26.7
-	Have you felt as though the event was re-occurring?	53	26	21
-	Have you been upset by some thing which reminded?	46.8	33.4	19.8
-	Have you been avoiding any thoughts or feelings about the event	40.6	31.8	27.6
-	Have you been avoiding doing thing s or going into situations which remind you about the event?	24.9	40.3	34.8
-	Have you found yourself unable to recall important parts of the event	7.4	16.6	76.0
-	Have you had difficulty enjoying things?	11.2	54.9	33.9
-	Have you felt distant or cut off from other people	15.9	40.3	43.8
0 -	Have you been unable to have sad or loving feeling	14.9	47	38
1 -	Have you found it hard to imagine along life span fulfilling your goals?	16.2	30.6	53.2
2 -	Have you had trouble falling asleep or staying a sleep?	23.2	41.7	35
3 -	Have you been irritable or had outbursts of anger?	18.2	44.7	37.1
4 -	Have you had difficulty concentrating?	17.9	52.3	29.7
5 -	Have you felt on edge, been easily distracted, or had to stay on guard	18.9	50	31.1
6 -	Have you been jumpy or easily startled?	16.1	49.1	34.8
7 -	Have you been physically upset by reminders of the event?	14.7	34.6	50.7

Table 7 shows that, the most common post traumatic stress disorder reactions reported by the children were: having difficulty to enjoy the daily life (54.9%), having temper tantrums (52.3%), having difficulty in concentration (50%), having easily distractibility (49.1%), feeling absent of love and amusement (47%).

Table 8
Gender differences and development of PTSD
(N = 434 children)

Sex	Mean	S.D	t- value	p.value
Male	14.54	5.77	0.682	0.01
Female	14.92	5.86		

Table 8 shows that, there is significant statistical differences between male children and female children and the total score they got when developing PTSD, were, the male mean of post traumatic stress disorder reactions was 14.54 and SD = 5.77 but the female mean was 14.92 and SD = 5.86, t – value was 0.682 which is not significant value.

Table 9
Prevalence of PTSD reactions by
(No = 434 children)

PTSD	Male		Female	
	No.	%	No.	%
Developed PTSD	78	36.8	89	40.1
Not developed PTSD	134	63.2	133	59.9

Graph 3
Prevalence of PTSD reactions by
(No = 434 children)

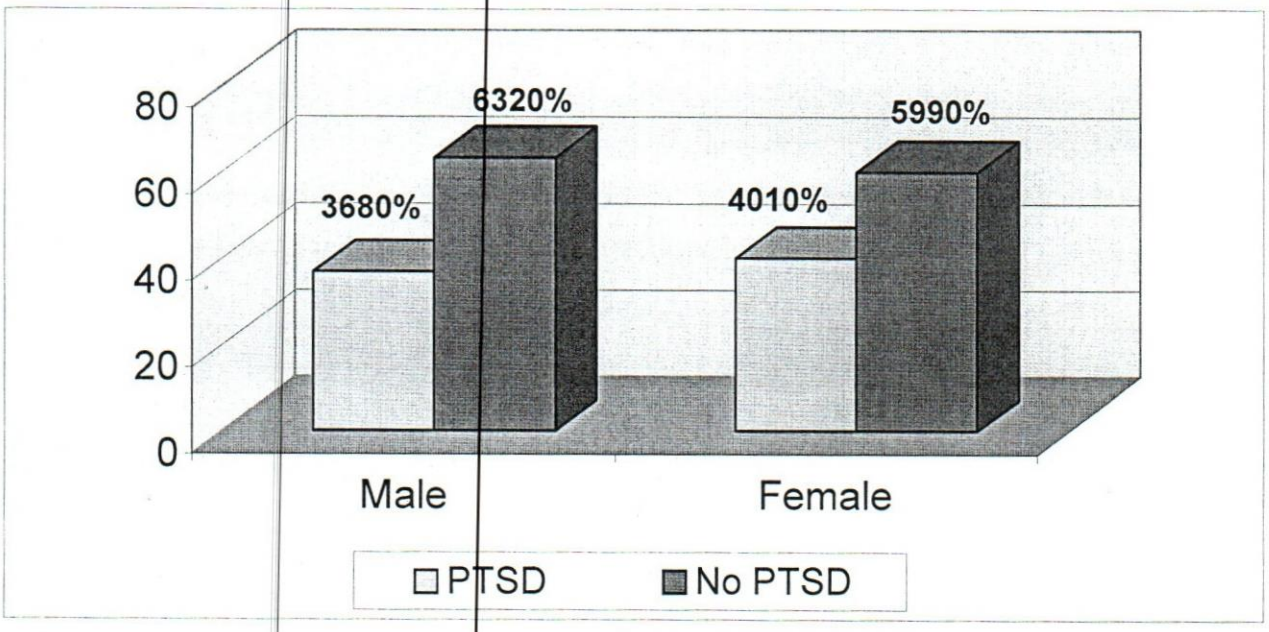

Table 9 shows that, there is significant statistical differences between the male and female children and the development of post traumatic stress reaction, in which the percent of developing PTSD among males was 36.8% and the females was 40.1%.

78 (36.8%) male children have developed post traumatic stress disorder reactions and 134 (63.2%) male children haven't developed Post - traumatic stress disorder reactions, while 79 (40.1%) female children have developed post - traumatic stress disorders reactions but 133 (59.9%) female children haven't developed post - traumatic stress disorder reactions, were $X^2 = 0.498$ which is not statistically significant.

Table 10
PTSD reactions according to place of residency
(No = 434children)

	Jabalia camp		Bet – Hanon		El – Remal	
	No.	%	No.	%	N0.	%
PTSD	55	39.3	54	38.8	58	37.4
No PTSD	85	60.7	85	61.2	97	62.6

Graph 4
Development of PTSD reactions according to place of residency

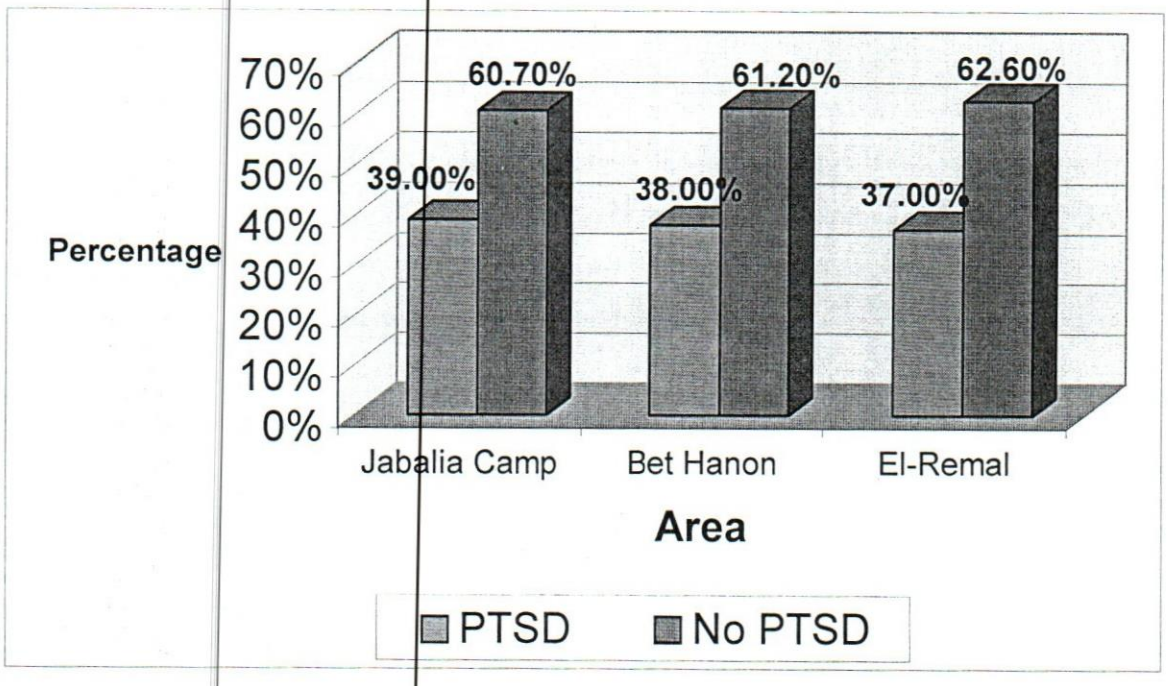

Table 10 shows that, there is significant statistical differences between the three places Jabalia camp, Bet – Hanon village, and El – Remal city, were, 55 (39.3%) children have developed PTSD are living in Jabalia camp area but 97 (60.7%) children haven't developed PTSD, while 54 (38.8%) children have developed PTSD are living in Bet – Hanon area and 85 (61.2) children haven't developed PTSD, and 58 (37.4%) children have developed PTSD are living in El – Remal area but 97(62.6) children haven't developed PTSD reactions, $X^2 = 0.120$ which is not significant value.

Sperman test indicated that, there is correlation between the traumatic events and the developing of post traumatic stress disorder reactions, were Sperman correlation = 0.294 and p. value 0.01.

Table 11
Perceiving parenting support
(No = 434 children)

No.	Item	Yes	Sometimes	No
1	My parents sharing me my favorite playing	35.7	20	44.3
2	My parents express a lot of forgiveness to me	7.4	61.5	31.1
3	Me relations with my parents is unique	7.8	72.8	19.4
4	Punishment is the first mean used with me	23	27.6	49.3
5	My parents brought to me a lot of toys	33.6	35.5	30.9
6	My parents gratitude me when I am doing good things	13.8	53.2	32.9
7	When I feel ill my parents take me to doctor	10.1	73	16.8

8	My parents teach me lessons at home	28.6	32	39.4
9	My parents give me many orders at the same time	27.6	43.1	29.3
10	My parents express their affections frankly	21.7	49.5	28.8
11	My parents ignore some of my faults	33.2	23.5	43.3
12	My parents provide me all my personal needs	17.3	39.9	42.9
13	My parents reward me by presents and money	31.3	21.9	46.7
14	My parents visiting me at school	27.6	36.4	35.9
15	My parents support me even when I am guilt	51.6	19.3	29
16	My parents respect my trials to achieve some things	13.8	56.5	29.5
17	My parents respond to my questions and not ignore them	16.4	45.2	38.5
18	My parents encouraging me to retrial when I fail	33.6	42.2	24.2
19	My parents put them self in my position	30.2	25.8	44
20	I don't feel close to my parents	25.1	19.8	55.1
21	My parents are not harsh when I am express disobedience	31.6	18.2	50.2
22	I miss my parents when they away from me	10.1	71.7	18.2
23	When me parents are absent I feel loss of very expensive thing	10.8	66.6	22.6
24	My parents helping me to solve my problems	16.4	56.9	26.7
25	Usually my parents threatening me	23.7	23	53.2

26	My parents are guiding me	11.8	63.6	24.7
27	My parents give me the full freedom to explore my self and my surrounding	16.6	52.3	31.1
28	My parents keep the good contact with me	13.4	59	27.6
29	My parents teach me to be flexible	8.5	72.4	19.1
30	My parents impose certain discipline on me	47.7	33.4	18.9
31	My parents clarify the good and the wrong to me	5.5	82.5	12
32	My parents encouraging me to be dependent	13.1	56.5	30.4
33	When I need help I go to my parents	10.8	56.2	32.9
34	My parents encouraging me to trial by my self	15	47	38
35	My parents respects my desire in certain things	9.2	52.1	38.7
36	My parents valued me when expressing my opinion	11.1	55.3	33.6
37	My parents encouraging me to formulate me personality	10.4	63.8	25.8
38	My parents clarifying the correct when I fault	9.7	71.9	18.4
39	I doubt in my parents love	34.6	25.6	39.9
40	My parents expressing anxiety and fear on me	27.4	35.7	36.9
41	No barricades between me and my parents	15.9	57.1	27
42	My parents are valuing me	15.2	56.5	28.3
43	I depend on my parents so much	28.3	35	36.6
44	My parents are humiliating me even on simple	29.3	24.7	46.1

	things			
45	My parents encouraging me to be honest	6	80.9	13.1
46	My parents encouraging me to do my religious rituals	10.1	72.4	17.5
47	My parents ordered are opposite	20.5	30.9	48.6
48	My parents using punishment more than reward in dealing with me	56.5	24.4	19.1
49	My parents keeping honestly when talking to me	9	68.9	22.1
50	My parents respected and valued my feeling	10.4	65	24.6

Table 11 shows that, the most common parenting support behaviors were;

My parents support me even when I am guilt (51.6%), my parents sharing me my favorite playing (35.7%), my parents brought to me my a lot of toys (33.6%), my parents encouraging me to retrial when I fail (33.6%), But the most common not supporting parenting behaviors were; my parents using punishment more than rewards with me (56.5.)% my parents imposing certain discipline on me that I have to keep close to it (47.7%), I doubt in my parent's love (34.6 .%).

Table 12

The relationship between the perceived parenting support and place of residency

Parenting support level	**Jabalia camp**		**Bet- Hanon**		**El - Remal**	
	No.	%	No.	%	No.	%
Low support	25	17.9	10	7.2	25	61.1
Moderate support	103	73.6	103	74.1	97	62.6
High support	21	8.5	26	18.7	33	21.3

Graph 5

The relationship between the perceived parenting support and place of residency

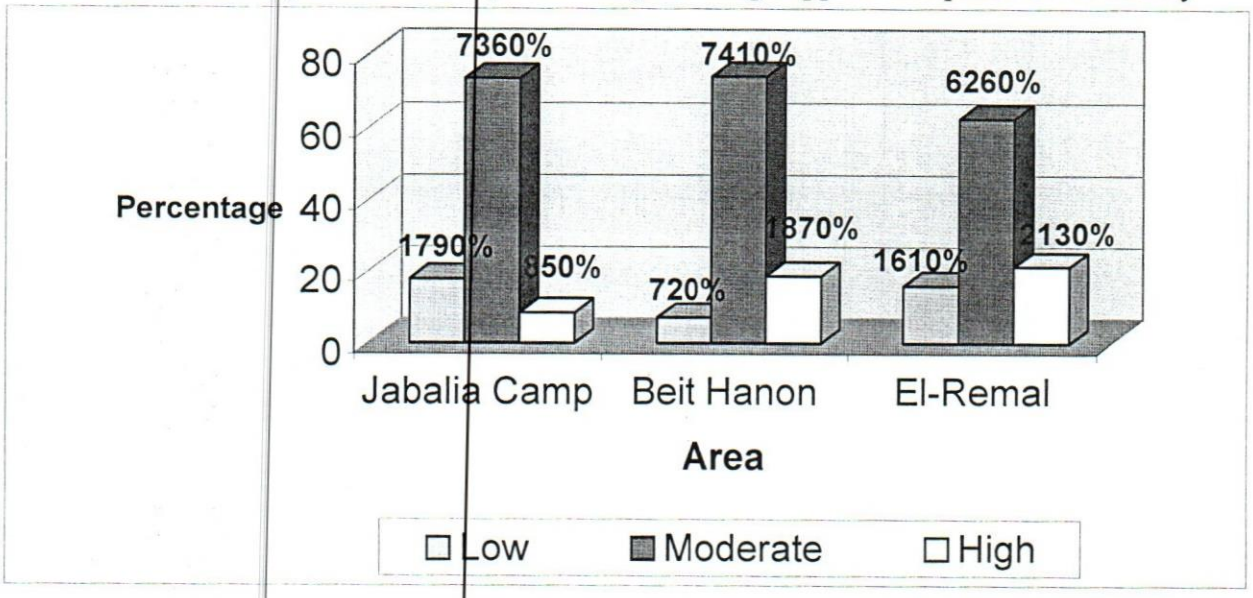

Table 12 shows that there is statistical differences between perceived parenting support and place of residency, in which, were, 25 (17.9%) children are living in Jabalia camp are perceiving low parenting support, and 103 (73.6%) children are perceiving moderate parenting support, while 21 (8.5%) children are perceiving high parenting support. 10 (7.2%) children are living in Bet - Hanon are perceiving low parenting support, and 103 (74.1%) children are perceiving moderate parenting support, while 26

(18.7%) children are perceiving high parenting support. 25 (16.1%) children are living in El - Remal are perceiving low parenting support, and 97 (62.6%) children are perceiving moderate parenting support, while 33 (21.3%) children are perceiving high parenting support, this means that, Jabalia camp has the low parenting support and El – Remal city have the high parenting support, $X^2 = 16.434$ at p value 0.01.

Table 13
The relationship between parenting support and sex of child

Parenting support level	**Male**		**Female**	
	No.	%	No.	%
Low support	37	17.5	23	10.4
Moderate support	151	71.2	152	68.5
High support	24	11.3	47	21.2

Graph 6
The relationship between parenting support and sex of child

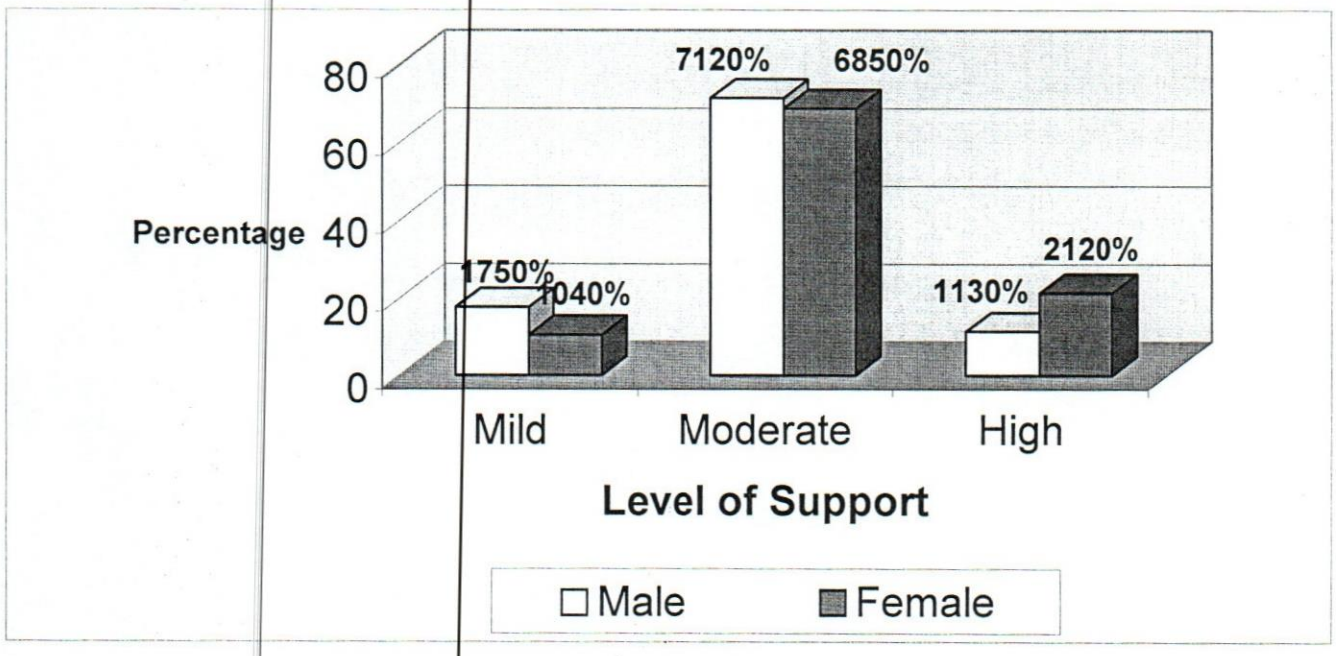

Table 13 shows that, there is presence of significant statistical differences between the perceived parenting support and sex, in which, were 37 (17.5%) male children have receiving low parenting support, but 23 (10.4%) female children have perceiving low parenting support. While 151 (71.2%) male children have perceiving moderate parenting support, but 152 (68.5%) female children have perceiving moderate parenting support. While 24 (11.3%) male children have receiving high parenting support, but 47 (21.2%)female children have perceiving high parenting support, this means that the female children perceive parenting support more than the male children, $X^2 = 10.496$, p – value 0.01.

Table 14
Gender differences and the parenting support

Sex	**Mean**	**S.D**	**t- value**	**p.value**
Boys	95.35	9.76	3.165	0.01
Girls	98.36	10.03		

Table 14 shows that, there is significant statistical differences between the perceived parenting support and the sex, were, the boys mean of parenting support was 95.35 and SD = 9.67, while the girls mean of parenting support was 98.36 and SD = 10.03, which means that the girls children have supported by parents more than the boys children, t = 3.165, p value = 0.01.

Table 15
The relationship between parenting support and age of child
(N = 434 children)

Age	Low support		Moderate support		High support	
	No.	%	No.	%	No.	%
12 years	9	12	49	65.3	17	22.7
13 years	17	14.5	81	69.2	19	16.2
14 years	19	13.3	102	71.8	21	14.6
15 years	12	13.2	65	71.4	14	15.4
16 years	3	33.3	6	66.7	-	-

Graph 7
The relationship between parenting support and age of child

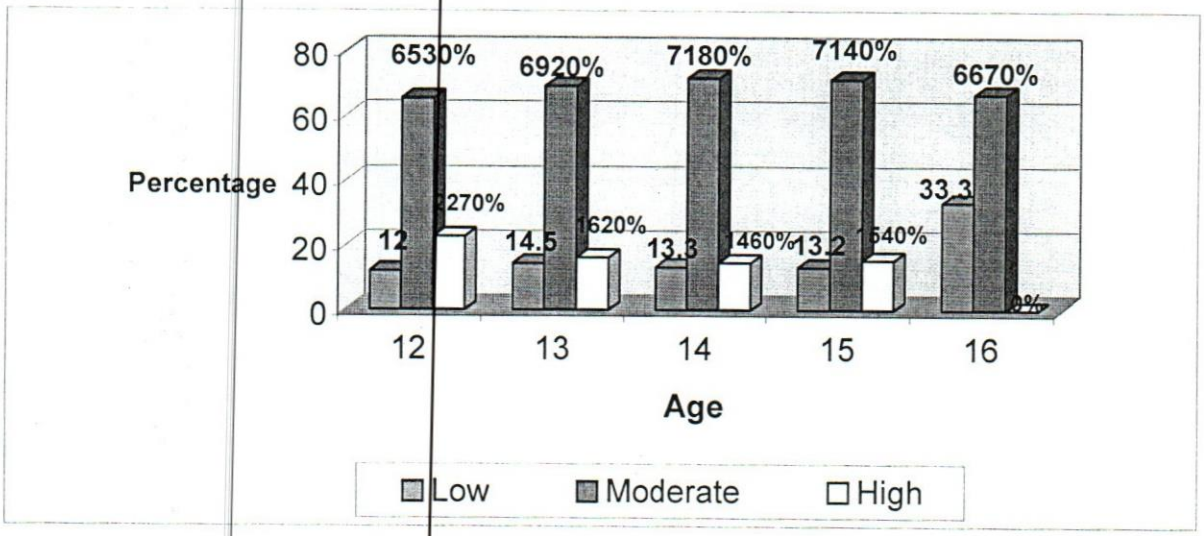

Table 13 shows that, the parenting support is increase toward the small children, the moderate parenting support is almost equal among all ages, while the low parenting support is increase toward the older children, were, 9 children of 12 (12%) years old perceiving low parenting support, but 49 (65.3%) children perceiving moderate

parenting support, while 17 (22.7%) children perceiving high parenting support. 17 (14.5%) children of 13 years old perceiving low parenting support, but 81 (69.2%) children perceiving moderate parenting support, while 19 (16.2%) children perceiving high parenting support, while 19 (13.3%)children of 14 years old perceiving low parenting support, but 102 (71.8%) children perceiving moderate parenting support, while 21 (14.6%) children perceiving high parenting support. 12 (13.2%) children of 15 years old perceiving low parenting support, but 65 (71.4%) children perceiving moderate parenting support, while 14 (15.4%) children perceiving high parenting support. And finally, 3 (12%) children of 16 years old perceiving low parenting support, but 49 (65.3%) children perceiving moderate parenting support, while 17 (22.7%) children perceiving high parenting support.

Table 16

The relationship between paternal educational level and the perceived parenting support

Paternal educational level	**Parenting support mean**	**SD**
Illiterate	94.56	9.58
Elementary school	95.61	10.04
Primarily school	95.46	9.17
Secondary school	95.72	9.5
Diploma	96.00	9.9
University	100.42	10.69
High educated	99.84	8.85

Table 16 shows that, the parental educational level of children parents and the parenting support mean is observed as follow, the illiterate mean of parenting support mean was 95.46 and SD = 9.17, the elementary school parenting support mean was 95.61 and SD = 10.04, the primary school parenting support mean was 94.56 and SD = 9.58, the secondary school parenting support mean was 95.72 and SD = 9.5, the diploma parenting support mean was = 96.00 and SD = 9.9, the university parenting support mean was 100.42 and SD = 10.69, and the high degree parenting support mean was 99.84 and SD = 8.85.

Table 17
Parenting support and parenting educational level

Parental educational level		**Sum of Squares**	**Df**	**Mean Square**	**F**	**p.value**
Illiterate Elementary Primary Secondary Diploma University High educated	Between groups	128.665	6	188.111	3.824	0.01
	Within groups	228.213	427	89.895		
	Total	356.878	433			

Table 17 One-way ANOVA identify that, there is significant statistical differences between parenting support and parental educational level, were, the F- value to 3.824, p – value = 0.01, were the university level parents are providing parenting support to their children more than the other levels.

Table 19

Relationship between parenting support and the total number of traumatic event scale

Parenting support	Traumatic events mean	SD
Low parenting support	8.23	2.95
Moderate support	8.53	3.11
High support	7.64	3.53

Table 20 shows that, there is no presence of significant statistical differences between the parenting support and the exposure to traumatic events, in which, the mean of traumatic events of low parenting support was 8.23 and SD = 2.95, but the mean of traumatic events for the moderate parenting support was 8.53 and SD = 3.11, while the mean of high parenting support was 7.64 and SD = 3.53, F = 1.507 which is not significant value.

Table 20

Relationship between parenting support and the total number of CPTSD – Index.

Parenting support	PTSD – Index mean	SD
Low parenting support	18.06	4.98
Moderate support	14.86	5.27
High support	11.38	6.88

To find relationship between level of parenting support and PTSD – Index One – way ANOVA was conducted considering PTSD – Index as dependent variables and level of parenting support as independent variables, the results showed that, there was significant statistical differences between the level of parenting support and the total score of PTSD – Index, in which, the mean of PTSD - Index of low parenting support was 18.06 and SD = 4.98, but the mean of PTSD – Index for the moderate parenting support was 14.86 and SD = 5.27, while the mean of PTSD – Index for high parenting support was 11.38 and SD = 6.88, that means when the parenting support is high the PTSD reactions is decreased, F = 24.4, p value = 0.01.

Table 21

Relationship between traumatic events, CPTSD, parenting support and age (N= 434 children)

Traumatic events	Age	Mean	SD	F	p.value
	12	8.29	3.42	1.864	
	13	7.76	3.13		
	14	8.06	2.79		
	15	8.86	3.13		
	16	7.55	2.00		
CPTSD – Index scale	12	14.70	6.34	0.306	
	13	14.92	5.11		
	14	14.33	6.14		
	15	15.14	5.65		
	16	14.77	7.03		
Parenting support	12	98.74	9.69		0.96
	13	98.74	9.94		
	14	96.65	10.64		
	15	96.98	9.22		
	16	96.26	8.01		

Table 22 shows that, the mean number of traumatic events reported by children ages 12 years was 8.39 and SD = 3.42, the mean number of traumatic events reported by children ages13 years was 7.67 and SD = 3.13, the mean number of traumatic events

reported by children ages14 years was 8.06 and SD = 2.79, the mean number of traumatic events reported by children ages15 years was 8.86 and SD = 3.13, the mean number of traumatic events reported by children ages16 years was 7.55 and SD = 2.00. But the mean for the CPTSD - Index of 12 years old children was 14.70 and SD = 6.34, the mean for the CPTSD – Index of 13 years old children was 14.92 and SD = 5.11, the mean for the CPTSD - Index of 14 years old children was 14.33 and SD = 6.14, the mean for the CPTSD - Index of 15 years old children was 15.14 and SD = 5.56, the mean for the CPTSD - Index of 16 years old children was14.77 and SD = 7.03.

While, the mean for the parenting support of 12years old children was 98.74 and SD = 9.69, the mean for the parenting support of 13 years old children was 98.74 and SD = 9.94, the mean for the parenting support of 14 years old children was 96,65 and SD = 10.64, the mean for the parenting support of 15years old children was 96.98 and SD = 9.22, the mean for the parenting support of 16 years old children was 96.26 and SD = 8.01.

Tables 22 also shows that, there was no presence of statistical significant differences among the three scales and the age of the children, F = 1.864 for traumatic events scale, and F = 0.306 for PTSD – Index scale and F = 0.96 for parenting.

Chapter 5

Discussion

5. Overview

Post traumatic stress disorder is consider one of the psychological problem worldwide, mainly in Palestine were the Palestinian people are facing ongoing trauma and continuous violation of human rights, this aggression is not limited to certain individual but it reach to all living objects in Palestine. The children are considered a target group for the Israelis occupation forces. Hundreds of children had been killed, injured, handicapped. Posttraumatic stress disorder is one of the main reactions following traumatic events was adopted by the children and the adults, but the children suffered so hardly and seriously because of their limited life experience and coping strategies.

This study was carried out in winter 2003 this period was a very sensitive and difficult period for the Palestinian people. A period full of a serious Israelis aggression is extended to Gaza strip, after the Israelis aggression in the West Bank which is continue and escalated, the socioeconomic status of the population become to reach a catastrophically situation after a very along period of Israeli measures taken against the civilian population. These measures include road closure, military barriers that prevented people from reaching their works and preventing basic nutritional needs to enter the resign with long periods of curfew in some places, siege and collective punishment. This bad situation includes a miserable state of people's economical condition; a large segment of Palestinian people depend on humanistic aids.

The study of post traumatic stress disorder among refugees helped in finding people at high risk of mental disorder, behavioral disturbances, because of the miserable socio - economical and political situation, as it is evident in (Table 2), we can notes that every child has been exposed to more than one traumatic event from the most 19 traumatic events experienced during Al - Aqsa Intifada.

The distribution of the sample was divided on the three main residency characteristics in Palestinian territories, Bet Hanon village as represents the villages of the Gaza Strip, Jabalia camp as represents the Gaza Strip refugee camps, and El – Remal city as represents the Gaza Strip cities.

5.1 Exposure of the study sample children to various traumatic events

In this study, the impact of political and armed conflict on Palestinian children is both severe and widespread. This appears to have happened within a brief period with the outbreak of violence in the area. In our study findings revealed that, the boys are exposed to traumatic events more than girls, this can be interpretated as resulting from the socialization of girls in contemporary Palestinian society, girls at home are under stricter surveillance and protection than boys, but the boys are participating in the activities of the intifada more than girls. According to the Arab culture girls are expending their time at home helping the mothers in homework, so they are exposed to less traumatic events than boys. Our results are confirmed and supported by the results of (Thabet et al, 2001) were, they founds that, boys were significantly more exposed to high traumas than girls. But our findings are different from the results of Qouta et al,

1995, where, they founds no differences in the exposure to traumatic events between boys and girls.

5.2 The most common traumatic events that experienced by the children

Our findings revealed that, the most common traumatic events were, children watching the pictures of martyr and injured people in the TV, watching home demolishing in TV, witnessing the bombardment by aircraft, witnessing targeted assassination by aircraft, hearing of invasion. But in contrast the most less common traumatic events that experienced by the children of the study were in order as the follow, being shot by bullets, witnessing the demolishing of one own home, watching the invasion, witnessing the bombardment of one own home, hearing of killing of a close relative, the result indicated that, the vast majority of the children were exposed to indirect (no physical harm) traumatic events and the less minority were exposed to direct traumatic events (physical harm) (Table No. 4).

These finding are similar to the results of (Thabet et al, 2001), were, they found that, the most common type of traumatic event was watching pictures of victims on television, and the least common type of traumatic event was being shot with bullet. While in another study of (Thabet, et al 2002) they found that, the exposure to bombardment was the main predictor for developing post traumatic stress disorder. Also in a study (Pfefferbaum, et al 1995), they found that, television watching of the blast in Oklahoma City was the primary predictor for developing post traumatic stress disorder among the children who watch the event on television. Also (Macksoud, et al

1996) found in Lebanese children exposed to different types of traumatic events that, children were exposed to shelling or combat exhibited more post traumatic stress disorder symptoms, children were exposed to displacement, children were witnessing violent acts, children were exposed to separation from parents. While in other areas of conflicts and war zones in Croatia and Bosnia, the traumatic events were such as, death or injury of a family member and friend, exposure to enemy attacks such as shelling, witnessing violent acts, being in a shelter, loss of home, loss of personal belonging, separation from family members.

But Betty et al (1997), found that, separation from parents immediately after a natural disaster, ongoing maternal preoccupation with the event, and altered family functioning were more predictive of post traumatic stress disorder reactions.

Other studies indicated that exposure to different types of war related traumatic events lead to development of different types of psychological disturbances, mainly Post traumatic stress disorders reactions, depressions, anxiety, hyperactivity, (Allodi et al, 1980), while Kinzie et al.(1986), found that, 50% of Cambodian children who had been exposed to war and genocide during the Pol Pot regime met the diagnostic criteria for post traumatic stress disorder, while Swick, et al (2002) he found that, the children who lost parents in the events of September 11th have developed serious psychiatric symptoms mainly post – traumatic stress disorder.

5.3 Level of exposure to traumatic events

Our findings confirmed that, every child have experienced at least one traumatic event, so we considered the exposure to 0 - 4 traumatic events classified as mild exposure,

while the exposure to 5 – 10 traumatic events was classified as moderate exposure, and the exposure to 11 or more traumatic events classified as sever exposure. Our findings revealed that, the boys experience less mild level of traumatic events, but experienced equal moderate level of traumatic events, and more sever level of traumatic events in comparison with the girls. This might be result from the fact that, the more active participation of boys in the activity of the Al - Aqsa Intifada than the girls.

Our results are similar to those results of (Thabet et al, 2001), were, they found that, the mean number of traumatic events experienced by children was 4 with arrange of 0-10 events, children were exposed to low traumatic level (4 or fewer events), and other children were exposed to high traumatic levels (5 or more events). Also our study was similar to the results of (Macksoud, 1992), were, she found that, the number of war traumas experienced by Lebanese children during the war ranged from 0 to 20 traumas, with an average of six traumas per children, every Lebanese child has experienced at least one traumatic event during his or her lifetime, and some events were experienced several times. Also in another

5.4 Relationship between demographic residency and the exposure to traumatic events

Our findings revealed that, the type of residency has a role in the level of traumatic events exposure. In which, Bet – Hanon children were exposed to sever traumatic events (more than 11 traumatic events), but in El - Remal city and Jabalia camp children were exposed to less traumatic events. The rural area were significantly more likely to have high exposure levels to traumatic events than children living in the

camps or urban area, this might result because, Bet - Hanon was exposed to repeated incursion and continuous hostility of Israeli forces more than Jabalia camp and E -l Remal area. Contrary to the study of (Thabet et al, 2001), where they found that, the children living in the urban area were significantly more than likely to have high exposure levels to traumatic events than children living in camps or in rural area.

5.5 Post traumatic stress disorder symptoms

Our findings revealed that, the most common post traumatic stress disorder reactions, experienced by the children i.e. items rated as occurring most or all of the time were, having difficulty to enjoy the daily life, having temper tantrums, having difficulty in concentration, having easily distractibility, feeling absent of love and amusement, these findings might be interpretated by the fact that, the ongoing and continuous traumatic events could lead to more psychological problems such as frustration, depression, PTSD symptoms. Our findings are different from the results of (Thabet, et al 2001), were, they found that, the most common post traumatic stress disorder reactions were, waves of strong feelings about the event, being distressed when thinking about the event, and reminders of the event.

5.6 The prevalence of post traumatic stress disorder

Our findings indicated that, there was presence of post traumatic stress disorder reactions among the study sample children, whom were diagnosed according to the criteria of DSM - IV, which means, presence of A.B.C.D criteria, we found that, girls developed post traumatic stress disorders reactions more than boys, and this might

result from the fact that, biological and environmental factors are different from boys to girls, and also from cultural point view the family supporting for the boys is more than the family support to girls. These findings are supported by the results of (Thabet et al, 2001), (Punamaki et al, 1995), (Macksoud 1996), were, all of their studies indicated that, girls are more vulnerable to develop post traumatic stress disorder more than boys.

5.7 The prevalence of post - traumatic stress disorder reactions, and demographical residency

Our findings indicated that, El – Remal children were express significantly high post traumatic stress disorders reactions, in comparison with Bet – Hanon and Jabalia Camp children. These findings prove that in spit of highly exposure of Bet - Hanon children to more types of traumatic events but they are suffering less from post traumatic stress disorders reactions. But in El - Remal children, who exposed to less traumatic events but they expressing more post traumatic stress disorders reactions. These findings might be explained by the presence of social support in Bet – Hanon which is manifested by familial relationships more than other areas like Jabalia camp and El - Remal city, these findings are similar to other studies results in Lebanon which indicated that, the Lebanese children who resided in certain regions (e.g. outside greater Beirut or in the southern Suburbs) experienced a greater number of traumatic events than those children in other regions (e.g. near the demarcation line or in East Beirut), (Macksoud,1992). But in another study (Macksoud,1996) indicated that,

children living in the south of Lebanon reported less post traumatic stress disorder symptoms than children living in East Beirut or in the southern suburbs.

In another study of Bosnian adolescents, post traumatic stress disorder reactions were, present weakly, moderately and severely in the adolescent study sample, (Ajdukovic, 1998).

5.8 Children perception of parenting support

Our findings indicated that, the children were perceiving parenting support, and these parenting support behaviours such as, his parents support him even when he is guilt, his parents sharing him his favorite playing, his parents brought to him a lot of toys, his parents encouraging him to retrial when he fails. Also, there were some parenting behaviours that were stressful for the children such as, his parents using punishment more than rewards with him, his parents imposing certain discipline on him that he have to keep close to it, he doubt in his parent's love. From these findings we can notes that, the answering of the children physical and psychological demands from the parents consider the most comfortable behaviours help children to cope with the difficult periods. But in a study of (Thabet, et al 2001), they found that, mothers psychopathology was a strong predictor of children's post traumatic stress disorders symptoms, also traumatized mothers are at risk of transferring their fears, anxiety and other symptoms to their children which in turn make them vulnerable to developing further mental health problems.

Also the result of (Qouta, et al 1997) he found that, the most perceived parenting behaviours were, his parents always meets him with a smile, his parents enjoys doing things with me, his parents are proud of him.

While the children of Holocaust survivors perceived their parents, lacking emotional involvement as a function of the seriousness of their traumatic experiences (Last, 1989).

5.9 The relationship between traumatic events and parenting support

Our findings revealed that, there is no relationship between the traumatic events and the parenting support, that means, the parents are providing parenting support to their traumatized children. Our findings are contrary to the results of (Qouta et al, 1997), were, they found that, the more the children were exposed to traumatic events, the more they perceived their parents as strictly disciplining, rejecting, and hostile.

This might be interpretated by the fact that, the children in this current study are exposed to the traumatic events even when they are passive and not participating actively in the activities of the current Al – Aqsa Intifada, so they might exposed to the traumatic events in their homes, schools, streets and every where and not to be responsible about their exposure to the traumatic events and their adverse consequences, but in the other study which conducted on children participated in the first Intifada were them selves have the initiation to go and to participate in the activities of the Intifada.

5. 10 The relationship between parenting support and post traumatic stress disorder

Our findings revealed that, there is positive relationship between parenting support and post traumatic stress disorder reactions, that means, when the parents are providing parenting support to their traumatized children, the symptoms of post traumatic stress disorder are decline. This might be interpretated by the fact that, the children have limited life experience needs external intervention and the reciprocal relationship between parents and children is very important factor, the parent – child attachment are considered important in providing a protective shield for children's psychological well – being in dangerous conditions, and emerged as an important factor in mediating children's stress response.

5.11 relationship between Perceived parenting support and place of residency

Our finding shows that, the children living in Bet - Hanon are perceiving low parenting support in comparison with the children of jabalia camp and El – Remal city, while El – Remal city children are perceiving high parenting support more than the children of both Jabalia camp and Bet – Hanon village, These findings can be interpretated by the fact that, the people are living in the cites are in more close contact and expending enough time with their children in comparison with the parents of the camps and villages, noticing that; the number of children in the families living in the

cities are less than the number of the children in the families living in camps and villages, also the parents in the cities are working as employee in governmental and non governmental institutions so they don't have economical burden as the parents living in the camps and villages whom don't have regular income, the parents living in the cities have enough time to contact and listen to their children and answering their demands. Contrary the parents living in the camps or villages have limit time to expend with their children, they have number of children more than the number of families living in the cities, the socio – economical statues for them is more complicated than that of the cities, so they have the first priority is to bring bread to their children and family members, so the time they are expending with their children is limited in comparison with the parents of the cities which prevent them from answering the demands of their children.

5.12 Perceived parenting support and sex of child

The parenting support and intervention is very important for boys and girls mainly in the period of crisis and stressful situations, the eastern parents have often revealed feelings of ambivalence, pain, and guilt about bringing up children in conditions of war and violence (Lieblich, 1978, Punamaki, 1988),

Our findings indicated that, the parenting support for girls is more than the parenting support for boys, this may result from the fact of the Palestinian culture and religion, in which, the girls are very weak and sensitive person, they are easily expressing their fears, worries obviously more than boys, so they attract the attention of their parents, also the Islamic religion insist Moslems to offer kindness with the females and not to

abuse them by any manner or under any condition. While (Qouta, et al 1997) found that, boys perceive both parents as being more strictly disciplining, rejective and hostile than girls do. Furthermore, boys perceived their mothers as showing more negative evaluation than girls did. . In another studies of (Punamaki, 1987), Brtce and Walker (1986), they reported that, the Lebanese mothers were poor child rearers in war conditions. Also (Daniel, et al 2000), in his study on Chinese parents found that, fathers, as compared with mothers, were perceived to be less responsive, less demanding, demonstrate less concern, less communication with children. The father – adolescent relationship was evaluated more negatively than the mother – adolescent relationship, adolescent girls as compared with adolescent boys perceived their parents to be more demanding but less harsh.

5.13 Parenting support and age of child

Our finding indicated that, some children are perceiving low and high parenting support, but the majority of children are perceiving moderate parenting support. Our findings revealed and conclude that, the vast majority of the children are in great need for more attention and more parenting support. These findings might be interpreted by the fact that, the parents them selves are exposed to the same traumatic events and they might become psychologically disturbed and vulnerable to develop different psychiatric problems which might decrease the parent attention and care of their children, also the majority of parents are focusing on finding jobs or social assistances to their family members which also lead to decrease of parenting support. But even though, the small children 12 years old are perceiving high parenting support, and the

majority of 14 years old children have more moderate parenting support in comparison with other age groups, this may explained by the fact that the children of 12 years old are weak and have limited life experiences so their parents tried to provide more support also on the other hand the14 years old children whom have more moderate parenting support because they are present in transitional stage between the childhood period and the adolescent period were they have some physical (biological, hormonal) and psychological changes which attract the attention of the parents to them, so the parents are response and satisfy the needs of these children more in comparison with other children age group.

5.14 The relationship between parental educational level and parenting support perceived by children

Our findings indicated that, parental educational level has positive effects on the psychological statues of children, Our study findings showed that, the relationship between parental educational level of parents and the perceived parenting support is observed significantly high among the university educational level, and decrease among the illiterate level, this result might give us the impression that educated parents are more oriented to the psychological problems of children and also they might know when and how to intervene with their traumatized children.

And also, the results of our study showed that, illiterate children mothers are twice higher than illiterate children fathers, and the high educated children father are three doubles than high educated children mothers, this picture about education of fathers and mothers may firstly, reflects the real situation of the Palestinian society, where it is

believed that men have more chances for education than women due to cultural and socio - economic reasons, secondly, the big difference between the parents educational level might reflect one of the main Arab culture trait, that is, patriarchal society, in which the society focus on the male more than on female, thirdly, in the Arab culture the early marriage of the females minimize their chance to continue and complete their educations.

5.15 The relationship between parenting support and parenting occupational status

Our findings indicated that, the type of parents job was not related to the level of parenting support. These findings might interpretated by the fact that, parents are oriented for the holy mission toward their children even under the most critical situations, so they are tried to offer and satisfy the physical and psychological demands for their children. Our findings are differ from the results of (Macksoud et al 1996), were, they found that, children whose fathers held high – statues occupations were more likely to report more adaptive behaviours than children whose fathers held low – status occupations. While, Martha, et al (1998), in study on Mexico children found that, the lower the occupational statues of the father the higher the dysfunction in the family, the father's occupation also affected the mother's parenting style, the higher status the father's occupation, the harsher the mother's parenting, (Martha et al, 1998).

CHAPTER 6

Conclusions and recommendations

6.1 Conclusions

The purpose of this study was to assess a possible relationship between parenting support and it's impact on the posttraumatic stress disorder reaction, among primary school children in the Gaza Strip.

A cross-sectional design was used to accomplish this mission.

It is worth noting that, this study is one of the first studies in the resign that investigate such a psychological problem in the current situation, given that posttraumatic stress disorder is not only a psychological problem but also a political, economical and social problem. Were the children become adversely affected by the consequences of the traumatic events that would affect his or her academic achievement, peer relation, social interaction, his personal ambition and career?

The total sample that participated in the study was 450 primary school children, with respond rate about 96.4%. This response rate was expected duo to the strong self - motivation, positive intervention of schools headmasters, teachers and parents, the current political situation which give the children the real and internal motivation to participate and to express their psychological feelings and troubles.

A comprehensive review of the local and international recent and ancient literatures was done and demonstrated about the problem of posttraumatic stress disorder and the impact of parenting interaction and interventions in traumatic or political violence and war.

The relation ship between posttraumatic stress disorder and the impact of parenting was widely reviewed, and there have been a considerable number of articles that touch and focus on this issue in different parts allover the world.

Result of the study revealed that posttraumatic stress disorder is prevalent among school children in Gaza Strip.

The children have exposed to different type of war traumatic events, some of them develop Posttraumatic stress disorder reaction, others children did not developed Posttraumatic stress disorder reactions, and girls developed PTSD more than boys.

There was relationship between demographical residency and the type of the traumatic events.

There was relationship between parenting support and parental educational level and occupation.

The children perceived parenting support but it is not enough, the majority of parents providing a moderate level of parenting to the traumatized children.

6.2 RECOMMENDATIONS

It is quiet obvious from the study and other studies that children are highly vulnerable to have posttraumatic stress disorder as well as other population categories, as result of direct and indirect exposure to traumatic events, this problem is worsen during the Intifada Al-Aqsa and they are in great need for immediate interventions. So on the light of these results; efforts must be done and continue, to eliminate the major source of this problem which is the Israeli occupation, continuous Israeli aggression and

hostility against the Palestinian people, and the daily collective punishments against the civil society of Palestine.

On the national level, efforts should be done in order to discover risk groups of posttraumatic stress disorder, especially the children and adolescence population category, were they have limited life experience and limited self-dependency and low coping strategies. Good attention from policy makers should be concentrated on this problem through wide public awareness and parenting education. Discovering of high-risk group could be done through visiting the areas of conflicts (crisis intervention), Telephone counseling, clinical interview, home visits.

Since there is an important role of parenting support in decreasing the posttraumatic stress disorder, so special attention and efforts should be focused on parents through public meetings with parents, leaflets to instruct parents how to deal when their child exposed to traumatic experience.

Addressing efforts of mass media toward mental health issues, mental health services centers.

For decreasing the posttraumatic stress disorder reactions among the whole population, this could be done through good social interaction among palestinian people, support group, visiting families of martyrs and injured people, sharing others in expressing the internal feeling and worries to a family member or to close friends.

Health education programs should be toke place at schools for pupils and teachers about the signification of physical and psychological reactions of the traumatic experience, and how we can seek help in order to overcome the adverse effects of the traumatic events.

Professionals in mental health field have to cooperate together to create some treatment program in order to overcome and decrease the prevalence cases of PTSD.

Training programs for the schools health workers to use some questionnaires in order to help them discovering the new cases of the children.

Free telephone counseling program should be available at any time to provide mental health instructions and support to those people anywhere in Palestine.

Health promotion measures have to be started, since it was concluded that parenting support decrease the posttraumatic stress disorder reactions among children through continuous parental education, awareness, and support.

6.3 Recommendations for further research

Further research needed to be conducted in this field is that, does traumatized parents can provide the needed parenting support to their children.

Follow - up studies are needed on a regular annual basis for detecting of posttraumatic stress disorder level among traumatized children.

Continuous survey to detect the prevalence of posttraumatic stress disorder among different population categories, mainly children and adolescence.

Posttraumatic stress disorder and it's long - term consequences on children academic achievements.

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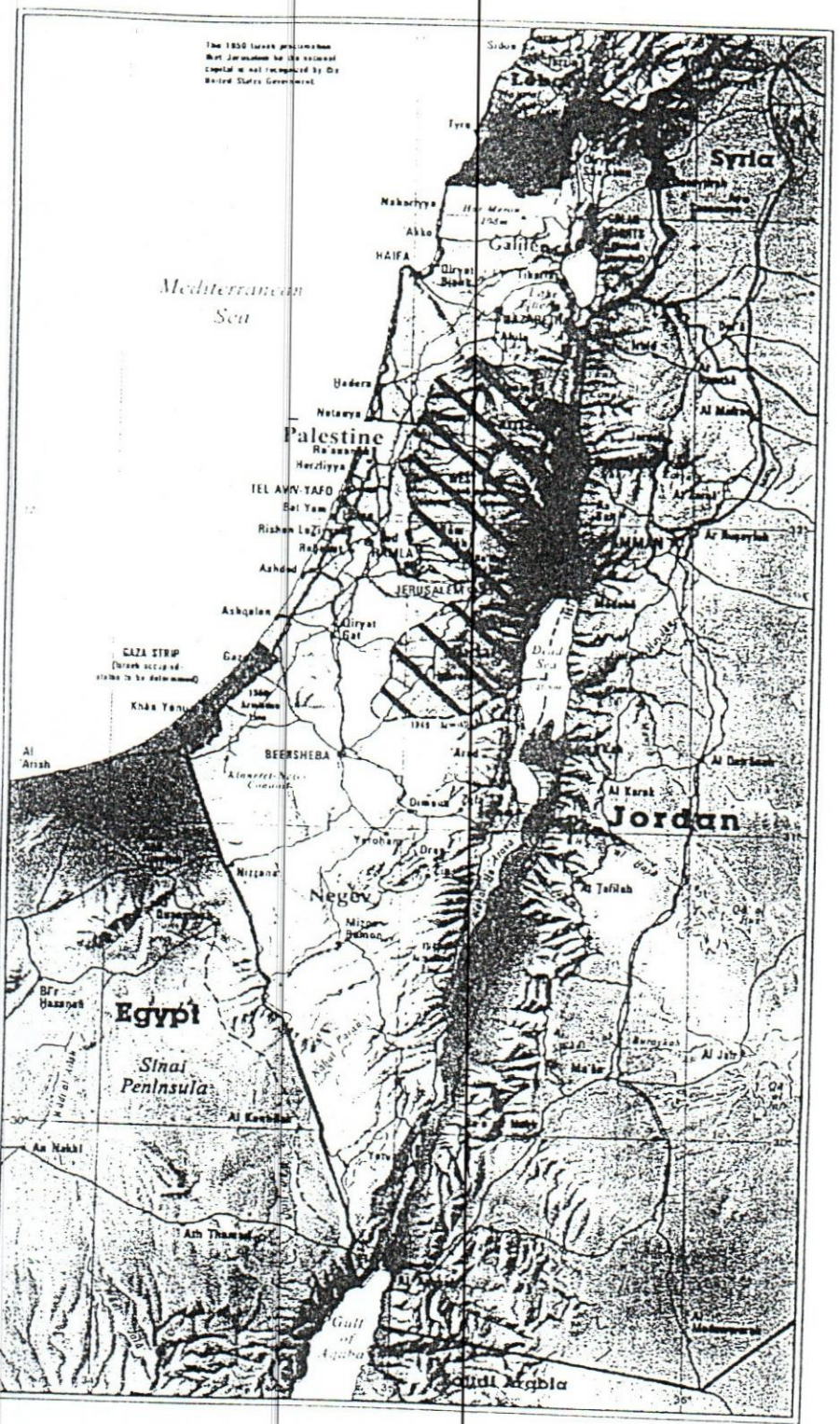
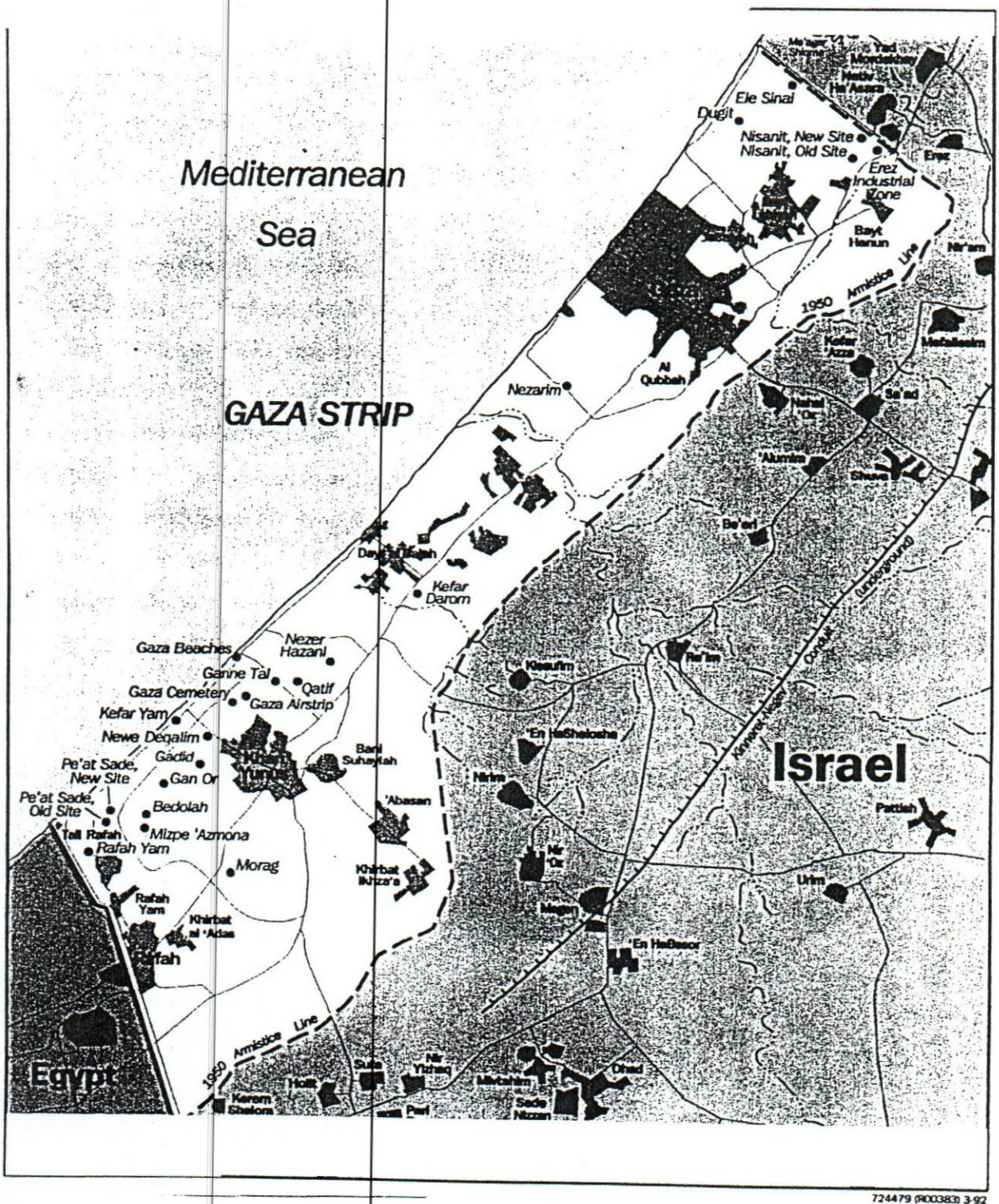
Annex 1 Map of Palestine



Palestine

Annex 2 Map of Gaza Strip



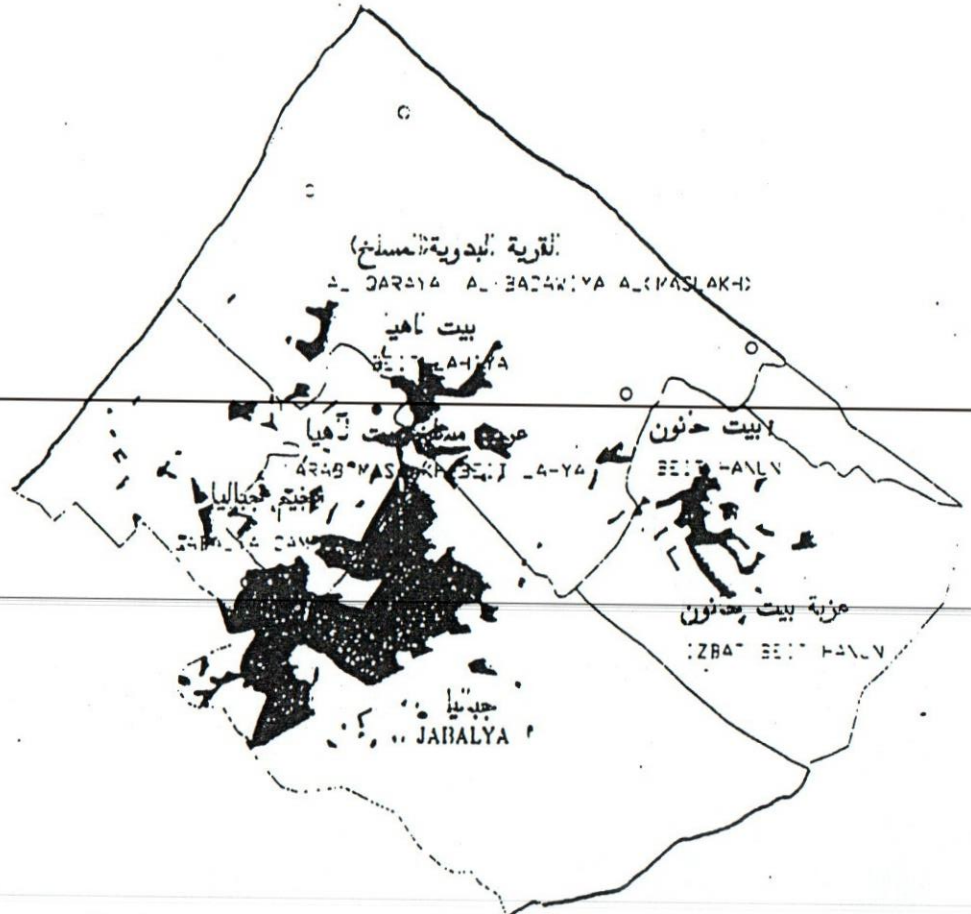
Annex 3

الجهاز المركزي للاحصاء الفلسطيني

PALESTINIAN CENTRAL BUREAU OF STATISTICS

محافظة شمال غزة

NORTH GAZA GOVERNORATE



Annex 4

Palestinians (Martyrs) in Al-Aqsa Uprising (Intifada), by District of Residence and Age Group(2001).

District of residency	Age Group					
	Less than 18	18 -29	30 - 39	40 - 49	50+	Total
North Gaza	15	86	7	4	3	115
Gaza	58	104	29	15	14	220
Dier El Balah	27	63	10	7	9	116
Khan Younis	43	79	17	10	6	155
Rafah	43	91	23	7	6	170
Total	186	423	86	43	38	776

Annex 5

DSM-IV Criteria for Posttraumatic Stress Disorder

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

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

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

(1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

(3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.

(4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

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

(1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) Efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) Inability to recall an important aspect of the trauma

(4) Markedly diminished interest or participation in significant activities

(5) Feeling of detachment or estrangement from others

(6) Restricted range of affect (e.g., unable to have loving feelings)

(7) Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

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

(1) Difficulty falling or staying sleep

(2) Irritability or outbursts of anger

(3) Difficulty concentrating

(4) Hypervigilance

(5) Exaggerated startle response

Annex 6

بسم الله الرحمن الرحيم

Palestinian National Authority
Ministry of Health
Helsinki Committee

السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

Date: 2/3/2003

التاريخ: ٢٠٠٣/٣/٢

Mr./ Ibrahim Abo Nada

السيد: ابراهيم أبو ندى

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

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

The Impact of Parenting Support and Traumatic Stress Disorder on Palestinian Children"

"تأثير الدعم الوالدي على أعراض ما بعد الخبرة الصادمة على الأطفال الفلسطينيين الذين يعيشون في غزة"

In its meeting on January 2003

و ذلك في جلستها المنعقدة لشهر مارس ٢٠٠٣

and decided the Following:-

و قد قررت ما يلي:-

To approve the above mention research study.

الموافقة على البحث المذكور عاليه.

Signature
توقيع

Member	Member	Chairperson
عضو	عضو	

Conditions:-

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

غزة مجمع النصر الطبي-تلفاكس ٢٨٧٨١٦٦-٧-٩٧٢ ص ب (٥٣١٤) البريد الإلكتروني: ghsrc@palnet.com
Gaza El-Nasser Medical Complex. Telefax 972-7-2878166 P.O.Box (5314) E. Mail ghsrc@palnet.com

Annex 7

بسم الله الرحمن الرحيم

التاريخ : - / / 2003

عزيزي الطالب / عزيزتي الطالبة

السلام عليكم ورحمة الله وبركاته

أمامك بعض الاستمارات التي تحتوى على أسئلة وهى من متطلبات رسالة الماجستير الخاصة بي في مجال الصحة النفسية المجتمعية بجامعة القدس (كلية الصحة العامة) وتهدف الدراسة إلي معرفة مدى تأثير الدعم الوالدى وعلاقته بإعراض الخبرة الصادمة علي الأطفال الفلسطينيين في المرحلة الإعدادية والذين يعيشون في قطاع غزة وهذه الدراسة تهدف إلي التطور والبحث العلمي فقط.

لذا أرجو منك الإجابة على جميع الأسئلة بصراحة وواقعية والحرص علي إعادة الاستبيانات إلي المدرسة .

وشكرا لحسن تعاونكم

وتقبلوا بفائق الاحترام والتقدير

الباحث/

إبراهيم أبو ندى

طالب ماجستير في الصحة النفسية المجتمعية

ملاحظة /

المقصود بالخبرة الصادمة : - هي أي حدث يتعرض له الشخص وتظهر بعدها عليه أعراض نفسية وجسمانية.

التدعيم الوالدى : - هو المساندة والحماية والرعاية التي يوفرها الأب أو الأم أو كليهما معا لابناءهما.

رقم هاتف العمل 2457875 البيت 2472123 جوال 775037

Annex 9

مقياس غزة للخبرات الصادمة
Gaza Traumatic events checklist

عزيــزي/ تــى : أمــامك مجموعة من البنود التي توضح أنواع الخبرات الصادمة (الأحداث المؤلمة) التي يــتعرض لها أي شخص في الظروف الصعبة مثل الحروب ،الاحتلال والتي تشمل ما تعرضت له خلال الأ الماضية. نرجو أن تضع علامة صح في الخانة الموجودة أمام السؤال:

الرقم	الحدث/ الخبرة الصادمة		نعم	لا
1	إصابتك شخصيا بالرصاص			
2	سماعك لمقتل صديق			
3	سماعك لمقتل أب/أخ/أم/أخت			
4	مشاهدة أحد أصدقائك وهو يقتل من الجيش			
5	مشاهدة إصابة صديق لك بالرصاص من الجيش			
6	مشاهدة مناظر وصور الجرحى والشهداء في التلفزيون			
7	مشاهدة منظر تفجير البيوت في التلفزيون			
8	مشاهدة أب/أخ/أم/أخ وهو يقتل من الجيش			
9	سماعك لعمليات اقتحام من الجيش			
10	مشاهدة عمليات اقتحام من الجيش			
11	مشاهدة إقتحام منزلكم أو منزل الجيران ليلا			
12	مشاهدة بيتك وهو يهدم من الجيش			
13	تعرض أرضك للتجريف			
14	مشاهدة بيت أحد أصدقائك وهو يهدم			
15	مشاهدة بيتك يقصف بالمدفعية والرشاشات			
16	مشاهدة بيوت الجيران تقصف بالمدفعية والرشاشات			
17	مشاهدة قصف البيوت والمقرات بالصواريخ من الطائرات			
18	مشاهدة عملية اغتيال بالصواريخ			
19	مشاهدة أحد أقرباءك وهو يقتل برصاص الجيش الإسرائيلي			

Annex 10

مقياس الاضطرابات النفسية الناتجة عن خبرة صادمة

CPTSD- RI Scale according to DSM - IV

ترجمة / د. عبد العزيز ثابت

عزيزي / عزيزتي

الأسئلة التالية تتعلق بالخبرة الصادمة التي تعرضت لها خلال الفترة الماضية . كل سؤال يصف التغيرات التي حدثت في صحتك ومشاعرك خلال الفترة السابقة . من فضلك أجب علي كل الأسئلة .

وشكرا لتعاونك/ي

الرقم	أعراض الخبرة الصادمة		أحيانا	دائما	لا
1 -	هل تنتابك صور ، ذكريات ، وأفكار عن الخبرة الصادمة				
2 -	هل تنتابك أحلام مزعجة عن الخبرة الصادمة				
3 -	هل تنتابك مشاعر فجائية أو خبرات بأن ما حدث سيحدث مرة أخرى				
4 -	هل تتضايق من الأشياء التي تذكرك بما تعرضت له من خبرة صادمة				
5 -	هل تتجنب المواقف أو المشاعر التي تذكرك بالخبرة الصادمة				
6 -	هل تتجنب الأفكار أو المشاعر التي تذكرك بما تعرضت له من خبرة صادمة				
7 -	هل لديك فقدان للذاكرة للأحداث الصادمة التي تعرضت لها				
8 -	هل لديك صعوبة في الاستمتاع بالحياة والنشاطات اليومية				
9 -	هل تشعر بالعزلة وبأنك بعيد عن الآخرين				
10 -	هل تشعر بعدم الحب والانبساط				
11 -	هل أنت غير قادر علي الشعور بمشاعر الحزن والفرح				
12 -	هل تجد من الصعوبة التخيل بأنك ستعيش لفترة طويلة لتحقق أهدافك في الحياة				
13 -	هل لديك صعوبة في النوم أو البقاء نائما				
14 -	هل تنتابك نوبات من التوتر والغضب				
15 -	هل تعاني من صعوبات في التركيز				
16 -	هل من السهل أن يشتت انتباهك				
17 -	هل تستثار من أتفه الأسباب ودائما مستفز				

nex 11

مقياس الرعاية الو الدية للأبناء

عزيزي / عزيزتي

السلام عليكم ورحمة الله وبركاته ..وبعد

فيما يلي بعض الممارسات التي تصدر عن الأباء في تعاملهم مع أطفالهم، برجاء وضع علامة ( ) أمام كل عبارة وذلك في الخانة التي ترى أنها أكثر انطباقا عليك مع عدم وضع أكثر من علامة واحده أمام كل عبار علما بأنه ليست هناك إجابة صحيحة وأخرى خاطئة . كذلك فهذه المعلومات سرية للغاية ولإغراض البحث العلمي فقط. شاكرين لكم حسن تعاونكم معنا..

الرقم	العبارة		نعم	أحيا نا	لا
1	يشاركني والداي في كثير من الألعاب التي أقوم بها				
2	يبدى والداي كثيرا من التسامح معي				
3	علاقتي بوالداى تتميز بالدفء والمحبة				
4	العقاب هو أول وسيلة يستخدمها والداي للتهذيب عندما أخطئ				
5	يحضر لي والداي كثيرا من الألعاب التي تناسب سني				
6	يثنى علي والداي عندما أفعل شيئا يطلب منى				
7	عندما أمرض يتولى والداي أمر عرضي علي طبيب				
8	يراجع والداي دروسي معي ويتأكدون من أدائي لها				
9	يعطيني والداي العديد من التوجيهات في وقت واحد				
10	يعبر والداي بصراحة عن عاطفتهما نحوى				
11	يتغاضى والداي عن بعض الأخطاء التي أرتكبها				
12	يلبي والداي جميع متطلباتي واحتياجاتي				
13	يكافئني والداي بالكثير من المال والهدايا				
14	يحرص والداي علي مراجعة مدرسة ومناقشتهم في شئوني				
15	يقف والداي إلي جانبي حتى وإن كنت مخطئا				
16	يحترم والداي محاولاتي في القيام ببعض الأشياء بل ويشجعونني علي ذلك				

17	يجيب والداي عن التساؤلات التي أوجهها لهما بكل موضوعية وبدون تجاهلها				
18	عندما لا أستطيع أداء ما يطلب منى فإن والداي يتقبلون ذلك بشكل طبيعي ويشجعوني علي أن أكرر المحاولة				
19	عندما يتحدث إلي والداي فإنهما ينظرون إلي الموقف من وجهة نظري أنا				
20	لا أعتقد أنني أقرب الناس إلي والداي				
21	يتساهل معي والداي عندما أبدى عدم الطاعة				
22	أفتقد والداي كثيرا عندما يكونا بعيدين عنى				
23	حينما يبتعد عني والداي بعض الوقت أشعر وكأن هناك شيئا ثمينا أفتقده				
24	يساعدني والداي في حل ما أتعرض له من مشكلات				
25	عادة ما يهددني والداي بسحب الحب				
26	يعمل والداي على إعادة توجيه اهتماماتي وأنشطتي				
27	يعطيني والداي الحرية في اكتشاف نفسي ما حولي				
28	يحافظ والداي على خطوط الاتصال مفتوحة بيننا				
29	يعلمني والداي الأخذ والعطاء في التعامل				
30	يفرض علي والداي نظاما معينا يصبح علي أن التزم به				
31	يوضح لي والداي الصواب والخطأ والحلال والحرام				
32	يشجعني والداي علي تكوين وجهة نظر مستقلة				
33	ألجأ إلي والداي عندما أحتاج إلي المساعدة				
34	يشجعني والداي في أن أجرب كل شئ بنفسي				
35	يحترم والداي رغبتي عندما أبديها في شئ معين				
36	يقدر والداي رائي عندما أبديه ويناقشونني فيه				
37	يشجعني والداي في تكوين شخصيتي المستقلة				
38	عندما أرتكب خطأ معين فإن والداي يوضحون لي الصواب				
39	كثيرا ما أشك في حب والداي لي				
40	يبدى والداي قلقا وخوفا واضحا مما يجعلني ألاحظ ذلك				
41	لا توجد حواجز بيني وبين والداي				

42	يقدرني والداي لذاتي				
43	أعتمد علي والداي بدرجة كبيرة				
44	والداي دائمي التوبيخ لي حتى علي الأمور البسيطة				
45	يشجعني والداي علي أن أكون صادقا وأمينا				
46	يعودني والداي علي أداء بعض الشعائر الدينية				
47	تعليمات والداي لي متضاربة				
48	يستخدم والداي العقاب أكثر من الإثابة في التعامل معي				
49	يحرص والداي علي أن يكونا صادقين في الحديث معي				
50	يراعى والداي مشاعري ويقدرانها				

شكرا لحسن تعاونكم

المشرف علي تطبيق الاستمارات

إبراهيم أبو ندى

Annex 12

إستبانة بحث حول تأثير التدعيم الوالدى علي أعراض ما بعد الخبرة الصادمة لدى طلاب المرحلة الإعدادية في قطاع غزة.

مقدمة موجهة إلي المجيبين علي الاستمارات ووالديهم :-

هـــذه دراســـة علمية يقوم بتطبيقها الباحث / إبراهيم حسن أبو ندى وهى من ضمن متطلبات برنامج الماجستير في مجال الصحة النفسية المجتمعية التابع لجامعة القدس (كلية الصحة العامة).

الهـــدف من هذا البحث هو التعرف علي إمكانية وجود علاقة بين التدعيم الوالدى وأعراض الخبرة الصادمة لدي تلاميذ المرحلة الإعدادية في قطاع غزة ، لذا نرغب أن تجيب علي عدد من أسئلتنا ، ليس هناك جواب صحيح أو جواب خطأ .

إن الاشـــتراك في الإجابة علي أسئلة هذا البحث اختياري وأن اشتراككم أو عدمه ليس له تأثير علي حقوقكم للحصول عـــلي الخدمات الطبية والاجتماعية من أي سلطة أو مؤسسة ، فنحن نتعهد أن الإجابات التي تقدمونها سوف تبقى سرية ولـــن نقوم بإعطاء اسمكم أو أسم طفلكم إلي أي شخص ولن ننشر أي معلومات يمكن أن تؤدى إلي التعرف علي اسم أي فرد أو إلي عائلاتكم.

موافقة ولى الأمر

Annex 13

بسم الله الرحمن الرحيم

l – Quds University
Jerusalem
School of Public Health

جامعـــة القـــدس
القـــــدس
كلية الصحة العامة

لمن يهمه الأمر

تشـــهد كلـــية الصـــحة العامة–جامعة القدس بأن طالب إبراهيم أبو ندا ملتحق لدينا ببرنامج ماجســـتير الصحة النفسية المجتمعية تحت الرقم الأكاديمي 20111913 و مسجل لدينا خلال الفصل الدراسي الأول من العام الأكاديمي 2003/2002

و قد أعطيت له هذه الشهادة بناء على طلبه.

عميد كلية الصحة العامة

د. سوزان شعشاعة

Annex 14

مدارس الإعدادية (ذكور و إناث) الواقعة في بيت حانون ، م . جباليا ، الرمال والتابعة لوكالة الغوث

الرقم	اسم المدرسة	عدد صفوف وطلاب الأول الإعدادي		عدد صفوف وطلاب الثاني الإعدادي		عدد صفوف وطلاب الثالث الإعدادي	
		عدد الشعبة	عدد الطلاب	عدد الشعب	عدد الطلاب	عدد الشعب	عدد الطلاب
1 -	مدرسة ذكور جباليا الإعدادية / أ	10	462	7	321	8	366
2 -	مدرسة ذكور جباليا الإعدادية / ب	9	444	11	525	7	332
3 -	مدرسة بنات جباليا الإعدادية / أ	13	647	9	444	5	234
4 -	مدرسة بنات جباليا الإعدادية / ب	6	290	11	547	11	538
5 -	مدرسة ذكور جباليا الإعدادية / ج	13	635	9	431	7	320
6 -	مدرسة بنات جباليا الإعدادية / ج	13	616	8	400	8	394
7 -	مدرسة بنات بيت حانون الإعدادية	10	482	10	455	7	346
8 -	مدرسة ذكور بيت حانون الإعدادية	10	458	7	346	7	325
9 -	مدرسة ذكور صلاح الدين الإعدادية	6	261	5	213	4	176
10	مدرسة ذكور الزيتون الإعدادية	8	390	8	362	7	334
11	مدرسة بنات المأمونية الإعدادية	4	199	5	212	5	203
12	مدرسة بنات الرمال الإعدادية	7	311	7	323	6	294
Total		109	5195	97	4579	82	3868

عدد الطلبة والطالبات حسب مدارس المناطق المذكورة	الأول الإعدادي	الثاني الإعدادي	الثالث الإعدادي	الإجمالي
عدد طلاب وطالبات منطقة م . جباليا	3094	2668	2184	7946
عدد طلاب وطالبات منطقة بيت حانون	940	801	671	2412
عدد طلاب وطالبات منطقة الرمال	1161	1110	1007	3278

عدد الطلاب والطالبات الإجمالي في المناطق المذكورة هو 13636

مدارس الإعدادية (ذكور و إناث) الواقعة في بيت حانون ، م. جباليا ، الرمال والتابعة لوكالة الغوث والتي تم تطبيق الاستبيانات فيها

الرقم	اسم المدرسة	عدد الدعوات	عدد الاستجابات
-1	مدرسة ذكور جباليا الإعدادية / أ	75	75
- 2	مدرسة بنات جباليا الإعدادية / ج	75	75
- 3	مدرسة بنات بيت حانون الإعدادية	75	75
- 4	مدرسة ذكور بيت حانون الإعدادية	75	75
- 5	مدرسة ذكور صلاح الدين الإعدادية	75	75
- 6	مدرسة بنات الرمال الإعدادية	75	75

Annex 15

بسم الله الرحمن الرحيم

التاريخ : - ٦ / ٢ / ٢٠٠٣

تحية طيبة وبعد ::::

أود التكرم بإحاطة سيادتكم علما بأنني أقوم بعمل دراسة بعنوان

The impact of parenting support and the post - traumatic stress disorder on Palestinian Children (preparatory school) living in Gaza. (Cross sectional study).

وذلك من متطلبات رسالة الماجستير في الصحة النفسية المجتمعية بجامعة القدس (كلية الصحة العامة)

وتهدف الدراسة إلي معرفة مدي تأثير الدعم الوالدي وعلاقته بإعراض الخبرة الصادمة علي الأطفال الفلسطينيين في المرحلة الإعدادية والذين يعيشون في قطاع غزة.

هذا للعلم وتقبلوا بفائق الاحترام والتقدير

مقدمه

إبراهيم أبو ندى

طالب ماجستير في الصحة النفسية المجتمعية

رقم هاتف العمل ٢٤٥٧٨٧٥ البيت ٢٤٧٢١٢٣ جوال ٧٧٥٠٣٧

O/C Col. Prog.
5/2/2003