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Post-traumatic Stress Disorder due to War Trauma and Social and Family Support among Adolescent in the Gaza Strip

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بسم الله الرحمن الرحيم

"وَلَنَبْلُوَنَّكُمْ بِشَيْءٍ مِنَ الْخَوْفِ وَالْجُوعِ وَنَقْصٍ مِنَ الْأَمْوَالِ وَالْأَنْفُسِ وَالثَّمَرَاتِ وَبَشِّرِ

الصَّابِرِينَ * الَّذِينَ إِذَا أَصَابَتْهُمْ مُصِيبَةٌ قَالُوا إِنَّا لِلَّهِ وَإِنَّا إِلَيْهِ رَاجِعُونَ"

سورة البقرة 155-156

Dedication

I dedicate this work for:

My mother and father for their support

My husband Khaled for his patience and precious support

My sisters and brothers who stand with me

My friends, relatives, and everybody who encourage me to finish this hard work

All Palestinian martyrs who sacrificed their lives for freedom

To all injured in Palestine

Niveen A. AL-Sheikh

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 of its parts) has not been submitted for higher degree to any other university or institution .

Signed: …….

Niveen Ahmed AL.Sheikh

Date: / / 2017

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With my best wishes

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Abstract

This study aimed to investigate the relationship between war trauma, PTSD, social and family support among adolescent in the Gaza Strip. The sample consisted of 400 students (200 boys and 200 girls) from the five governorates of the Gaza Strip aged from 13-18 years old. Descriptive analytic, cross sectional, stratified design was used. By using four applied tools as follow: Gaza traumatic events checklist, Post-traumatic stress disorder checklist, social support scale, and family crisis oriented personal evaluation scales, also use socio-demographic characteristic questionnaire.

The result show that the total mean of traumatic experiences was 12.19. There were statistically significant differences in traumatic experiences according to sex toward boys, and statistically significant according to age. Also, the results show that there were no statistically significant according to type of school, place of residence, monthly income.

Until, the result show that 133 of adolescents (33.3%) show no PTSD, 130 of adolescents (32.5%) show at least one criteria of PTSD (B or C or D), 100 show partial PTSD (25%), and 37 of adolescents show full criteria of PTSD (9.3%). And the result show that there were statistically significant in PTSD scores according to sex favor of male. and no statistically significant differences according to age, type of school, place of residence, number of family member, and family monthly income.

Also, the result show that the mean of total scores of social support was 83. And show that there were statistically significance differences in social support according to age, and no statistically significance differences according to *sex, type of school, place of residence, number of the family member, and family monthly income.*

And show that the mean of family support was 3.24, and there were statistically significant differences in family support according to age, type of school and place of residence. But there were no statistically significant differences in family support according to sex, number of family member, and family monthly income.

Also the result show that there was significant correlation between total traumatic events, total PTSD and family support, but no significant correlation between traumatic events experience and the social support. Also there was significant correlation between PTSD, social support, and family support. Until, there was significant correlation between social support and family support. Conclusion: the results confirms the importance of assessing PTSD in schools settings.

Table of contents

List of tables

List of figures

List of annexes

Abbreviations

A-DES	Adolescents and Adolescents Dissociative Experiences Scale
ANOVA	Analysis of Variables
CD-RISC	Connor–Davidson Resilience Scale
CPM	Child Psychological Maltreatment
CPTSD-RI	Child Post Traumatic Stress Reaction Index
CRF	Corticotropin-Releasing Factor
CV	Community Violence
DSM-I	Diagnostic and Statistical Manual of Mental Disorders first edition
DSM-III	Diagnostic and Statistical Manual of Mental Disorders third edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders fourth edition
DSM V	Diagnostic and Statistical Manual of Mental Disorders fifth edition
DSRC	Depression Self-Rating scale for Children
DTS	Davidson Trauma Scale
EP	Economic Pressure
EMDR	Eye Movement Desensitization and Reprocessing
FAS	Family Ambiance Scale
FCMNS	Fulfillment of Child's Material Needs Scale
F-COPES	Family Crisis Oriented Personal Evaluation Scales
GIS	Gender Inequities Scale
GS	Gaza Strip
GTEC	Gaza Traumatic Events Checklist
HDS	Harsh Discipline Scale
HPA	Hypothalamic-Pituitary-Adrenal
ICD-10	International Classification of Diseases system
ISSB	Inventory of Socially Supportive Behaviors
LSD	Least Significant Difference
MFQ	Mood and Feelings Questionnaire
MOH	Ministry of Health
NGOs	Non-Governmental Organisation
OCHA	Office for the Coordination of Humanitarian Affairs
PC	Progressive Counting
PCBS	Palestinian Central Bureau of statistics

PHIC	Palestinian Health Information Center
PPSS	Perceived Parenting Support Scale
PSS	Parental Support Scale
PSSS	Perceived Social Support Scale
PTG	Posttraumatic Growth
PTGI	Posttraumatic Growth Inventory
PTS	Posttraumatic Stress
PTSD	Posttraumatic Stress Disorder
PTSS	Posttraumatic Stress Symptoms
RCMAS	Revised Children's Manifest Anxiety Scale
RRT	Relational Regulation Theory
SCQ-P	Positive Simplified Coping Style Questionnaire
SES	Socioeconomic Status
SPSS	Statistical Package for Social Sciences
SRQ	Social Reactions Questionnaire
SSQ	Social Support Questionnaire
SSS	Social Support Scale
STAI	State-Srait Anxiety Inventory
STS	Secondary Traumatic Stress
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
US	United State
WB	West Bank
WHO	World Health Organization

Chapter (1)
Introduction

1.1 Background

The Palestinian people live in a very hard and difficult condition in all side of their life, economic, social, political and psychological. So Palestinians are at high risk of exposure to traumatic events that have the capacity to produce traumatic stress reactions. Child and adolescent exposed to high level of trauma and conflict may be develop diagnosable mental health problems as posttraumatic stress disorder, anxiety and depression (Thabet et al., 2008).

Trauma as a life-threatening event affects children's mental health and development extensively, research has largely focused on psychological symptoms such as posttraumatic stress disorder (PTSD), while the impact of trauma on social relations and other developmental aspects, as important as they are, is ignored (Peltonen et al., 2010).

Post-traumatic stress disorder is a chronic disorder marked by intrusive recollection of the traumatic event, as well as avoidance manifested in behaviors such as withdrawal psychic numbing, and loss of interest in previously enjoyed activities, in addition to arrange of hyperarousal symptoms such as concentration and sleep difficulties, startle reactions, irritability, hostility, and outbursts of range. And it is one of the psychiatric disorder developed due to exposed to traumatic events.

Social support that the environment is a source of effective social support, and the availability of people are interested of the individual, caring for the child, trust him, and take his hand and stand beside him when needed, such as Family, friends, neighbors (Sarason et al., 1983).

Social support as: satisfying the basic needs of the individual love , respect ,appreciation, understanding, communication, sympathy , share concerns ,and provide information, and this is with persons who have great importance in the life of the individual, especially at the time of crisis and pressure (Cutrona, 1996).

Adolescence is a highly stressful period of development in which the individual is faced with numerous challenges. Adolescents were at greater risk than adults for developing

PTSD. Adolescence therefore can potentially represent a period of heightened vulnerability during which risk of experiencing trauma is particularly high, as compared to both childhood and adulthood, but the ability to adaptively cope with that trauma is particularly fragile (Van der Kolk, 1985).

Adolescent are developed different of physical and psychological reactions after exposure to traumatic events, these symptoms are specific for PTSD, e.g.: re-experiencing symptoms, avoidance symptoms, hyperarousal, and hypervigilance symptoms (Dekel & Solomon, 2006).

The adolescent and their families were exposed to the same stressful situation, traumatic events, and under the death threatening. However, the family has the responsibility to provide a shelter for their traumatized adolescents. So, family-adolescent relationship is very important source in providing a protective shield for adolescent psychological well-being in threatening situation (O'Doherty et al., 2006).
The positive influence of the family on treatment and rehabilitation, suggesting that family interventions can reduce relapse rates among persons with mental problems and help their rehabilitation in the community (O'Doherty et al., 2006).

World Health Organization "WHO" (2003), defined the mental health as it is "a state of emotional and psychological well-being in which an individual is able to use his or her cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life. So posttraumatic stress disorder (PTSD) is reactive psychopathological response to traumatic event, and it is reported poor life satisfaction, psychological, behavior and emotional problems" (Schnurr & Green, 2004).

The Gaza Strip is characterized by good social and family cohesions, they give him the Optimistic and the confidence among the population, the Palestinian people have social cooperation as one family, because there are a lot of habits, values and good manners that lead to improve mental stat and social context, and able to adapt and deal with changing events (Abu Rahma, 2012).

The last war on the Gaza Strip was in August 2014, it is considered the most destructive one in comparison with two previous wars, which lasted for 51 day. This war caused

killing 2,145 Palestinians, 578 of them were children and adolescents, about 11,000 others had been wounded, more than 500,000 Palestinians internally displaced at the height of the hostilities, Over 100,000 still displaced, and approximately 18,000 housing units destroyed or severely damaged (OCHA, 2014).
And according to Palestinian Central Bureau of Statistics (2010), there are direct and indirect exposure to violence is common among children and adolescents in Palestine, and especially among those living in the Gaza Strip.

The Gaza Strip has been badly affected by wars and conflicts over the last many years especially in 2008, 2012, and 2014. Many reports and statistics demonstrated that the conflict in 2014 was the most sever and destructive one on all aspects of life and population in the Gaza Strip.

Local and international researcher published large number of research studies due to political violence, and the important of family and social support of the adolescent during the stressful situation and traumatic experience as well as their adolescent (e.g. Thabet et al., 2004; 2012; 2014). This study try to investigate concerns with traumatic events experience and it possibility to develop PTSD among adolescents in the Gaza Strip, so it tries to investigate the relationship between PTSD and family and social support.

1.2 Research problem

The Gaza Strip considered one of the most hot areas in the world that exposed regularly for extensive conflicts and wars. Especially that Gaza Strip exposure to three wars continuously in short time between this events in 2008, 2012 and 2014, that's mean that some people lived in all of this conflicts in the child hood and return in adolescent period.

Exposure to traumatic events can cause behavioral and emotional problems in children and adolescents. So many of studies focused on the traumatic effect of wars and conflicts Gazans people who live in the Gaza Strip, and this studies reported that children and adolescents living in war and conflict area are at high risks for developing mental health problems such as post-traumatic stress disorder, depression, and anxiety (Thabet et al., 2004; 2008, Altawil et al., 2008; Afana et al., 2010; El-Sarraj et al., 2011).

A millions of people are diagnosed with each year, in Australia, estimates for 12-month prevalence range between 1.3% (Creamer et al., 2001), and in USA 3.6% (Narrow et al. 2002). But in Palestinian study, a large-scale survey of 2,100 adolescents found that 35% of those in the West Bank and 36% of those in the Gaza Strip reported symptoms of PTSD (Abdeen et al., 2008).

More recently, Thabet et al. (2014) in a study showed that 29.8% of adolescents reported symptoms of PTSD. And Thabet et al., (2015a), study showed that 37.6% have full criteria of PTSD, but Qeshta (2015), study show that 16.4% of children have full criteria of PTSD. Also, Al ibwaini (2015), study reported that 20.1% of adolescents had full criteria of PTSD.

The traumatized people need supports to live in good life and resilience. So the intention of this research is to investigate the relationship between family and social support and PTSD among adolescent in the Gaza Strip, with particular reference to their experience during wars and conflicts. From this point of view the researcher build up the problem statement for this study to highlight PTSD and effects of family and social support among the target group.

The study will investigate the relationship between war trauma and Post-traumatic stress disorder, social and family support among adolescent in the Gaza Strip.

1.3 Justification

The last war 2014 different from last two wars (2008, 2012) in duration and severity, all of the Gazans people had panic and fear from the death. And during the researcher was worked in the psychiatric mental health clinic during the last war 2014, a lot of adolescent visited the clinic had symptoms of PTSD as restlessness, insomnia, night mars and other symptoms.

And most of their families did not know how to deal with them, and did not know about the important of family and social support to decrease the PTSD symptoms. So the families came to the clinic very confused and worry about these new changes in their children behaviors, and asked many questions about the ways of intervention. A lot of them did not know how to deal with that symptoms and they did not know about the important roll

which it was played by the family members and the community in order to decrees the trauma symptoms.

Also, adolescence is a highly stressful period of development in which the individual is faced with numerous challenges. So the researcher decided to make a research about the family and social support and how they affect of the PTSD symptoms. And the important of this study arise from circumstance during the conflict, where most of families were exposed to many traumatic events; also the researcher believes that these symptoms might be decline or reduce if the adolescent provided support from his family and surrounding environment.

And when reviewing the articles and literature the researcher found that there is not a lot studies about these type of study the social and family support together did in the Gaza Strip. So the researcher want to detect the relationship between PTSD due to war trauma and social and family support. On other hand, the researcher predicts through the result of the study to add new approach in dealing with PTSD through family and social support. And this study may provide guidelines of other researchers to conduct future studies.

1.4 Study objectives

1.4.1. General objective:

The objective of this study is to investigate relationship between war trauma, PTSD, social and family support among adolescent in the Gaza Strip.

1.4.2. Specific objectives:

1. To identify the types and severity of trauma among adolescent in the Gaza Strip.
2. To find the prevalence the PTSD among adolescent in the Gaza Strip.
3. To identify the types level of family and social support among adolescent in the Gaza Strip.
4. To explore the relationship between trauma, PTSD, social and family support and other sociodemographic variables.

1.5 Research Question

1. What are the types and severity of trauma among adolescent in the Gaza Strip?
2. What is the prevalence of PTSD among adolescent in the Gaza Strip?
3. What is the relationship between the trauma and PTSD symptoms among adolescent in the Gaza Strip?
4. What is the level of family support among adolescent in the Gaza Strip?
5. What is the level of social support among adolescent in the Gaza Strip?
6. Are there statistically significant differences in the level of PTSD due to the level of family and social support among adolescent in the Gaza Strip?

1.6 Context of the study

This study was conducted in the Gaza Strip, which is part of Palestine. Therefore, here are some information about the geographic context, demographic context, and health care providers.

Since 1948 when Israeli forces occupied Palestine, most Palestinian people were live in refugees' camps in the Gaza Strip, West Bank, and neighbor countries. And Israeli occupation captured The Gaza Strip and West Bank in 1967. Also in 1987, the Intifada started against the Israeli occupation in the Gaza Strip and West Bank, and current Intifada "Al-Aqsa Intifada" in September 2000. The extended effects of wars and conflicts depend on a complex interaction of different factors that include demographic considerations and the specific nature of the individuals war and traumatic experience (Jagodic, 2000).

In the Gaza Strip, at the end of war 2008, more than 1420 Palestinians died, at least 4000 houses were totally destroyed and 16000 partially damaged (Palestinian Red Crescent, 2008). And war 2012 for 8 days, 158 Palestinians were killed (Palestinian Center for Human Right, 2012), also the last war on the Gaza Strip was in 2014 for 51 day, were killed 2.145 Palestinians, 578 of them were children and adolescents, and approximately 18.000 housing destroyed or severely damaged (OCHA, 2014).

1.6.1. Geographic context:

Palestine is about 27.000 km^2, stretches from Ras Al-Nakoura in the north to Rafah in the South. Palestine is boarded by Lebanon in the north, Egypt in the south, Syria and Jordan in the east and Mediterranean Sea in the west. Now Palestine is limited to two geographically separated area, Gaza Strip (GS), and West Bank (WB), total both area is 6020 km^2, which represent 22% of historical Palestine area (MOH, 2006).

The Gaza Strip is an important part of historical Palestine; it is borders from east and north by the 1948 occupied area, Mediterranean Sea from west and Sinai from south. A narrow area of land, 46km in length, and 5-12km in width, with an area of 362km^2 (MOH 1999).

1.6.2. Demographic context:

According to Palestinian health information center (PHIC) 2015, the estimated number of population in Palestinian territories is 4.550 million of which 2.31 million male (50.8%) and 2.24 million are female (49.2%); In West Bank there are 2.79 million (61.3%), 1.42 million are male and 1.37 million are female, but the Gaza Strip is considered one of the heavily population 1.76 million (38.7%) from Palestine population, about 899 thousand male and 866 thousand female.

1.7 Operational definition

1.7.1. Trauma

Psychological trauma is the unique individual experience of an event or enduring conditions, in which the individual's ability to integrate his/her emotional experience is overwhelmed or the individual experiences (subjectively) a threat to life, bodily integrity, or sanity (Pearlman & Saakvitne, 1995).

1.7.2. PTSD

According to American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-V, 2013), PTSD is "an anxiety disorder that can develop after a person is exposed to one or more traumatic events, such as major stress, sexual assault, warfare, or other threats on a person's life. Symptoms include disturbing recurring flashbacks, avoidance or numbing of memories of the event, and hyperarousal, continue for more than a month after the occurrence of a traumatic event".

According to American Psychiatric Association (DSM-IV, 1994), it is an event that is outside the range of usual human experience and that would be markedly distressing to almost any one.

According to Thabet and Vostanis (1999), PTSD 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.

1.7.3. Family support

Is ability of family adjust with client and provide care and assist care provider in mental health care planning. And help the client to use the community services to promote health the well-being (Abu Rahma, 2012).

1.7.4. Social support

Social support is a way of categorizing the rewards of communication in a particular circumstance. An important aspect of support is that a message or communicative experience does not constitute support unless the receiver views it as such (Al Kurd, 2012)

1.7.5. Adolescence

It is the period in life when most of a person's biological, cognitive, psychological and social characteristics are changing in an interrelated manner from what is considered childlike to what is considered adult like. United Nations defined the adolescents as individual aged from 10 to 19 years. In this study the researcher defines the adolescents as individuals aged from 13 to 18 years.

Chapter (2)

Theoretical framework and literature review

Introduction

In this chapter the researcher will talk about theoretical framework and literature review.

The first part present a review about the concept of trauma, PTSD, social support and family support, by examining the early use of these terms in research and theories that interpreted these concepts, and factors associated with them.

The second part will present the previous studies about the four concepts (trauma, PTSD, social support and family support), and the relationship between these concept.

Part I: Theoretical framework

2.1 Conceptual framework

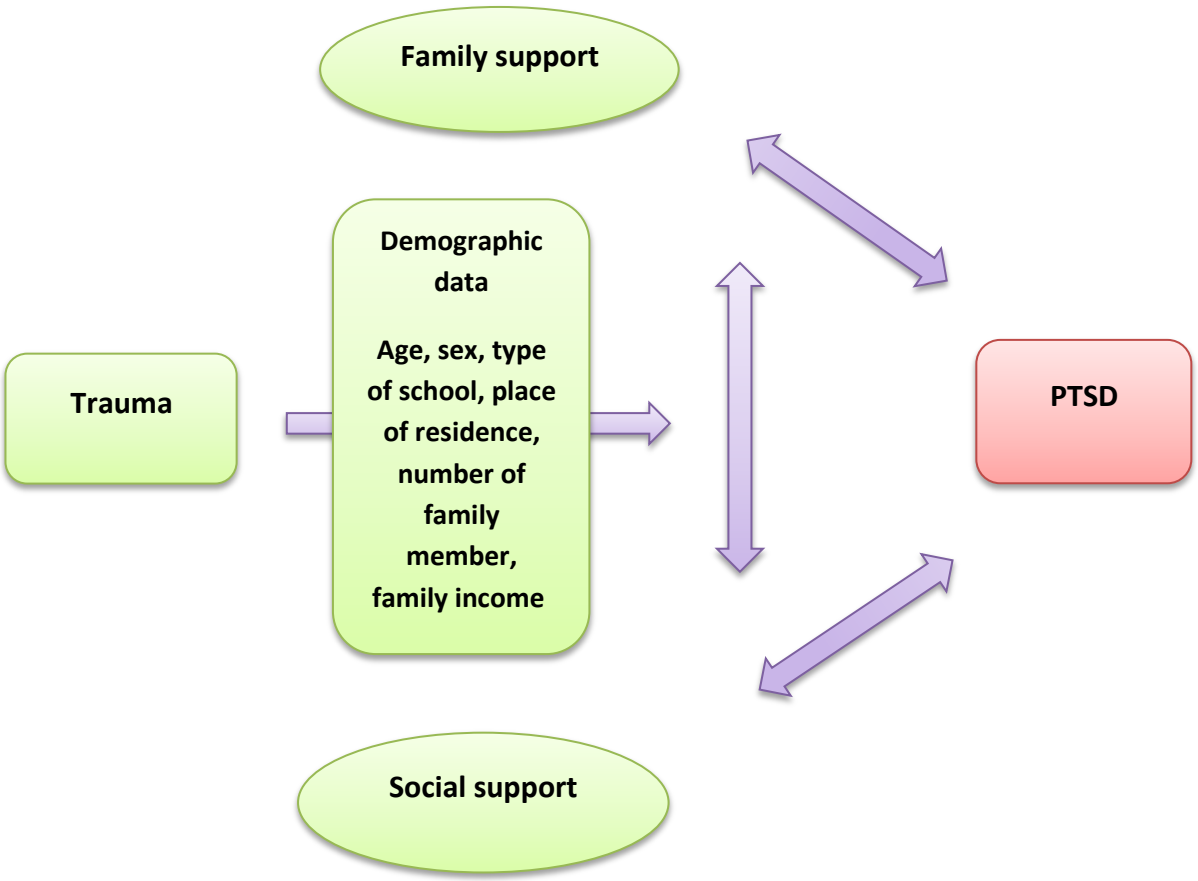

Figure 2.1: Conceptual framework diagram- self developed

This conceptual framework was developed by the researcher to portray the relationship between trauma, family and social support with it is domains, contents and effect at each domain on post-traumatic stress disorder.

This diagram clarifies the independent variable were trauma, family and social support the cause of posttraumatic stress disorder patients as dependent variable .
The researcher explains that there are three major elements in that process: the first is the trauma in which the adolescent emotionally response to a terrible event and experience, witness, a threat to the physical integrity of self or other, or threatened death or serious injury. The second element is the PTSD which is a development of characteristic symptoms following exposure to an extreme traumatic stressor and the symptoms of avoidance, hyper arousal, and re-experiencing the trauma appeared and continued for more than one month. The third element is the social and family support that's mean the ability of family and social adjust with client and provide care and assist care provider in mental health care planning. And help the client to use the community services to promote health the well-being.

Many studies indicate that potentially traumatic experiences varies by basic socio-demographics (e.g. age, sex, race/ethnicity, socioeconomic status). Demographic variables play a role in determining the ways in which adolescents react to violence (Turner et al., 2006). Furthermore, Komarovskaya et al. (2011), study that aimed to examine gender differences in traumatic exposure and associated posttraumatic stress disorder symptoms reported that male higher rates than female, but Brodsky & Lally (2004), concluded that the rates of exposure to traumatic events are similar for males and females. However, for age differences, there are many researches published from 2000 to 2011 indicate that adolescents are at greater risk of experiencing trauma than either adults or children (Nooner et al., 2012).

Social support from parents, peers, and others has been shown to play a protective role both before and after a trauma, with a possible explanatory mechanism being that the presence of social support decreases the likelihood of exposure to repeated trauma (Lee et al., 2007).

Similarly, Thabet et al. (2004), study have indicated that exposure to war trauma constitutes a risk factor for chronic mental health problems, mainly posttraumatic stress disorder, depression and anxiety. Moreover, research indicated that there is a correlation between previous and the number of traumatic experiences, and PTSD, with more exposure leading to an increase of symptoms of trauma. In particular, a strong association was found between children and adolescents who were exposed to war stressors and high levels of PTSD symptoms and grief reactions (Smith et al., 2001). Furthermore, gender is important factor that associated with vulnerability to develop PTSD. Thabet et al. (2014), females are approximately twice as likely as males to develop PTSD following exposure to a traumatic event. Also Komarovskaya et al., (2011), concluded that women showed higher rates of PTSD when compared to men, also, age has been associated with the development of PTSD. Adolescence is a developmental period of heightened vulnerability to trauma and PTSD (Khamis, 2005).

Social factors play an important role in developing PTSD. Pine and Cohen (2002), emphasized that social support is an important factor to assess when working with children exposed to trauma. And explain that the role of less than optimal familial and social support cannot be overestimated as a potential vulnerability factor for developing PTSD, highlighting that disruption of social and familial support plays an important role in the development of psychiatric disturbance.

In addition, the researcher will clarify and measure the social and family support with it is domain as emotional, instrumental, informational, with common interest, and spiritual support. Also the researcher want to investigate many factor that may affect the previous process and play an important role in social and family support, response to traumatic events and in developing PTSD. These socio-demographic factors include age, sex, type of school, place of residence, number of family member, and family income. All of those domains will affect positive or negative on posttraumatic stress disorder patient.

Age and sex very important factors and most of researchers take these two important variable into account in their studies. The researcher believes that there are great physical, cognitive, and emotional differences between males and females, also there are ability differences according to age group which will select. These inevitable differences make age and sex variables deserved to be consider and study.

Also the place of residence factor included to be studied despite the fact that Gaza is a-small piece, and many people belief that this variable it is not important to study, and there is no difference between adolescents live in the Gaza Strip according to their residence. However there are many studies conducted in Gaza which found differences among people according to their place of residence, so the researcher considered that, and studied this factors.

The researcher studied the number of family member factor and if it play a role in PTSD or effect of family and social support development among adolescents. Also the researcher studied the father and mother education and job factor and if it play a role in develop PTSD or effect of family and social support development among adolescents.

Gazans people complain of bad economic status, and there are a high unemployment and poverty rates in the Gaza and these dangerous rates are increasing with time. The researcher thinks that income level is so sensitive and important factor and certainly it would interfere and affect mental health status and family and social support among adolescents.

2.2 Background

2.2.1. Trauma

Most people will experience at least one traumatizing event in their lifetime (Monch, 2014). And prolonged exposure to violence increases the risk of accumulation of major traumatic events and daily life stressors, including physical and economic insecurity, all of which have negative mental and psychosocial consequence (Miller & Rasmussen, 2010; Tol et al., 2011).

Rice and Groves (2005), it is know that every child and adolescent who exposed to a-previous traumatic events will experience and respond to it in his own way, depending on their age, developmental stage, the type of the previous traumatic events and social environment surrounding the child.

2.2.1.1. Definition:

The definition of trauma differs among individuals by their subjective experiences. People will react to similar events differently. In other words, not all people who experience a-potentially traumatic event will actually become psychologically traumatized (Storr et al. 2007).

DSM-IV-TR (2000), defines trauma as direct personal experience of an event that involves actual or threatened death or serious injury, threat to one's physical integrity; or witnessing an event that involves the above experience or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member of close associate.

2.2.1.2. History of trauma theory:

The relationship between trauma and mental illness was first investigated by the neurologist Jean Martin Charcot, a French physician who was working with traumatized women in the Salpetriere hospital. During the late 19th century, a major focus of Charcot's study was hysteria, a disorder commonly diagnosed in women. Hysterical symptoms were characterized by sudden paralysis, amnesia, sensory loss, and convulsions. Until Charcot, the common treatment for hysteria was hysterectomy. Charcot was the first understand that the origin of hysterical symptoms was not physiological but rather psychological in nature, although he was not interested in the inner lives of his female patients. He noted that traumatic events could induce a hypnotic state in his patients and was the first "describe both the problems of suggestibility in these patients, and the fact that hysterical attacks are dissociative problems the results of having endured unbearable experiences" (Van der Kolk et al., 1996).

(Herman, 1992), in Salpetriere, young women who suffered rape, violence and sexual abuse found safety and shelter, and Charcot presented his theory to large audiences through live demonstrations in which patients were hypnotized and then helped to remember their trauma, a process that culminated in the abrogation of their symptoms.

Some theories suggest childhood trauma can increase one's risk for mental disorders including PTSD, depression, and substance abuse. Childhood adversity is associated with neuroticism during adulthood (Jeronimus, et al. 2013).

2.2.1.3. Theories of trauma: (Lever, 2012)

A. Classical Freudian perspective: Repression

Freud's theory, relative to the role of trauma in pathology, went through several refinements. In this early collaboration with Josef Breuer, their work with hysterics led them to postulate that these patients suffer from "reminiscences" which were conceptualized as a return to conscious awareness of an anxiety–provoking memory in the symbolic form of a symptom, in this early formulation, the trauma given rise to the anxiety was considered to be intra-psychic rather external. In other words, any memory, feeling or thought, that might be considered unacceptable or overwhelming to the person's ego given him personality and idiosyncratic sensitivities, could by definition be considered "traumatic" and therefore pushed into forgetfulness by the ego. The process of pushing traumatic material into forgetfulness or what come to be trauma as the process of repression, ordinarily relieved the person of the anxiety associated with the traumatic memory, thought, or, feeling. For hysteria, however, the process of forgetting or repression was only partially successful .

Although the content of the traumatic memory or idea might be forgotten, the associated affect remained and was expressed as a symptom, indirectly and often somatically. This early formulation providing a basic for understanding trauma experience broadly, functionally and idiosyncratically:" trauma" was anything (whether a memory of an actual event or thought or feeling) that was capable of creating within the individual sufficient intra-psychic conflict such that it would, if left in conscious awareness, produce an intolerable level of anxiety. Repression involved an unconscious defensive pushing out of awareness of the actual conflictual material. Treatment of the hysterics symptom involved reconnecting the displaced affect with its original content through catharsis and, indeed. Freud took the successful symptom relief provided by this treatment as support for the underlying causal mechanisms postulated in his theory of repression of traumatic material (Lever, 2012).

Within just a few years, Freud had further refined his history. He found in his work with hysterical patients that the content was uncovered did not always seem to have sufficient traumatic power or to be sufficiently connected to hysterical symptom. He postulated that there must be some experience or memory at work that did possess sufficient traumatic

power to account for his patient's symptoms, a memory that had been pushed even further into unconscious. Thus, in Freud etiology of Hysteria, he proposed that every case of hysteria could be linked to premature sexual experience, that is to an earlier sexual trauma experienced in childhood .This refinement in Freud's earlier thinking is typically referred to his seduction theory, suggesting that the adult patient presenting with the symptoms of hysterical conversion had in fact been traumatized as a child by adult, and that the memory of the event itself the content of the memory, but not the associated affect had been pushed from conscious awareness through repression. The symptoms currently being experienced by the adult patient were traceable back to that earlier traumatic experience (Lever, 2012).

The third refinement of Freud's theory came with the development fantasy theory. By this time Freud wanted to find a more universal explanation for the causes of neurotic symptoms, and he recognized that it was necessary to postulate that an actual sexual trauma was at the base of every patient's symptoms. However, he wished to retrain his emphasis and found what he thought would provide a more universal basic for the emergence of neurotic symptoms in what he understood to be the nature of childhood sexuality. In this reformulated account, sufficient and more universal explanations for the neurotic's symptoms could be found by positing that all children experienced sexual fantasies toward a parent, fantasies which generated intra-psychic conflict which therefore must be repressed. This intra-psychic conflict was called Oedipal complex for boys and Electra complex for girls. However, because psychic energy is conserved, the repressing of the child's conflictual desires was rarely entirely successful and typically would emerge during adulthood in the form of neurotic symptoms. These symptoms, again, indirectly and symbolically pointed to their underlying cause. Perhaps Freud's most enduring contribution to trauma theory rests with neither seduction theory nor fantasy theory but, rather, with his initial formulation of the functional and idiosyncratic understanding of the traumatic experience. In his initial formulation, trauma is understood as that which subjectively intolerable to the individual which, therefore, is pushed from conscious awareness in an effort to reduce the associated anxiety (Lever, 2012).

B. New psychoanalytic approach: Character

Freudian psychoanalytic has itself undergone numerous revisions in the century or so since it was the first proposed. Many clinicians now accept, with few reservations, Freud's notions that the childhood experiences continue to exert an influence on the person

throughout childhood, and that some forms of psychopathology reflect the operation of unconscious process and conflicts. These clinicians do not necessarily accept other psychoanalytic propositions such as drive theory or the presumed etiology of neurosis in the Oedipal / Electra complex (Lever, 2012).

Relevant to trauma theory is one perspective that incorporates the more widely accepted aspects of psychoanalytic. The mere fact of traumatic experience is not sufficient to understand its impact on the individual; one must takes into account the person's characteristic ways of organizing and interpreting his experiences. In this regard, character pathology refers to a dynamic and restrictive way of organizing conscious experience through which entire aspects of ongoing subjectivity (including thoughts, reactions, sensations and feelings) are effectively excluded, leaving the patient estranged from himself or herself. This process of self-alienation can refer both to one's past traumatic experiences as well as to ongoing experiences in the present. Similar to Freud earlier view, this view proposes that the experience and interpretation of events as traumatic is subjective and idiosyncratic. Importantly, working with clients entails understanding the interpretive lens of character. This approach focuses on helping clients become more able to explore feelings, thoughts and reactions to past trauma, as well as, to any area of conflicts (Lever, 2012).

C. Contemporary trauma theory: Dissociation

Many contemporary trauma theorists have adopted a trauma genic approach to psychopathology that is based on the process of dissociation rather than that of repression entailed in the Freudian model. With dissociation, a traumatic experience is thought to be recorded in memory whole and intact, unaltered by any interpretive process on the part of the one experiencing trauma. Whereas repression involves a motivated or defensive forgetting, dissociation reflects a passive encoding and encasing of the traumatic experience. In this view, the traumatic memory is segregated memories and remains nonconscious. The dissociated traumatic memory, however, can continue to influence the person in various ways of particular relevance are trigger experiences which typically come in the form of cues in the environment that enactment , they can lead to behavioral cortical processing . In a certain sense, the person who has been traumatized is essentially passive, transmitting into the future and reliving in the present the traumatic experience that happened in the past (Lever, 2012).

D. Self-determination theory: Basic psychological needs

It is empirically grounded theory of motivation, personality and development that has roots in the existential–phenomenological and humanistic traditions. However, it is also shares an appreciation for the understanding of unconscious and defensive process first explored by Freud and, in particular, for Freud's articulation of the synthetic function of the ego. In Freudian thought, the synthetic function suggests that the ego serves to organize and integrate aspects of experiences into a coherent and meaningful whole. In addition, self-determination theory acknowledges the contributions of newer psychodynamic approaches such as the attachment and object relations perspectives; these perspectives underscore the importance of interpersonal experiences that serve to support or underscore the psychological needs of the child and later of the adult throughout development. Self–determination theory argues that there are three basic psychological needs that humans require for optimal growth and development from childhood and throughout the life span. These are the needs for relatedness or the feeling of being connected in meaningful and mutually satisfying ways to important others, competence, or the feeling that one is able to use and to extend one's current abilities through experiences of optimal changes; and for autonomy for the feeling that one is able to make personally meaningful choices, and that one endorses or stands behind the choices one makes. Although the needs for relatedness and competence are restively uncontroversial in contemporary psychological theorizing, the need for autonomy has required some justification, as it has frequently been confused with independence or individualism (Lever, 2012).

2.2.1.4. Type of trauma:

- *Simple:* this type of trauma is usually caused by a single. The incident is usually one that involves life threatening events and/or events that have the potential to cause serious injury. Examples: car accident, fire cyclone, and shooting (Meichenbaum, 1997).

- *Complex*: this type of trauma is usually longer in duration and involves multiple incidents. The incidents are usually ones that involves interpersonal violence or violation and as a result they are almost always associated with a sense of shame and stigma.
Examples: all forms of child abuse, bullying, experiences of war, and imprisonment (Meichenbaum, 1997).

- *Primary traumatic stress*: is the term used for individuals who respond with intense fear or helplessness after experiencing a traumatic event firsthand (Zimering et al., 2003).

- *Secondary traumatic stress (STS):* occurs as a result of indirect exposure to trauma through a firsthand account or narrative of a traumatic event (Zimering & et al., 2003).

- *Generational trauma:*

Generational trauma may be defined as a secondary form of trauma that results from the transfer of traumatic experiences from parents to their children. This form of trauma is also referred to as intergenerational, transgenerational, or secondary trauma. Generational trauma can result from any number of different types of disturbing incidents or experiences (Davidson & Mellor, 2001).

- *Psychological trauma:*

Psychological trauma is a type of damage to the mind that occurs as a result of a severely distressing event (SAMHSA, 2014).

2.2.1.5. Traumatic event:

Wethington et al. (2008), most everyone has been through a stressful event in his life. When the event, or series of events, causes a lot of stress, it is called a traumatic event. Traumatic events are marked by a sense of horror, helplessness, serious injury, threat of serious injury or death. Traumatic events affect survivors, rescue workers, friends and relatives of victims who have been involved. They may also have an impact on people who have seen the event either firsthand or on television.

2.2.1.6. Trauma Victims:

There are two types of trauma victims: (Dayton, 2000; perry, 2006)

a) Primary Trauma Victim: Individuals who are directly involved in the trauma.
b) Secondary Victim: Individuals who are directly involved in the trauma. These include relatives and loved ones, members of the surrounding area or immediate community and of course may include relief workers and persons who respond to the incident, and people who experience the trauma through the media.

2.2.1.7. Symptoms:

The severity of the symptoms depends on the person, the type of trauma involved, and the emotional support they receive from others. Reactions to and symptoms of trauma can be wide and varied, and differ in severity from person to person. A traumatized individual may experience one or several of them (Carlson & Josef, 2005).

After a traumatic experience, a person may re-experience the trauma mentally and physically, hence avoiding trauma reminders, also called triggers, as this can be uncomfortable and even painful. They may turn to psychoactive substances including alcohol to try to escape the feelings. Re-experiencing symptoms are a sign that the body and mind are actively struggling to cope with the traumatic experience.

Triggers and cues act as reminders of the trauma, and can cause anxiety and other associated emotions. Often the person can be completely unaware of what these triggers are. In many cases this may lead a person suffering from traumatic disorders to engage in disruptive or self-destructive coping mechanisms, often without being fully aware of the nature or causes of their own actions.

Consequently, intense feelings of anger may frequently surface, sometimes in inappropriate or unexpected situations, as danger may always seem to be present, as much as it is actually present and experienced from past events. Upsetting memories such as images, thoughts, or flashbacks may haunt the person, and nightmares may be frequent.
Trauma doesn't only cause changes in one's daily functions but could also lead to morphological changes. Such epigenetic changes can be passed on to the next generations, thus making genetics as one of the components of the causes of psychological trauma (Frommberger, 2014).

Rothschild (2000), the person may not remember what actually happened, while emotions experienced during the trauma may be re-experienced without the person understanding why. This can lead to the traumatic events being constantly experienced as if they were happening in the present, preventing the subject from gaining perspective on the experience. his can lead to mental health disorders like Acute stress and anxiety disorder, traumatic grief, undifferentiated somatoform disorder, conversion disorders, brief psychotic disorder, borderline personality disorder, adjustment disorder...etc.

2.2.1.8. The effects of trauma:

Rice & Groves (2005), it is known that every child or adolescent who is exposed to a previous traumatic events will experience and respond to it in his or her own way, depending on their age, developmental stage, the type of the previous traumatic events and the social environment surrounding the child. Young trauma victims often come to believe there is something inherently wrong with them, that they are at fault, unlovable, hateful, helpless and unworthy of protection and love, such feelings lead to poor self-image, self-abandonment, and self-destructiveness. Children who experience severe early trauma often develop a foreshortened sense of the future. They come to expect that life will be dangerous, that they may not survive, and as a result, they give up hope and expectations for themselves that reach into the future.

Van der Kolk, et al. (1996), described the following long term effects of trauma:

- Generalized hyper-arousal and difficulty in modulating arousal
  a. Aggression against self and others
  b. Inability to modulate sexual impulses
  c. Problems with social attachments – excessive dependence or isolation
- Alterations in neurobiological processes involved in stimulus discrimination
  a. Problems with attention and concentration
  b. Dissociation
  c. Somatization
- Conditioned fear responses to trauma related stimuli
- Loss of trust, hope, and a sense of personal agency
- Social avoidance
- Loss of meaningful attachments
- Lack of participation in preparing for the future

2.2.1.9. Treatment:

A number of psychotherapy approaches have been designed with the treatment of trauma in mind: Eye movement desensitization and reprocessing (EMDR), progressive counting (PC), Somatic Experiencing, biofeedback, Internal Family Systems Therapy, and sensorimotor psychotherapy. There is a large body of empirical support for the use of

cognitive behavioral therapy, for the treatment of trauma-related symptoms including posttraumatic stress disorder (Schnurr et al., 2007).

Briere and Scott (2014), trauma therapy allows processing trauma-related memories and allows growth towards more adaptive psychological functioning. It helps to develop positive coping instead of negative coping and allows the individual to integrate upsetting-distressing material(thoughts, feelings and memories) resolve internally. It also aids in growth of personal skills like resilience, ego regulation, empathy...etc.

Processes involved in trauma therapy are:

• Psychoeducation: Information dissemination and educating in vulnerabilities and adoptable coping mechanisms.

• Emotional regulation: Identifying, countering discriminating, grounding thoughts and emotions from internal construction to an external representation.

• Cognitive processing: Transforming negative perceptions and beliefs to positive ones about self, others and environment through cognitive reconsideration or re-framing.

• Trauma processing: Systematic desensitization, response activation and counter-conditioning, titrated extinction of emotional response, deconstructing disparity (emotional vs. reality state), resolution of traumatic material (state in which triggers don't produce the harmful distress and able to express relief).

• Emotional processing: Reconstructing perceptions, beliefs and erroneous expectations like trauma-related fears are auto-activated and habituated in new life contexts, providing crisis cards with coded emotions and appropriate cognition's. (This stage is only initiated in pre-termination phase from clinical assessment and judgement of the mental health professional).

• Experiential processing: Visualization of achieved relief state and relaxation methods.

2.2.2. PTSD

The term "posttraumatic stress disorder" was coined in the late 1970s, due to diagnoses of US military veterans of the Vietnam War. The concept of stress-induced mental disorder was known since the 19th century (Gale Group, 2015).

In World Health Organization (2011),the DSM-IV, the spelling "posttraumatic stress disorder" is used, while in the World Health Organization ICD-10 (2014), the spelling is "post-traumatic stress disorder".

2.2.2.1. Definition:

The World Health Organisation's International Classification of Diseases system (ICD-10, 2014) definition of PTSD states that this disorder arises as a delayed or protracted response to a stressful event of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone (for example, natural or man-made disaster, combat, serious accident, witnessing the violent death of others, or being the victim of torture, terrorism, rape, or other crime).

But American Psychiatric Association DSM-IV (1994), define it as characterized by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma.

And according to American Psychiatric Association DSM-V (2013), define PTSD as an anxiety disorder that can develop after a person is exposed to one or more traumatic events, such as major stress, sexual assault, warfare, or other threats on a person's life, and Fear of separation from loved ones is common after traumatic events such as a disasters, particularly when periods of separation from loved ones were experienced during the traumatic event.

Another definition from Gale Group (2015), as a debilitating psychological condition triggered by traumatic event, such as rape, war, death of loved one, catastrophic accident or a natural disaster, it is marked by hyperarousal, upsetting memories or thoughts of the ordeal. And PTSD can affect adults of all ages, rank, culture or gender.

Also PTSD caused by the experience of a wide range of traumatic events, but specific cause of PTSD after trauma are not clear. The illness is marked by uncontrollable thoughts, extreme anxiety, nightmares and flashbacks. PTSD sometimes causes short-term memory loss and can have long-term chronic psychological repercussions. There is evidence that susceptibility to PTSD is hereditary. Approximately 30% of the variance in PTSD is caused from genetics alone. A monozygotic twins exposed to traumatic, have increased risk of PTSD compared with dizygotic twins (Monch, 2014).

Not every person have experiences of traumatic event will develop PTSD. People who experience assault-based trauma are more likely to develop PTSD (Monch, 2014). And

central symptoms concern intrusions about, and avoidance of, memories associated with the traumatic event itself, whereas in separation anxiety disorder, the worries and avoidance concern the well-being of attachment figures and separation from them (DSM-V, 2013).

Many of people who have experienced a traumatic event will not develop PTSD, and the adults are more likely to experience PTSD after trauma than Children (Gale group, 2015), especially if they are under ten years of age (Monch, 2014), so the rate of PTSD may be higher in adults than children, but in the absence of therapy, symptoms may continue developed (Gale group, 2015). Men are more likely to experience a traumatic event, but women are more likely to experience the kind of high-impact traumatic event that can lead to PTSD (Monch, 2014).

2.2.2.2. History:

The 1952 edition of the DSM-I includes a diagnosis of "gross stress reaction", which has similarities to the modern definition and understanding of PTSD, it defined as a "normal personality (utilizing) established patterns of reaction to deal with overwhelming fear" (Andreasen, 2010). And early in 1978, the term was used in a working group finding presented to the Committee of Reactive Disorders (Arieh et al., 2000), the condition was added to the DSM-III, which was being developed in the 1980s, as posttraumatic stress disorder (Arieh et al., 2000; Andreasen, 2010).

2.2.2.3. Theories of posttraumatic stress disorder

2.2.2.3.1. Early theories

Early theories can be divided into three types.

- Social-cognitive theories primarily focus on the way trauma breaches existing mental structures and on innate mechanisms for reconciling incompatible information with previous beliefs.
- Conditioning theories deal with learned associations and avoidance behavior.
- Information-processing theories focus on the encoding, storage, and recall of fear-inducing events and their associated stimuli and responses. Within their frame of reference, all of them are consistent with much of the available evidence and have provided important insights into PTSD (Horowitz, 1997).

A. Theory of shattered assumptions

The origins of this social-cognitive model also lie in the tradition of individual internal models or assumptive worlds that, though they may be illusory, help to sustain people in their everyday lives and motivate them to overcome difficulties and plan for the future.

The three common assumptions Janoff-Bulman (1992), regarded as the most significant in influencing response to trauma are that the world is benevolent, the world is meaningful, and the self is worthy. That is, other people are in general well-disposed towards us, there are reliable rules and principles that enable us to predict which behaviors will produce which kinds of outcome, and we ourselves are personally good, moral, and well-meaning.

Being attacked by a complete stranger without any provocation, being involved in a serious road traffic accident when we have been obeying the rules of the road, and putting our own survival ahead of anything else when our life is threatened are all situations that have the potential to be traumatic in that they may shatter deeply held and probably unexamined assumptions about how we believe the world and ourselves to be. Updating of assumptions can take place spontaneously through the re-experiencing and avoidance cycle described by Horowitz (1997). In addition, updating can be made to occur deliberately by reflecting on the trauma. As in stress response theory, the strength of the approach lies more in its description of longer term adjustment after a trauma rather than the specification of how trauma impacts on the individual in the short term or how trauma is represented in memory. The theory of shattered assumptions is important, however, in identifying common themes in schema change, specifying the role of the person's social and interpersonal context in facilitating or blocking this process, and emphasizing the possibility of positive reframing of the trauma and of posttraumatic growth .

B. Conditioning theory

This approach sought to apply conditioning theories developed for other anxiety disorders to PTSD. Following Mowrer's (1960), two-factor learning theory, an initial phase of fear acquisition through classical conditioning results in neutral stimuli present in the traumatic situation acquiring fear-eliciting properties through their association with the unconditioned stimulus (in this case, those elements of the traumatic situation that directly arouse fear). Keane et al., (1985), proposed that a wide variety of associated stimuli would acquire the ability to arouse fear through the processes of stimulus generalization and

higher order conditioning. Although repeated exposure to spontaneous memories of the trauma would normally be sufficient to extinguish these associations, extinction would fail to occur if the person attempted to distract themselves or block out the memories, rendering the exposure incomplete. Avoidance of the conditioned stimuli, whether through distraction, blocking of memories, or other behaviors, would be reinforced by a reduction in fear, leading to the maintenance of PTSD.

C. Information-processing theories

Foa et al., (1989), cognitive theories that have focused mainly on the traumatic event itself rather than on its wider personal and social context have been termed ‘‘information-processing’’ theories. The central idea is that there is something special about the way the traumatic event is represented in memory and that if it is not processed in an appropriate way, psychopathology will result. Like social-cognitive theories, this approach emphasizes the need for information about the event to be integrated within the wider memory system.

However, the difficulty in achieving this is attributed more to characteristics of the trauma memory itself than to conflict with preexisting beliefs and assumptions. Most early theories had their origins in attempts to understand fear conditioning and phobic responding, and particularly in the work of Lang (1979). Lang reformulated behavioristic accounts of fear conditioning that depended on the learning of associations between stimuli and responses within a more comprehensive cognitive framework. He proposed that frightening events were represented within memory as interconnections between nodes in an associative network. A fear memory consisted of interconnections between different nodes representing three types of propositional information: Stimulus information about the traumatic event, such as sights and sounds, information about the person’s emotional and physiological response to the event, and meaning information, primarily about the degree of threat. Thus, cognition and affect were integrated within an overall response program designed to rapidly escape or avoid danger .

D. Anxious apprehension model

Jones and Barlow (1990), argued that variables implicated in the etiology and maintenance of panic disorder are also involved in PTSD, and that there is a marked similarity between panic attacks and traumatic flashbacks. While recognizing the role of biological vulnerability, the trauma itself, and the experience of intense emotions at the time, their

key point is the inclusion of cognitive factors that occur after the trauma and produce a feedback cycle of anxious apprehension. That is, patients with PTSD focus their attention upon and are hypervigilant for information about 'emotional alarms' and associated stimuli. Although in the face of actual trauma, the alarm is genuine, false alarms can occur subsequently in the absence of danger, as described in Barlow's (1988), model of panic disorder.

In PTSD, the focus of people's anxious apprehension is on cognitive and physiological cues from the time of the actual trauma as they wish to avoid the distress generated by alarms. The learned alarms generate hyperarousal symptoms, which through their association to cues present at the time of the original trauma (the real alarm) result in a negative feedback loop ensuring successive re-experiencing symptoms. To prevent the triggering of alarms, the person will tend to avoid emotional interoceptive information, for example, through emotional numbing, as well as avoid external trauma-related stimuli.

Jones and Barlow (1990), argued that coping styles and social support can, as in other anxiety disorders, moderate the expression of PTSD. This approach emphasizes the similarity of PTSD to other anxiety disorders and the importance of distorted information processing in PTSD. Consistent with the model, panic symptoms are often reported both during and after trauma and may be a risk factor for later PTSD symptoms (Barlow's, 1988).

2.2.2.3.2. Recent theories:

A. Emotional processing theory

The earlier network theory of Foa et al. (1989), has been elaborated by Foa and Rothbaum (1998), in several ways in order to take account of accumulating knowledge, particularly with respect to assault and rape victims. One development was to elaborate the relationship between PTSD and knowledge available prior to the trauma, during the trauma, and after the trauma. They proposed that individuals with more rigid pre-trauma views would be more vulnerable to PTSD. These could be rigid positive views about the self as being extremely competent and the world as extremely safe, which would be contradicted by the event, or rigid negative views about the self as being extremely incompetent and the world as being extremely dangerous, which would be confirmed by the event. Another

development was an increased emphasis on negative appraisals of responses and behaviors which could exacerbate perceptions of incompetence. Foa et al. (1989), outlined how these appraisals might relate to events that took place at the time of the trauma, to symptoms that developed afterwards, to disruption in daily activities, and to the responses of others. Beliefs that were present before, during, and after the trauma could interact to reinforce the critical negative schemas involving incompetence and danger that they hypothesized underlie chronic PTSD .

B. Ehlers and Clark's cognitive model

Ehlers and Clark (2000), drew attention to the paradox in PTSD whereby patients feel anxious about the future, even though the trauma lies in the past. They proposed that pathological responses to trauma arise when individuals process the traumatic information in a way that produces a sense of current threat, either an external threat to safety or an internal threat to the self and the future. The two major mechanisms that produce this effect involve negative appraisals of the trauma or its sequelae, and the nature of the trauma memory itself.

Expanding on the work of Foa and Rothbaum (1998), Ehlers and Clark (2000), identified a wide range of relevant negative appraisals. Some of these are focused on the traumatic event and signal overgeneralization of danger, or negative appraisal of own actions. Other appraisals focus on sequelae, such as the PTSD symptom of numbing, other people's reactions, and life prospects. The different types of appraisal, variously involving danger, violation of standards by self or others, or loss, explain the variety of emotions reported by patients with PTSD.

2.2.2.4. Pathophysiology

2.2.2.4.1. Neuroendocrinology:

PTSD symptoms may result when a traumatic event causes an over-reactive adrenaline response, and PTSD causes biochemical changes in the brain and body that differ from other psychiatric disorders such as major depression, also during traumatic experiences the high levels of stress hormones secreted suppress hypothalamic activity, that may be a major factor may development of PTSD. In addition, most people with PTSD also show a low secretion of cortisol and high secretion of catecholamines in urine, in which both catecholamine and cortisol levels are elevated after exposure to a stressor, corticotropin-

releasing factor (CRF) concentrations and brain catecholamine levels are high. Together, these findings suggest abnormality in the hypothalamic-pituitary-adrenal (HPA) axis (DeKloet et al. 2008).

Olszewski and Varrasse (2005) indicate that people who suffer from PTSD have chronically low levels of serotonin, but Dopamine levels in a person with PTSD can help contribute to the symptoms associated, such as anxiety, ruminations, irritability, aggression, suicidality, and impulsivity. Increased levels of dopamine can cause psychosis, agitation, and restlessness, but Low levels of dopamine can contribute to anhedonia, apathy, impaired attention, and motor deficits. Hyper responsiveness of norepinephrine receptors in the prefrontal cortex can be connected to the flashbacks and nightmares frequently experienced by those with PTSD (Olszewski & Varrasse, 2005).

2.2.2.4.2. Neuroanatomy:

Three areas of the brain function may be altered in PTSD have been identified: the prefrontal cortex, amygdala, and hippocampus. Media coverage plays role in pediatric and adult onset of PTSD symptoms (Newport et al., 2010).

2.2.2.5. Screening and assessment:

A number of screening tools, including the UCLA PTSD Index for DSM-IV (Elhai et al., 2013), Primary Care PTSD Screen (Prins et al., 2016), and PTSD Checklist (Wortmann et al., 2016; Bovin et al., 2015; Blevins et al., 2015), which have good reliability and validity, are used for the screening of PTSD for children and young adults (Elhai et al., 2013).

2.2.2.6. Diagnostic and statistical manual

from the introduction of DSM-IV, the number of events that might be used to diagnose PTSD has increased, and the Standardized screening tools such as Trauma Screening Questionnaire and PTSD Symptom Scale can be used to detect possible symptoms of PTSD and suggest the need for a formal diagnostic assessment (Breslau & Kessler, 2001).
Posttraumatic stress disorder is classified as an anxiety disorder in the DSM IV, but in DSM-V published in (May, 2013), PTSD is classified as a trauma- and stress-related disorder, and the characteristic symptoms are not present before exposure to the violently traumatic event (Monch, 2014).

A diagnosis of PTSD requires exposure to stressor that is life-threatening**,** and the content of the defining symptoms refers to the stressor, for example, re-experiencing the stressor and avoidance of stimuli that symbolize the stressor. Temporal ordering is also required: when sleep problems and other symptoms of hyperarousal are part of the clinical picture, they must not have been present before the stressor occurred (Breslu et al., 2002).

2.2.2.7. Diagnosis and differential diagnosis

According to World Health Organization (1992), the diagnostic criteria for PTSD according to International Statistical Classification of Diseases and Related Health Problems 10 (ICD-10), requires that, first, the patient has been exposed to a traumatic event, and second, suffers from distressing re-experiencing symptoms. Patients will usually also show avoidance of reminders of the event, and some symptoms of hyperarousal and/or emotional numbing. Annex 1 (Diagnostic criteria for PTSD according to ICD–10).

The DSM–IV diagnosis of PTSD is stricter, that it puts more emphasis on avoidance and emotional numbing symptoms. It requires a particular combination of symptoms (at least one re-experiencing symptom, three symptoms of avoidance and emotional numbing, and two hyperarousal symptoms). In addition, DSM–IV requires that the symptoms cause significant distress or interference with social or occupational functioning. Annex 2 (Diagnostic criteria for PTSD according to DSM–IV).

In contrast to the ICD–10 definition, a DSM–IV diagnosis of PTSD further requires that the symptoms have persisted for at least 1 month. In the first month after trauma, trauma survivors may be diagnosed as having acute stress disorder according to DSM–IV, which is characterised by symptoms of PTSD and dissociative symptoms such as depersonalisation, derealisation and emotional numbing. The ICD–10 diagnosis does not require a minimum duration. For the purposes of this guideline, we include PTSD symptoms that occur in the first month after trauma.

From Gale Group (2015), a diagnosis of PTSD, symptoms must include at least one of the following so-called "intrusive" symptoms:

- flashbacks
- sleep disorders: nightmares or night terrors
- intense distress when exposed to events that are associated with the trauma

In addition, the person must have at least three of the following "avoidance" symptoms that affect interactions with others:

- trying to avoid thinking or feeling about the trauma
- inability to remember the event
- inability to experience emotion, as well as a loss of interest in former pleasures (psychic numbing or blunting)
- a sense of a shortened future

Finally, there must be evidence of increased arousal, including at least two of the following:

- problems falling asleep
- startle reactions: hyperalertness and strong reactions to unexpected noises
- memory problems
- concentration problems
- moodiness
- violence

Also Symptoms of PTSD are distinct and prolonged stress reactions that naturally occur during a highly stressful event. Common symptoms are:

1. hyperalertness
2. fear and anxiety
3. nightmares and flashbacks
4. sight, sound, and smell recollection
5. avoidance of recall situations
6. anger and irritability
7. guilt
8. depression
9. increased substance abuse
10. negative world view
11. decreased sexual activity.

The International Statistical Classification of Diseases and Related Health Problems 10 diagnostic guidelines state. In general, this disorder should not be diagnosed unless there is evidence that it arose within 6 months of a traumatic event of exceptional severity (World Health Organization, 2014).

2.2.2.8.Clinical Features: (Henigsberg et al., 2001)

1. Post-traumatic stress disorder is a psychiatric syndrome that arises after an exceptionally stressful event, or trauma .

2. The stressful event is of an exceptionally severe magnitude. It involves death, serious injury or disruption of physical integrity, either actual or threatened, to the person or others .

3. The person does not have to be threatened, or be harmed themselves, to develop the disorder; witnessing such circumstances is enough .

4. Examples of exceptionally stressful events include: combat, torture, rape, domestic violence, violent assault, major fires, motor vehicle accidents and natural disasters .

5. The clinical features consist of 3 sets of related symptoms:

- Re-experiencing the event. The patient may have difficulty in recalling the event voluntarily, but despite this, may involuntarily experience intense images from the trauma (often described as “flashbacks” or “like a video”) or have recurring painful dreams about aspects of the trauma.
- Avoidance of cues and emotional numbing. The second group of symptoms includes avoidance of reminders of the event coupled with a decreased ability to feel emotion, a sense of detachment, and feeling of having a lack of interest in one’s surroundings.
- Hyper-arousal. These symptoms include insomnia, poor concentration, anxiety and irritability. There may be autonomic disturbances. The patient may be hyper-vigilant and easily startled .

6. Additionally, social and occupational difficulties may accompany the disorder .

7. There is some evidence that the symptom profile of PTSD varies according to the type of trauma suffered. The symptoms of hyper-arousal were more common in combat related PTSD, whereas victims of rape with PTSD suffered more avoidance symptoms and fewer hyper-arousal symptoms.

8. The onset of the condition is generally a few weeks to months after the trauma, but generally not more than 6 months after the event.

2.2.2.9. Predisposing factors: (Brewin et al., 2000)

Not all individuals exposed to trauma will go on to develop PTSD, even if they are exposed to events of similar magnitude. Social and cultural factors will have a part to play. However, the following predisposing risk factors have been shown to increase an individual's risk of developing PTSD after a traumatic event.

1. Female gender is a risk factor for developing PTSD in civilian life,14 and one study found women had a higher rate of PTSD than men after war experience.
2. Lower intelligence, lower social class and lower education.
3. The experience of childhood abuse.
4. The experience of other adversity during childhood.
5. A personal history of psychiatric disorder.
6. A family history of psychiatric disorder.
7. Experience of previous trauma.
8. Genetic susceptibility There is a genetic susceptibility to PTSD but the exact nature of this is unknown.
9. Other risk factors In one study an individual abusing alcohol or having a personality disorder increased the risk of the development of PTSD.

Gale group (2015), Statistics gathered from past events indicate that the risk of PTSD increases in order of the following factors.

- female gender
- middle-aged (40 to 60 years old)
- little or no experience coping with traumatic events
- ethnic minority
- lower socioeconomic status (SES)
- children in the home
- women with spouses exhibiting PTSD symptoms
- pre-existing psychiatric conditions
- primary exposure to the event including injury, life-threatening situation, and loss
- living in traumatized community

But according to National Collaborating Centre for Mental Health (2005), people at risk of PTSD include:

1. Victims of violent crime (e.g. physical and sexual assaults, sexual abuse, bombings, riots).
2. Members of the armed forces, police, journalists and prison service, fire service, ambulance and emergency personnel, including those no longer in service.
3. Victims of war, torture, state-sanctioned violence or terrorism, and refugees .
4. Survivors of accidents and disasters.
5. Women following traumatic childbirth, individuals diagnosed with a life-threatening illness.

2.2.2.10. Complications of PTSD:

The most common complications are:

- substance use disorders: PTSD sufferers may use alcohol, drugs, caffeine or nicotine to cope with their symptoms, which may eventually lead to dependence.
- Depression, including the risk of suicide.
- Other anxiety disorders, such as panic disorder, which may lead to additional restrictions in the sufferer's life, for example: inability to use public transport (National Collaborating Centre for Mental Health, 2005).

Other possible complications of PTSD include somatization, chronic pain and poor health (Schnurr & Green, 2003). Sufferers from PTSD are at greater risk of medical problems, including circulatory and musculoskeletal disorders, and have a greater number of medical conditions than people without PTSD (Ouimette et al., 2004).

2.2.2.11. Prognosis

The severity of the illness depends on the severity of the trauma, With appropriate medication, emotional support, counseling, and follow-up care, most people show significant improvement (Gale group, 2015).

2.2.2.12. Prevention

Gale group (2015), More studies are needed to determine if PTSD can actually be prevented, psychological preparation for individuals who will be exposed to traumatic events (i.e. policemen, paramedics, soldiers), and stress inoculation training (rehearsal of the event with small doses of the stressful situation). Social support can Protective and helps with recovery if PTSD develops, and psychological debriefing in an effort to prevent PTSD.

2.2.2.13. Prevalence

Post-traumatic stress disorder is common. A millions of people are diagnosed with each year , Prevalence rates indicate that approximately 3.5% or (7.7 million people) in the USA, (Kessler et al., 1995), estimated a lifetime prevalence of PTSD of 7.8%, (women 10.4%, men 5.0%), using DSM–III–R criteria. Estimates for 1-month prevalence range between 1.5–1.8% using DSM–IV criteria (Stein et al., 1997), and 3.4% using the less strict ICD–10 criteria (Andrews et al., 1999). In Australia, estimates for 12-month prevalence range between 1.3% (Creamer et al., 2001), and in USA 3.6% (Narrow et al., 2002). The disorder remains common in later life, but with the suggestion of a greater proportion of sub-syndromal PTSD in the older age group (van Zelst et al., 2003).

In Palestinian study, a large-scale survey of 2,100 adolescents (14- to 17-year olds) found that 35% of those in the West Bank and 36% of those in the Gaza Strip reported symptoms of PTSD (Abdeen et al., 2008). More recently, Thabet et al. (2014) in a study showed that 11.8% of adolescents reported no PTSD, 24.2% reported less than two clusters of symptoms, and 34.31% reported symptoms meeting criteria for partial PTSD, while 29.8% reported symptoms meeting criteria for full PTSD. And Thabet et al., (2015a), study showed that (6.7%) of adolescents have no PTSD, (20.5%) have one symptoms, (35.1%) have partial PTSD, (37.6%) have full in PTSD according to DSM-IV. But, Qeshta (2015), study show that (31.6%) of children have no PTSD, (26.5%) of children have at least one criteria of PTSD (B or C or D), (25.5%) of children have partial PTSD, and (16.4%) of children have full criteria of PTSD. Also, Al ibwaini (2015), study reported that 20.1% of adolescents showed no PTSD, 31.1% showed at least one criteria of PTSD (B or C or D), 29.7% showed partial PTSD, and 19.1% of adolescents showed full criteria of PTSD.

2.2.2.14. Coping and PTSD

Coping is often viewed as a factor that helps an individual maintain psychosocial adaptation in the face of stress. It is generally defined as the cognitive and behavioral strategies an individual employs to reduce distress and tension or eliminate stressors, and to manage internal or external demands that are perceived to exceed the individual's personal resources, as such, coping seems to have two functions:

- One function is to use resources to solve the problem that is creating the stress and thus change the situation, often referred to as problem-focused coping .
- The other function is to regulate the associated emotional arousal or tension, often referred to as emotion-focused coping.

Coping styles refer to the strategies people generally use to cope across a wide variety of stress, habitual preferences in coping with problems (Sandler,1997).

2.2.3. Family support

Families are unique social systems insofar as membership is based on combinations of biological, legal, affectional, geographic and historical ties (Carr, 2005). And family support is an important role in helping people with dual disorders, and people without family support are at a significant disadvantage and may require more formal treatment services and public assistance than those whose relatives give such support, and it is very important to a family's mental and physical health as well as its ability to cope (Clark, 2001).

2.2.3.1. Definition

Family support is a style of work and a wide range of activities that strengthen positive informal social networks through community based programmes and services. The main focus of these services is on early intervention aiming to promote and protect the health, well-being and rights of all children, young people and their families (Tusla, 2016).

2.2.3.2. History

The late 1970s and early 1980s are considered pivotal times for the development of respite and family support services, particularly through the demands and initiatives of parents of children with disabilities. However, by the 1990s, family support had become an established service reported regularly in the field of intellectual and developmental disabilities, and part of States' and local service systems in the US (Racino, 2002).

2.2.3.3. Family support services

Family support services are for families and individuals who need help. Family life is not always easy. Life events like birth, death, depression, redundancy, separation, illness, abuse or financial problems all put stress and strain on family life and relationships.

Family support services can help. There are many support groups for adults, teenagers, children and carers that give people the chance to tell their own stories and give support to each other. Family support services are generally provided to families in their own homes and communities (Tusla, 2016).

Family support services were considered one of the better ways of supporting families and their children, including "building on natural supports" and encouraging the integration of children in the community (Piersma, 2002).

2.2.3.4. Basis in theories related to family support

Racino (2000, 2005), Family support is based in part on theories related to families, particularly family systems theory, ecological and support theories, community support theories, life-span and life course theories, family psychosocial theories, family empowerment theory, and positivistic theories, such as the sociology of acceptance.

2.2.3.5. Murray Bowen family system theory

Rabstejnek (2011), in the 1950s Dr. Murry Bowen introduced a transformational theory, Family Systems Theory. Murray Bowen Family System Theory is one of several family models developed by mental health pioneers in the decade or so following the Second World War. For a short postwar period of time, drug therapy was not yet effective and parents were still implicated in their child’s behavior. Therapists began to explore the dynamics of family life after World War II.

2.2.3.6. Family systems theory: (Morgaine, 2001)

Families are considered systems because they are made up of interrelated elements or objectives, they exhibit coherent behaviors, they have regular interactions, and they are interdependent on one another. Families are systems of interconnected and interdependent individual. To understand the individual, we must understand the family system of that individual. People cannot be understood in isolation from one another.

The Components of family systems theory are as follows:

a. Have interrelated elements and structure. The elements of a system are the members of the family. Each element has characteristics, there are relationships between the elements, the relationships function in an interdependent manner. All of these create a-structure, or the sum total of the interrelationships among the elements, including membership in a system and the boundary between the system and its environment.
b. Interact in patterns. There are predictable patterns of interaction that emerge in a-family system. These repetitive cycles help maintain the family's equilibrium and provide clues to the elements about how they should function.
c. Have boundaries and can be viewed on a continuum from open to closed. Every system has ways of including and excluding elements so that the line between those within the system and those outside of the system is clear to all. If a family is permeable and vague boundaries it is considered "open." Open boundary systems allows elements and situations outside the family to influence it. It may even welcome external influences. Closed boundary systems isolate its members from the environment and seems isolated and self-contained. No family system is completely closed or completely open.
d. Function by the Composition Law: the Whole is More than the Sum of Its Parts. Every family system, even though it is made up of individual elements, results in an organic whole. Overall family images and themes are reflected in this wholistic quality. Unique behaviors may be ascribed to the entire system that do not appropriately describe individual elements.
e. Use messages and rules to shape members. Messages and rules are relationships agreements which prescribe and limit a family members' behavior over time. They are repetitive and redundant. They are rarely, if ever, explicit or written down. They give power; they induce guilt; they control or limit behaviors; and they perpetuate themselves and reproduce. Most messages and rules can be stated in one or a few

words. For example, More is good, Be responsible, and Be Perfect are all examples of messages/rules.

f. Have subsystems. Every family systems contains a number of small groups usually made up of 2-3 people. The relationships between these people are known as subsystems, coalitions, or alliances. Each subsystem has its own rules, boundaries, and unique characteristics. Membership in subsystems can change over time.

2.2.3.7. Type of families:

According to Bowen theory (1999), a family is a system in which each member had a role to play and rules to respect. Members of the system are expected to respond to each other in a certain way according to their role, which is determined by relationship agreements. Within the boundaries of the system, patterns develop as certain family member's behavior is caused by and causes other family member's behaviors in predictable ways. Maintaining the same pattern of behaviors within a system may lead to balance in the family system.

The family takes different forms according to their size as follows:

1. *Nuclear family*: a group consisting of parents and their children of unmarried
   The basic features of the nuclear family as a group, where it is a temporary group to end of death of one of the parents.
2. *Extended family:* a generations living in one house this type of family have found
   In feudal Europe and in farmers' groups of immigrants to the United States and in Japan, It consists of the extended family of the man and his wife, his children with the families in one house as in African and Arab communities.
3. *The marital family:* that is common in Western industrialized societies, and this family is Less dependent on relatives groups , and depend on the nuclear family emotional bonds between Couple and emphasizing the importance of marriage for the continuation of marital adaptation is the priority and importance in the former.

Relations between the spouses with their relatives, so when you lose men and women who shared a love Inseparable, without worrying about the relative group (Anany, 2000).

2.2.3.8. Function of the family:

The family has a functions and tasks created to do and that is**:** (Anany, 2000).

a. *Biological function:* the family is still essential system in the community and we cannot do anything without it and through it the human being Continue to remain and summarized the biological function of family is in reproduction.

b. *Psychological function:* the human doesn't need only food to grow but he needs to satisfy his-Psychological needs, such as the need for love and security, estimation, and this can not only through the family, where it is the first place where the individual who finds affection and emotional warmth.

c. *The social function:* this function is reflected in the socialization process that its influence seems to be In the first five years of a child's life, in particular, in this age is the normalization Child's social rolls (nutrition, modesty, sex education And independence) also includes a social function to give the role and social status of the right of the child. The definition of the child itself and the development of his concept of himself and his conscience-building and teaching social norms that help him to adapt and achieve mental health.

d. *Economic function:* this function have been to a major development as it a family function, and Most prominent of these developments, is that what appeared in the rural and Bedouin communities, as it no longer self-contained economically, and a number of its members migrated to urban communities for many reasons, and many of the families are still making a lot of their needs or special requirements in the home specially category of farmers and workers.

Positive influence of the family on treatment and rehabilitation, suggesting that family interventions can reduce relapse rates among persons with mental problems and help their rehabilitation in the community (O'Doherty et al., 2006).

Clark (2001), show that family economic support play an important role in helping client, and the people without family support may need more formal treatment. Also Liberman et al. (2014), report that family support influencing of recovery and lead to sustained remission of symptoms and normal or near normal level of function. Also psychosocial therapy and vocational therapy have play an important role in improving long term

outcome, and helping to support and sustain family care givers could be one of the most important functions that formal treatment providers can serve (Clark, 2001).

2.2.3.9. Family support and PTSD

Family support is the most important element in their lives. As part of their growth experience, adolescents usually expect a lot of things from their parents. Inadequate support from the parents will likely increase the chance of getting depression among adolescents who get into unfortunate situation with their parents. This occurs because adolescent usually become confused when they expect to get plenty of help and positive reinforcement from their parents, but it does not happen. A family can be conceptualized as parents' and children's subsystems that vary in the degree of symmetry and asymmetry in their responses and interactions. Families show high symmetry when all members respond to trauma similarly, for example when children and parents suffer from a high level of symptoms and lack access to positive resources. On the other hand, traumatized families show asymmetry when there is "a share of work" in expressing vulnerabilities and strengths. For instance, one of the parents and one of the children may show severe distress and lack resources, while other members are resilient, resourceful and without distress. The family systems theory has hardly been applied in trauma research, although researchers emphasize that the effects of trauma can be understood better through a family's typical coping efforts, adaptation styles and shared expression of pain than through focusing only on psychiatric distress and symptoms (Stice et al., 2004).

Research showing similarities in the severity of PTSD and depressive symptoms among siblings and parents in traumatized families provide examples of members' symmetric vulnerability to trauma. Familial mental illness has been found to be one of the main risk factor for PTSD among war veterans, and in community samples. Further, Research on war veterans has revealed that when the father suffers from PTSD, both the mother and children report high levels of PTSD or other psychiatric symptoms. Research among families living under war conditions shows correlations between the mothers' and their children's depressive symptoms, thus suggesting similarity or symmetry between family members' responses to trauma. The reasons for symmetric symptom expression have been explained by contamination of fear, generalization of anxiety and worry about each other's safety (Qouta et al., 2005).

Beside family support, peer support also is very important factor for adolescents. Children can expect a lot from their friends. Peer support can be considered as an alternate method of getting social support if the adolescents receive inadequate attention from their parents. This social support method is not as reliable as family support because young children could easily withdraw from their own friends if they become depressed. Another problem arises in this area, when the depressed students isolate themselves from public gatherings. This would prevent those suffering adolescents from getting any social support at all. Receiving social support is very essential for adolescents to become successful with them and achieve a satisfactory level at school (Stice et al., 2004).

2.2.4. Social support

Social supports is important, and it have the strongest size. And it is essential variable with great importance in the individual's life in general, the more age the individual was in need of social networking with others, which supports human life with love, acceptance, appreciation and belonging increases the strength to face the pressure of life. Therefore, social support linked with mental and health happiness and that absence are associated with the increasing of depressive symptoms (Brewin et al., 2000).

Support can come from many sources, such as family, friends, pets, neighbours, coworkers, organizations, etc. Government provided social support is often referred to as public aid (Taylor, 2011).

2.2.4.1. Definition

According to American Psychiatric Association (1994), social support has received attention as an important variable, which intervenes between the trauma and PTSD. Social support is one's awareness that the environment is a source of effective social support, and availability of people who interested the individual. In addition, it is the source of people who care about the child, take his hand, and stand besides him. Also people who are trusted by the child, such as: Family, friend, neighbors (Sarason et al., 1983).

Taylor (2011) postulated that social support is the perception and actuality that one is cared for, has assistance available from other people, and that one is part of a supportive social network. These supportive resources can be emotional (e.g., nurturance), tangible (e.g.,

financial assistance), informational (e.g., advice), or companionship (e.g., sense of belonging) and intangible (e.g. personal advice).

Catherine and Barbara (2015), social support is one of the important functions of social relationships. It is always intended by the sender to be helpful, thus distinguishing it from intentional negative interactions (such as angry criticism, hassling, undermining).
Tarrier et al. (1999), negative social support at least in the case of violent crime, appears to be more prevalent for women than for men victims, and in addition, the relationship between negative social support and later PTSD symptoms is stronger for women than for men. Negative social support by partners has also been found to predict a poorer response to treatment for PTSD.

Social support and family meta-analysis studies examining the risk/protective factors related to PTSD revealed social and family support to be among the strongest predictive factors of PTSD (Brewin et al., 2000).
Swindle (2000), informal social support networks are important for health and well-being and can be particularly helpful during difficult times. Social inter- actions involving support network members, however, can also be a source of stress. Recent evidence examining negative social interactions (e.g., criticisms, excessive demands) documents both the costs and benefits of social relation- ships for mental health.

2.2.4.2. History

According to Krzysztof (2005), in 1954, Barnes was the first to describe patterns of social relationships that were not explained by families or work groups, and in 1976, Cassel found a relationship with health. Most often social support is referred to as social interactions that provide individuals with actual assistance and embed them into a web of social relationships perceived to be loving, caring, and readily available in times of need.

2.2.4.3. Types of supportive behaviors:

Social support is commonly categorized into four types of behaviors (Catherine & Barbara, 2015).

1. Emotional: is associated with sharing life experiences. It involves the provision of empathy, love, trust and caring, as Close friends and family members provide hope and a listening ear
2. Instrumental: instrumental support involves the provision of tangible aid and services that directly assist a person in need. It is provided by close friends, colleagues and neighbors
3. Informational: involves the provision of advice, suggestions, and information that a person can use to address problems.
4. Appraisal: involves the provision of information that is useful for self-evaluation purposes: constructive feedback, affirmation and social comparison.

2.2.4.4. Functions of social support:

There are four common functions of social support: (Taylor, 2011)

1. Emotional support is the offering of empathy, concern, affection, love, trust, acceptance, intimacy, encouragement, or caring. It is the warmth and nurturance provided by sources of social support. Providing emotional support can let the individual know that he or she is valued. It is also referred to as "esteem support" or "appraisal support".
2. Tangible support is the provision of financial assistance, material goods, or services. Also called instrumental support, this form of social support encompasses the concrete, direct ways people assist others.
3. Informational support is the provision of advice, guidance, suggestions, or useful information to someone. This type of information has the potential to help others problem-solve.
4. Companionship support is the type of support that gives someone a sense of social belonging (and is also called belonging). This can be seen as the presence of companions to engage in shared social activities.

social support can be measured in terms of structural support or functional support. Structural support (also called social integration) refers to the extent to which a recipient is

connected within a social network, like the number of social ties or how integrated a-person is within his or her social network. Family relationships, friends, and membership in clubs and organizations contribute to social integration. Functional support looks at the specific functions that members in this social network can provide, such as the emotional, instrumental, informational, but emotional support may play a more significant role in protecting individuals from the deleterious effects of stress than structural means of support, such as social involvement or activity (Uchino, 2004).

2.2.4.5. Sources of social support

Social support can come from a variety of sources, including (but not limited to): family, friends, romantic partners, pets, community ties, and coworkers. Sources of support can be natural (e.g., family and friends) or more formal (e.g., mental health specialists or community organizations). The source of the social support is an important determinant of its effectiveness as a coping strategy (Hogan et al. 2002).

Early familial social support has been shown to be important in children's abilities to develop social competencies, and supportive parental relationships have also had benefits for college-aged students. Teacher and school personnel support have been shown to be stronger than other relationships of support (Repetti, 2002).

2.2.4.6. Social support through social media

Social support is also available among social media sites. As technology advances, the availability for online support increases. Social support can be offered through social media websites such as blogs, Facebook groups, health forums, and online support groups. The support is similar to face-to-face social support. Also, the support through social media also provides users with emotional comfort that relates them to others. This type of online communication can increase the ability to cope with stress. Social support among social media is available to any and every one and allows users to create relationships and receive encouragement for whatever issue they may be enduring (Coulson et al., 2007).

2.2.4.7. Theories to explain the social support's link to health:

Several theories have been proposed to explain social support's link to health.

1. *Stress and coping social support theory*

   According to this theory, social support protects people from the bad health effects of stressful events (i.e., stress buffering) by influencing how people think about and cope with the events (Lakey & Orehek, 2011).

   One problem with this theory is that, as described previously, stress buffering is not seen for social integration, and that received support is typically not linked to better health outcomes (Uchino, 2009).

2. *Relational regulation theory (RRT)*

   Relational regulation theory (RRT): is another theory, which is designed to explain main effects (the direct effects hypothesis) between perceived support and mental health. Perceived support has been found to have both buffering and direct effects on mental health. RRT was proposed in order to explain perceived support's main effects on mental health which cannot be explained by the stress and coping theory (Lakey & Orehek, 2011).

   RRT hypothesizes that the link between perceived support and mental health comes from people regulating their emotions through ordinary conversations and shared activities rather than through conversations on how to cope with stress. This regulation is relational in that the support providers, conversation topics and activities that help regulate emotion are primarily a matter of personal taste. This is supported by previous work showing that the largest part of perceived support is relational in nature (Lakey, 2010).

3. *Life-span theory*

   Life-span theory: is another theory to explain the links of social support and health, which emphasizes the differences between perceived and received support. According to this theory, social support develops throughout the life span, but especially in childhood attachment with parents. Social support develops along with adaptive personality traits such as low hostility, low neuroticism, high optimism, as well as social and coping skills. Together, support and other aspects of personality influence health largely by promoting health practices (e.g., exercise

and weight management) and by preventing health-related stressors (e.g., job loss, divorce). Evidence for life-span theory includes that a portion of perceived support is trait-like, and that perceived support is linked to adaptive personality characteristics and attachment experiences (Uchino, 2009).

2.2.4.8. Social support and PTSD

Another factor that seems helpful in the face of negative life events is perceived social support. Social support has been defined as "those social interactions or relationships that provide individuals with actual assistance or that embed individuals within asocial system believed to provide love, caring, or a sense of attachment to a valued social group".

Perceived social support, then, is the belief that these helping behaviors will occur when needed. In regards to coping with trauma, it appears that support from family and friends has appositive influence. In fact, social support was the strongest predictor found in a-meta-analysis by Brewin et al. (2000), accounting for 40% of variance in PTSD severity, in this meta-analysis, lack of social support emerged as a risk factor for PTSD across all population sample types but was noted to be especially strong with military rather than civilian samples (Brewin et al., 2000). Although most studies have only considered positive elements such as the perception of emotional and practical support, several recent investigations have also considered negative aspects of support such as indifference or criticism. When both positive and negative support elements are investigated, a negative social environment is a better indicator of PTSD symptomatology than lack of positive support. Moreover, negative appraisal of others' support attempts at initial assessment predicted PTSD symptoms 6 and 9 months later (Ullman & Filipas, 2001). Tarrier et al. (1999), Negative social support, at least in the case of violent crime, appears to be more prevalent for women than for men victims, and in addition, the relationship between negative social support and later PTSD symptoms is stronger for women than for men. Negative social support by partners has also been found to predict a poorer response to treatment for PTSD.

2.2.5. Summary of theoretical framework

This part summarized and discussed theoretical framework for the four variables trauma, PTSD, family and social support.

2.2.5.1Trauma

Trauma defines as direct personal experience of an event that involves actual or threatened death or serious injury, threat to one's physical integrity; or witnessing an event that involves the above experience or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member of close associate.

Most people will experience at least one traumatizing event in their lifetime. And some theories suggest childhood trauma can increase one's risk for mental disorders including PTSD, depression, and substance abuse.

The severity of the symptoms depends on the person, the type of trauma involved, and the emotional support they receive from others. Reactions to trauma can be wide and varied, and differ in severity from person to person.

A number of psychotherapy approaches have been designed with the treatment of trauma in mind: Eye movement desensitization and reprocessing, progressive counting, Somatic Experiencing, biofeedback, Internal Family Systems Therapy, and sensorimotor psychotherapy.

2.2.5.2. PTSD

PTSD define as an anxiety disorder that can develop after a person is exposed to one or more traumatic events, such as major stress, sexual assault, warfare, or other threats on a-person's life, and Fear of separation from loved ones is common after traumatic events such as a disasters, particularly when periods of separation from loved ones were experienced during the traumatic event.

Not every person have experiences of traumatic event will develop PTSD. But the people who experience assault-based trauma are more likely to develop PTSD, and the adults are more likely to experience PTSD after trauma than Children, especially if they are under ten years of age. Social and cultural factors will have a part to play.

Clinical features are: intrusive re-experiencing of aspects of the traumatic event, avoidance of reminders of the event, emotional numbing and hyper-arousal. And PTSD usually occurs within 6 months of the trauma, but a minority of those with PTSD appear to have a-delayed onset type. So the severity of the illness depends on the severity of the trauma, With appropriate medication, emotional support, counseling, and follow-up care, most people show significant improvement.

A number of screening tools use to diagnosed PTSD, including: UCLA PTSD Index for DSM-IV, Primary Care PTSD Screen, and PTSD Checklist. The diagnostic criteria for PTSD according to (ICD-10), requires that, first, the patient has been exposed to a-traumatic event, and second, suffers from distressing re-experiencing symptoms.

2.2.5.3. Family support

Families are unique social systems insofar as membership is based on combinations of biological, legal, affectional, geographic and historical ties. And family Support definition as a style of work and a wide range of activities that strengthen positive informal social networks through community based programmes and services.

Functions of the family includes: Biological function, psychological function, social function, and economic function. So family support services are for families and individuals who need help.

The positive influence of the family on treatment and rehabilitation, suggesting that family interventions can reduce relapse rates among persons with mental problems and help their rehabilitation in the community.

2.2.5.4. Social support

Social support is one's awareness that the environment is a source of effective social support, and availability of people who interested the individual. In addition, it is the source of people who care about the child, take his hand, and stand beside him.

social support networks are important for health and well-being and can be particularly helpful during difficult times.

Social support can come from a variety of sources, can be natural, or more formal. Sources of support including friends, romantic partners, pets, community ties, and coworkers. These supportive resources can be emotional (e.g., nurturance), tangible (e.g., financial assistance), informational (e.g., advice), or companionship (e.g., sense of belonging) and intangible (e.g. personal advice).

Part II: Literature review

In this part, the research represents previous researches which studied PTSD, trauma, family and social support.

2.2.6. Trauma

Several studies have highlighted the influence of exposure to war on children's physical health and daily functioning, as well as their mental health (Thabet et al., 2004, 2008).

In studies of Palestinian children in the Gaza Strip found that children experienced variety of traumatic events including witnessing killing of relatives, demolition of homes, bombardment, and arrest of relatives was associated with PTSD, anxiety, and depression. Such traumatic experiences severely deteriorate children's sleep and cause uncontrollable fears among babies and children, causing anxiety, panic attacks, and poor concentration. In more detail, military trauma in middle childhood and stressful life-events in early adolescence formed a risk for PTSD and depressive symptoms and decreased satisfaction with the quality of life in adolescence (Qouta et al., 2007).

And the study of Thabet et al. (2015a), aimed to investigate types of traumatic events due to war on Gaza experienced by Palestinian adolescents in relation to PTSD and anxiety and coping strategies as mediating factor. A stratified cluster random sample survey of 358 adolescents; 158 (44.1%) males and 200 (55.9%) females aged 15-18 years were assessed. The study use descriptive analytical design to represent the entire sample of population. The adolescents were interviewed by self–administrated questionnaire include sociodemographic scale, Gaza Traumatic Events Checklist, Spence Children's Anxiety Scale, Post-Traumatic Stress Disorder according to DSM-IV scale, and Adolescent-Coping Orientation for Problem experiences Scale. The study show that, the mean traumatic events reported by adolescents was 13.34. while the highest traumatic event (90.8%) of study

sample watching mutilated bodies on TV, 86.6% of study sample did not feel safe at home, while 90.8% were unable to protect themselves, 81.8% of study sample were unable to protect their families during the war, and 79.6% don't think that others were able to protect them, and show that there were significant differences in traumatic events according to sex in favor to males, and there were significant differences in traumatic events according to type of residence in favor to village. The result showed that 25 of study sample have no PTSD (6.7%), 74 of study sample have one symptoms (20.5%), 125 of study sample have partial PTSD (35.1%), while 134 of study sample have full in PTSD (37.6%) according to DSM-IV. The results showed that girls reported more PTSD than boys. Palestinian adolescents mainly cope commonly by developing social support, investing in close friends, and/or engaging in demanding activities. The study showed that adolescents experienced traumatic experiences developed less social support and positively asked more professional support as coping strategies. Adolescents with PTSD had coping by ventilating feelings, developing social support, avoiding problems, and Adolescents with less PTSD had looking more for solving his family problems. Adolescents with anxiety were ventilating feelings, developing social support, and engaging in demanding activities. Adolescents with less anxiety were seeking more spiritual support.

Also, Thabet and Vostanis (2015), study aims to investigate the impact of war trauma on child mental health; the mediating role of different coping strategies. The target population consisted of 462 children of 7 to 18 years, who were exposed to the war on the Gaza Strip between December 2008 and January 2009, and who lived in five localities of the Gaza Strip (North, Gaza, Middle, Khan Younis, Rafah) . The sample was selected randomly according to prepared list of number of boys and girls from the five localities of the Gaza Strip that had been exposed to war16 months earlier. Children completed the Gaza Traumatic Events Checklist 20 items-War on Gaza, UCLA PTSD index for DSM-IV adolescent, Depression self-rating scale for children (DSRC), Revised children's manifest anxiety scale (RCMAS), and Kidcope for children. The results of this study show that children reported many traumatic events (mean= 4). One third (32.5%) had partial and 12.4% had full criteria of PTSD. Children living in families with low family monthly income reported more emotional problems. There was significant association between exposure to traumatic events and developing PTSD. The rates of significant anxiety and depressive symptoms were 20.5% and 22.3% respectively. Girls reported significantly more depressive symptoms than boys. Children commonly used the following coping

strategies: wishful thinking, problem-solving, emotional regulation, and distraction. Trauma was negatively correlated with social support and wishful thinking, and positively correlated with self-criticism. Lack of social support and wishful thinking predicted all three types of mental health problems, while social withdrawal specifically predicted depression.

Moreover, Thabet et al. (2015b), study aims to estimate the prevalence of psychosomatic symptoms among traumatized Palestinian adolescents in the Gaza Strip. The study sample consisted of 380 adolescents randomly selected from secondary schools (ten schools) in the Gaza Strip, (two schools from each of the five governorates of the Gaza Strip, one all-boys and one all-girls school). From each school, three classes were selected randomly (10th, 11^{th} and 12^{th} class), of whom 171 were boys (45%) and 209 were girls (55%) between 15-18 years, with a mean of 16.6 years (SD=0.08). Data was collected using a socio-demographic checklist, the Gaza Traumatic Events Checklist, and the Psychosomatic Symptoms Scale. For statistical analysis, questionnaire data was normally distributed, for this reason independent t-test was used to investigate differences between two groups. Associations between continuous variables were measured by the Pearson's correlation coefficient test. One-way ANOVA post hoc Tukey was used to investigate differences between more than two groups. In the results: The most common reported traumatic events due to the war on Gaza were: watching mutilated bodies and wounded people in TV (92.3%), and hearing shelling of the area by artillery (89.4%), and 89.2% heard the sonic booms from jetfighters. While the lowest traumatic events were physical injury due to bombardment of your home (21.9%). The mean number of traumatic events experienced by Palestinian adolescents was 14, and 134 of study sample have mild traumatic events due to war on Gaza (35.3%) , while 177 of study sample have moderate traumatic events (46.6%), and 69 of study sample have sever traumatic events (18.2%). Boys reported significantly more traumatic events than girls. Adolescents from family with monthly income less than 150 US $ experienced more traumatic events than the other groups. There were significant differences between traumatic events and place of residence toward the group who live in North Gaza. that means the study sample who live in North Gaza had significantly greater level of traumatic events other than other groups which live in other places in (Gaza –Middle area –Khan Younis – Rafah). Mean psychosomatic symptoms was 48.19, digestive system symptoms was 19.97, cardiovascular symptoms was 10.23, respiratory system symptoms was 3.82, urogenital system symptoms was 2.98, skeletal

musculature symptoms was 5.29, and skin symptoms was 7.34. Boys scored more in total psychosomatic and skin symptoms. There was a significant relationship between traumatic experiences and psychosomatic symptoms.

Furthermore, Qeshta (2015), study aimed to investigate the relationship between war trauma and mental health problems (traumatic events, PTSD, anxiety and depression) among secondary school students in the Gaza Strip. The study sample consisted of 408 secondary school students (204 boys and 204 girls). The study used descriptive –analytical design, and used socio-demographic questionnaire; traumatic events scale, PTSD scale Arabic version, Depression Self-Rating Scale For Children, and The Revised Children's Manifest Anxiety Scale RCMAS. The results showed that the most common traumatic experiences reported by children were: watching mutilated bodies in TV (93.1%), hearing shelling of the area by artillery (92.4%), hearing the loud voice of drones (90.4%), , forced to leave you home with family members due to shelling (67.6%), and Inhalation of bad smells due to bombardment (67.6%). While, the least common traumatic experiences were: Witnessing arrest of a close relative by the army (10.8%), witnessing arrest of a friend, and physical injury due to bombardment of your home (10.3). Also the results showed that 4.2% of boys reported mild traumatic events, 22.8% reported moderate traumatic events, and 23 % reported severe traumatic events, 7.1% of Female reported mild traumatic events, 29.4% reported moderate traumatic events, and 13.5 % reported severe traumatic events. There were statistically significant differences toward boys. There were no statistically significantly differences in traumatic events and age of adolescents. There were no statistically significant differences in traumatic events according to adolescents children living. And there were no statistically significant differences in traumatic events according to families income. And the results showed that the most common post traumatic reactions in adolescence were: recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions (49%), Acting or feeling as if the traumatic event were recurring (44.8%), Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event (34.8%). The results showed that 129 of children (31.6%) showed no PTSD, 108 of children (26.5%) showed at least one criteria of PTSD (B or C or D), 104 showed partial PTSD (25.5%), and 67 of children showed full criteria of PTSD (16.4%). The results showed that there were no statistically significant differences in total PTSD scores (Mean 26.98 girls vs.

24.87 boys), and also no significant for avoidance, and arousal subscales, but the girls reported more re-experiencing symptoms than boys, there were no significant differences between the total means of PTSD according to age group of children, there were no significant differences between the total means of PTSD according to place of residence, and that there were significant differences between the total means of PTSD according to family income in favor of those who have less than 1700 NIS. The results showed that there was significant correlation between total traumatic events reported by children and total PTSD, re-experiencing, avoidance, and arousal. This means that experiences that are more traumatic lead to post traumatic stress disorder.

But, Thabet and Ghannam (2014), the aim of this study examine the effect of war trauma on occurrence of dissociative symptoms among Palestinian adolescents in the Gaza Strip and the role of resilience. The target population consisted of 430 children, between 15 to 18 years old, who were exposed to the war on the Gaza Strip on November 2012, and who lived in five localities of the Gaza Strip (North, Gaza, Middle, Khan Younis, and Rafah). The sample was selected randomly according to a prepared list of boys and girls (179 boys and 221 girls) from each of the 10 schools from the five areas. The adolescents were interviewed by: sociodemographic form, the Gaza Traumatic Checklist, Resilience Scale for Adolescents and Adolescents Dissociative Experiences Scale (A-DES). The results showed the most traumatic event was hearing shelling of the area by artillery (96.25%), watching mutilated bodies in TV (95.25%), (95%) experienced witnessing the signs of shelling on the ground, then hearing the sonic sound of the jetfighters (93.25%) and hearing the loud voice of drones that experienced by (92%). And the results showed that No statistically significant differences in dissociative symptoms according to sex, age, place of residence, parent's jobs and education. Mean resilience was 112.18, individual resources (such as personal skills, social skills, and peer support) was 44.06, physical and psychological caregiving by primary caregivers was 27.42, and contextual resources including spiritual, cultural and educational resources mean was 37.42. No statistically significance differences in the total resilience and subscales according to the socio-demographic factors as (sex, age, type of residence and parents work), whereas, resilience was more in adolescents with less siblings. There was a statistically significant negative relationship between dissociative symptoms and total resilience, individual resources, physical and psychological caregiving, and contextual resources. There was a statistically

significant positive relationship between traumatic events and total trauma and total resilience, individual resources, and contextual resources. Clinical implications: This study showed that Palestinian adolescents had been victims of continuous trauma which increased risk of psychopathology such as dissociative symptoms. Such symptoms had negative impact of adolescent's resilience in face of adversities. Such impact raises need for psycho-social interventions based on a public health and developmental process of children, usually include engaging children in community-based recreational and cultural activities in the war-affected populations, such as art and games, and have been found useful to heal.

However, Abu Sultan (2012), study aim to examine the impact to traumatic experiences resulting from the war on Gaza, on self-esteem and resilience among university student, and to explore the effect of socio-economic and demographic characteristics at the level and severity of trauma, resilience and self-esteem of the university students. This study use cross sectional descriptive analytic study was applied. The sample consisted of 399 (167 males and 232 females) students enrolled at four university in the Gaza Strip: Islamic university, AL-Azhar university, AL-Aqsa university and AL-Quds Open university. Also this study use four instruments are used in the study: the Gaza traumatic events checklist for war on Gaza, connor-Davidson resilience scale, state-trait anxiety inventory STAL, and demographic information sheet. So the results showed that the total mean of traumatic experience was 4.72 and there was relation between traumatic events and sex of the students in favor of males, but there were not any differences between traumatic events and name of the university, type of residence, and family income. Males and females students had the same level of both types of anxiety state and trait. And the study found correlation between anxiety state and total traumatic events and no correlation between anxiety trait and total traumatic event. And revealed watching mutilated bodies on TV was the highest traumatic experience (92.73%) of university students, then witnessing the shelling and destruction of another's home (47.37%) and witnessing firing by tanks and heavy artillery at neighbors' homes (47.12%).

And, Bensimon (2012), study divides and reports negative associations between negative (pathogenic; e.g., posttraumatic stress disorder; PTSD) and positive (salutogenic; e.g., posttraumatic growth, resilience) psychological responses to trauma. This study elaborates prior research by casting resilience as a trait rather than state. Participants with varied exposure levels (n=500) completed measures of resilience, trauma history، PTSD, and posttraumatic growth. Results of structural equation modeling with LISREL showed that trauma increased PTSD and growth levels, whereas resilience was associated positively with growth and negatively with PTSD. It is concluded that salutogenic and pathological responses to trauma show differential associations with trait resilience.

Until, Kazantzis et al. (2010), study aims to assess the prevalence and psychological impact of specific traumatic events in a New Zealand community sample. Methods: Prevalence and psychological impact of 12 traumatic events was examined in a community sample of 1,500 New Zealand adults using a three-stage cluster sampling method. Traumatic events, psychological distress, psychological well-being, and PTSD symptoms were assessed using modified versions of the Traumatic Stress Schedule, Mental Health Inventory, and Civilian Mississippi Scale. The effects of age, gender and ethnicity were controlled for while assessing impact of traumatic events. Results: Sixty-one per cent of the sample experienced trauma events in their lifetime, with 9% experiencing events in the past year. Accident-related events were most common in the present sample. Violent crime produced the greatest impact. Tests of interactions involving age, gender, and ethnicity were not significant. Conclusions: New Zealand community-residing individuals experience post-traumatic stress symptoms, reduced psychological well-being, and increased psychological distress following the experience of violent crime and accidents specifically.

And study of Kiser et al. (2008), article describes findings from a qualitative study designed to explore the impact of chronic traumas on family life through the voices of primarily African American caregivers coping with urban poverty. Structured interviews are conducted with 16 parents and/or guardians (caregivers) of children ages 6 to 9 years who had been exposed to multiple traumas and had symptoms of posttraumatic stress disorder. assessing the impact of violence and trauma on family processes. The larger project was a cross sectional study of 100 children aimed at exploring relationships between exposure, childhood traumatic stress, and family functioning. Families were

recruited from community programs and service agencies, such as afterschool programs, community/recreation centers, and a pediatric outpatient clinic. All of the children and their caregivers were living in poor, inner-city communities in a mid-Atlantic city. As violent crime statistics involving children rank this city among the highest in the nation, these communities represent poor urban neighborhoods with high risk for exposure to severe stressors and traumas. This was essentially a non-referred sample, although the recruitment materials indicated that the study focused on trauma so some caregivers may have participated because of concerns about their children's exposures to traumatic events. Twenty-eight of the 100 children met these requirements. The caregivers of these children were invited to participate in the interviews. Sixteen caregivers were available and agreeable to being interviewed. Following initial analysis of these interviews, the research team determined that additional interviews were unnecessary as new themes were no longer emerging. 28 who were eligible for interviews, and the 16 who participated in this study. Of the 16 caregivers who were interviewed, 9 had children who met full and 7 who met partial diagnostic criteria for PTSD. As were interested in the impact of multiple and chronic traumas on family life, and did not categorize families by type of trauma experienced, duration of trauma, or length of time since the trauma occurred. None of the caregivers interviewed were dealing with acute traumas; they were asked to recall family responses to events that occurred over the course of their child's lifetime. The result is all caregivers interviewed were parenting at least one child who had experienced multiple traumas. Their children's traumas included a shooting of a sibling, death of grandparents/cousins, a mother's illness and hospitalization, death of a pet, house fires, experiencing and witnessing domestic violence, being beaten up at school, being robbed at gunpoint, being hit by a car, experiencing and witnessing physical abuse, and having family members removed from their homes. Oftentimes, but not always, the caregivers directly experienced these events along with their children. The Family risk-protection models demonstrate the importance of family functioning for dealing with exposure to traumatic events. This qualitative study surfaced important themes and raised further questions about how families cope when bad things happen to them.

Also, Araya et al. (2007), study aim to an understanding of how quality of life is affected by severe trauma and mental distress may facilitate better intervention strategies for post conflict internally displaced persons, by identifying mediators, moderators, and independent risk factors. The study investigate the pathways involved in this process and also study the moderating roles of coping strategies and perceived social support. A-random sample of 1193 (62% women) between the ages 18 and 60 years, internally displaced Ethiopian adults. the study used Socio demographics and trauma instruments. Path analysis was employed to elaborate the mediating and moderating effects. Self-reported living conditions were also assessed. Results Mental distress increased and quality of life decreased with age. Mental distress mediated the effects of trauma in reducing the quality of life, and some trauma also reduced quality of life directly. These effects remained after adjusting for living conditions. Living conditions were related to quality of life also on their own. Coping strategies and perceived social support influenced mental distress and quality of life directly as well as indirectly by moderation, in part gender specific. Conclusions Intervention strategies aimed at reducing mental distress, modifying coping strategies, and encouraging social support may turn out to be useful in increasing the overall quality of life in post conflict situations, and are worth considering as complements to strategies that improve the living conditions.

2.2.7. Posttraumatic stress disorder

A high number of accumulated traumatic life events, economic pressure, and elevated prevalence of depression, anxiety and PTSD have been found among adults and children in the Gaza Strip (Thabet & Vostanis, 2012).

Al ibwaini (2015), study aimed to investigate PTSD and resilience among adolescents in the Gaza Strip, especially after 51 day war on the Gaza Strip. Descriptive analytic, cross sectional design was used. By using four applied tools as follow: socio-demographic characteristic questionnaire, Gaza traumatic events checklist, PTSD Scale for DSM-IV, and resilience scale for adolescents. The sample consisted of 408 students (209 boys and 199 girls) from the five governorates of the Gaza Strip aged from 13-18 years old with mean age=15.49. The result showed that the total mean of traumatic experiences was 10.91 (sever experiences), and mean of traumatic event in boys were 11.79, also 9.98 for girls. 10.6% of adolescents reported mild traumatic events, 40.9% reported moderate traumatic events, and 48.5% reported severe traumatic event. The result found that 48.5% of the

study sample experienced at least 11 traumatic events and there was relationship between trauma and sex, boys statistically significantly reported severe traumatic events than girls, and there were no statistically significant differences in traumatic experiences resulting from the war on Gaza according to age, place of residence, family monthly income. The study found that the highest traumatic events were: watching mutilated bodies in TV (93.1%), hearing shelling of the area by artillery (92.4%), hearing the loud voice of drones (90.4%), forced to leave you home with family members due to shelling (67.6%), and Inhalation of bad smells due to bombardment (67.6%). While, the least common traumatic experiences were: witnessing arrest of a close relative by the army (10.8%), witnessing arrest of a friend, and physical injury due to bombardment of your home (10.3%). The study found that the most common post traumatic reactions in adolescents were: recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions (43.6%), exaggerated startle response (41.4%), acting or feeling as if the traumatic event were recurring (40.7%), efforts to avoid activities, places, or people that arouse recollections of the trauma (40.2%), and efforts to avoid thoughts, feelings, or conversations associated with the trauma (40%).Also, the mean total scores of PTSD was 29.52, mean re-experiencing symptoms was 9.95, mean avoidance was 10.37, and mean arousal was 9.21. And 20.1% of adolescents showed no PTSD, 31.1% showed at least one criteria of PTSD (B or C or D), 29.7% showed partial PTSD, and 19.1% of adolescents showed full criteria of PTSD, also there were statistically significant differences in total PTSD, avoidance, and arousal symptoms according to place of residence in favor of adolescents from middle area, and there were no statistically significant differences in total PTSD scores and all subscales according to socio-demographic factors as (sex, age, family monthly income, and number of siblings). The results showed that there was significant correlation between total traumatic events reported by adolescents and total PTSD, re-experiencing, avoidance, and arousal.

Also, in study Thabet et al., (2014), 386 Palestinian children and adolescents from Gaza exposed to stressors due to siege and other political violence found that 12.4% (n=48) of the children and adolescents reported probable PTSD, and 22.37% (n=86) filled the two criteria partial PTSD, and 26.7% (n=103) the one criteria partial PTSD (re-experiencing or avoidance or hyperarousal) and more than a third (38.4%, n=149) of the children did not have PTSD.

Also, Sattler et al., (2014) study examines variables associated with posttraumatic stress symptoms (PTS) and posttraumatic growth among 2 independent samples of survivors following the Indian Ocean tsunami in Khao Lak, Thailand. Participants were exposed to unprecedented horror and loss of life and property. At 3 months participants (N = 248) 97 men, 151 women, were living in temporary shelters, and at 15 months a second sample (N=255) was living in homes built after the tsunami. Prior traumatic experiences, life threat, loss of personal characteristic resources and condition resources ,somatic problems, and social support accounted for close to half of the variance in PTS in each sample. At 3 months, emotion-focused coping and concerns about government favoritism also contributed to PTS. At 15 months, lack of prior disaster experience and loss of energy resources also contributed to PTS. Distress was higher among participants surveyed at 3 months than among those surveyed at 15 months. Posttraumatic growth was positively associated with social support and problem– focused coping in both samples.

Moreover, a study conducted in the Gaza Strip by Abu Nada et al. (2012), the aim of this study is investigates the impact of ongoing traumatic events on Palestinian adolescents, posttraumatic stress according to event-related and demographic factors. And this study use 368 Palestinian adolescents (49.2% males) was drawn from different areas of the Gaza Strip. Students were investigated on exposure to traumatic events and posttraumatic stress symptoms (PTSS) and PTSD. And the result of this study: Number of traumatic events experienced by the adolescents was 9.9 (SD = 3.20). Boys were significantly more exposed than girls, as were adolescents living in villages compared to those living in Gaza city or refugee camps. Adolescents mainly and pervasively experienced objective, non-personal material exposure (such as witnessing bombardments) (85% to 96%) and media exposure (95%). Up to 17% of the adolescents experienced direct, physical exposure (7% personal injury), exposure through injury and death of relatives. In this context, two fifths of the adolescents experienced mild, two fifths moderate and one fifth severe PTSS. Remarkably, adolescents did not differ significantly in PTSS despite exposure differences across gender, place of residency and family income.

Also, studies of PTSD in adolescence published from 2000 to 2011 indicate that adolescents are at greater risk of experiencing trauma than either adults or children, and that the prevalence of PTSD among adolescents is 3–57%. Age, gender, type of trauma, and repeated trauma are discussed as factors related to the increased rates of adolescent

PTSD. PTSD in adolescence is also associated with suicide, substance abuse, poor social support, academic problems, and poor physical health. And the mean rate of adolescent PTSD was nearly 14% among studies conducted in the last decade, and rates of PTSD in adolescence are related to type of trauma. Trauma that is associated with more shame and deviance is associated with higher rates of PTSD (e.g., for sexual abuse 57% have PTSD vs. 10% for natural disasters). Rates of traumatic exposure peak in adolescence compared to adulthood, which is associated with correspondingly higher rates of PTSD (adult PTSD 7% vs. adolescent PTSD 13%). Also adolescent females are twice as likely to develop PTSD following a significant trauma than males, and Adolescents with less social support are more likely to experience trauma and develop PTSD (Nooner et al., 2012).

But, Scarpa et al. (2006), study tested the relationship of community violence (CV) victimization to severity of PTSD, and the roles of coping style and perceived social support in moderating that relationship. Participants were volunteer psychology students who had reported experiencing a traumatic event in their lifetime. The current sample was taken from a larger sample of 440 participants (148 men, 292 women), age 18 to 22 years, self-reported on CV exposure, traumatic experiences, PTSD symptoms, perceived support from family and friends, and coping strategies. Results indicated that high CV victimization, high disengagement coping (i.e., avoidant styles), and low perceived social support from family and friends significantly predicted increased PTSD scores. Significant moderating effects indicated that the relationship between victimization and heightened PTSD severity was stronger at high levels of perceived friend support and disengagement. Thus, the protective function of friend support seemed to break down at increasing levels of victimization, whereas, as expected, avoidant styles of coping increased the risk for negative outcome. Findings are discussed in terms of event controllability, negative social reactions, and coping resources.

And, Khamis (2005), study was designed to assess the prevalence of PTSD among Palestinian school-age children. Variables that distinguish PTSD and non-PTSD children were examined, including child characteristics, socioeconomic status, family environment, and parental style of influence. The sample was 1,000 school age children, of whom 52.3% were males and 47.7% females. They ranged in age from 12 to 16 years. They were selected from governmental, private, and United Nations Relief Work Agency (UNRWA) schools in East Jerusalem and various governorates in the West Bank, About 60.9% were from governmental schools; 18.8% from private schools; and 20.3% from United Nations Relief Work Agency (UNRWA) schools. Geographically, 84.6% were from the West Bank and 15.4% from East Jerusalem, representing various residential patterns, 11.2% from refugee camps, 56.9% from urban areas, and 31.9% from rural areas. A stratified random sample design was used. Questionnaires were administered in an interview form at with children at school, and with the available parent at home. And this study used many instrumentations: Child characteristics and family data sheet, Post-traumatic stress disorder, Child Psychological Maltreatment (CPM), Gender Inequities Scale (GIS), Family Ambiance Scale (FAS), Parental Support Scale (PSS), Harsh Discipline Scale (HDS), Economic pressure (EP), and Fulfillment of Child's Material Needs Scale (FCMNS). The results of this study: A substantial number of children experienced at least one lifetime trauma (54.7%). PTSD was diagnosed in 34.1% of the children, most of whom were refugees, males, and working. Although the expected association between family environment, parental style of influence and PTSD symptomatology was found in this study, family ambiance (child's experience of anxiety in home environment) was the only predictor in the final model.

However, Thabet et al. (2004), study aim to examine the prevalence and nature of comorbid post-traumatic stress reactions and depressive symptoms, and the impact of exposure to traumatic events on both types of psychopathology، among Palestinian children during war conflict in the region. The 403 children aged 9- 15 years, who lived in four refugee camps, were assessed by completing the Gaza Traumatic Events Checklist, the Child Post Traumatic Stress Reaction Index (CPTSD-RI), and the Short Mood and Feelings Questionnaire (MFQ). The results of this study: Children reported experiencing a-wide range of traumatic events, both direct experience of violence and through the media. CPTSD-RI and MFQ scores were significantly correlated. Both CPTSD-RI and MFQ scores were independently predicted by the number of experienced traumatic events, and

this association remained after adjusting for socioeconomic variables. Exposure to traumatic events strongly predicted MFQ scores while controlling for CPTSD-RI scores. In contrast، the association between traumatic events and CPTSD-RI scores, while controlling for MFQ scores, was weak. The CPTSD-RI items whose frequency was significantly associated with total MFQ scores were: sleep disturbance, somatic complaints, constricted affect, impulse control, and difficulties in concentration. However, not all remaining CPTSD-RI items were significantly associated with exposure to traumatic events, thus raising the possibility that the association between depression and PTSD was due in part to symptom overlap.

But, Thabet and Vostanis (2000), study aim to establish rates of PTSD reactions and general mental health problems in children who had experienced war trauma. Alongitudinal study in the Gaza Strip with 234 children aged 7 to 12 years, who had experienced war conflict، at 1 year after the initial assessment, that is, during the peace process. Children completed the Child Post Traumatic Stress Reaction Index (CPTS-RI), while the Rutter A2 and B2 Scales were completed by parents and teachers. And the results of this study 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 1-year period. The total CPTS-RI score at follow-up was best predicted by the number of traumatic experiences recalled at the first assessment.

2.2.8. Family and social support

Social support from parents, peers, and others has been found to be a protective factor both before and after a trauma (Lee et al., 2007).

Al Kurd (2012), study aimed to identify the effect of family and social support on PTSD among the secondary school students in the Gaza Strip and to identify the socioeconomic and demographic information. In addition to, the gender, place of residency and home monthly income and test if that factor can affect the PTSD, family, and social support. The study was done in secondary school students on 10th, 11th , and 12th classes. The study sample was 434 students done on both sex meal and female (201 meals and 233 female).

The study design was descriptive analytical study the sample was random stratified sample it was taken from all governorate schools of the Gaza Strip. The scales ware used are, Gaza traumatic events chick list, Davidson Trauma Scale (DTS), Family Crisis Oriented Personal Evaluation Scales (F-COPES), social support scale, and socio demographic data. The scale was used as chick list and collected in November 2011 of study year 2011-2012. The results of the study showed that percentage of trauma was (61.5%) the most traumatic events the study sample was exposed " Watching mutilated bodies in TV 96%", followed by "Witnessed the shelling and destruction of another's home70%", then "Expose you to forced to leave your home with your family and relatives69%. While the least percent of traumatic events were being injured by burning phosphorous bombs and the regular bombs 52.5% ". Then " Use as a human shield for the inspection of houses of the neighborhood or a neighbor to catch you 52% "and" beaten and humiliated by the Israeli army50 %" . The most symptoms were appearing of PTSD in the study sample was "being upset by something which reminded (67.24%), Then, "fell as though the event was re-occurring 65.62%". The least symptoms was "being unable to have sad or loving feeling 32.21%", and flowed by" being unable to recall important parts of the event 25.02%". The result of social support according to Vivian Khamis scale for social support, which divided into three sub scales are as the fowling: First, Support perceived from family and relatives ,the average mean for all items equals 2.48, the weight mean equals 82.81% which is greater than 66.6%, this means that Support perceived from family and relatives are very high. Second sub scale is Psychosocial support provided by friends. The average mean for all items equals 2.26, the weight mean equals 75.27% which is less than 66.6%, this means that psychosocial support provided by friends is high. Third sub scale is psychosocial support provided by the institutions, the average mean for all items equals 1.60, and the weight mean equals 53.47 % which is less than 66.6%, it means psychosocial support provided by the institutions is weak, and The weight mean of all sub scales equals 74.27 % which is less than 66.6, it means that Social support provided to study sample are high and that can decrease the PTSD symptoms. The level of social support equals (74.27 %). And family support provided to study sample according the (F–copes) was divided into 5 sub scales. First of all, requesting for social support the average mean for all items equals 3.66, and the weight mean equals 73.25 % which is greater than 60%,this means that requesting for social support is high. Second Restructuring, the average mean for all items equals 3.94, and the weight mean equals 78.80% which is greater than 60% that means Restructuring is good. Third Requesting for spiritual

(religious) support, the average mean for all items equals 4.29, and the weight mean equals 85.77 % which is greater than 60%, this means Request for spiritual (religious) support is high. Fourth positive evaluation, the average mean for all items equals 3.63, and the weight mean equals 72.62 % which is greater than 60%, it means that the evaluation is positive. Fifth actions of the family, the average mean for all items equals 3.69, and the weight mean equals 73.83 % which is greater than 60%, this means that the actions of the family are good. For all sub scale the average mean for all items equals 3.82, and the weight mean equals76.41% which is less than 60%, it means the family support is good, and it affects positively on the PTSD symptoms. There were no statistically significance differences in Social support, and family support according to age, sex, number of family members, and family income. Also there were statistically significance differences in Social support, and family support according to place of residences favor of North. However, the difference in Gaza Traumatic events checklist and the difference in female's favor. The correlations, between each scale where there is a positive significant correlation between (Gaza Traumatic events checklist, and Davidson Trauma Scale), it means that when the trauma is increased the symptoms of PTSD will increased and vice versa, and negative correlation between Davidson Trauma Scale, Social support scale, and positive correlation between (Family Crisis Oriented Personal Evaluation Scales (FCOPES), and social support scale), it means when the social support increased the family support increased and vice versa.

Moreover, DeLong (2012), study analyzes three different variables (race/ethnicity, gender, and trauma type. Participants for this study included 200 men (24.5%, n=49) and women (75.5%, n=151) that were recruited from a PTSD treatment-outcome study at two sites. Thirty-five percent of participants who were evaluated for this study did not have a primary diagnosis of PTSD. Three measures, the Social Support Questionnaire (SSQ), the Inventory of Socially Supportive Behaviors (ISSB), and the Social Reactions Questionnaire (SRQ) will be utilized to compare differences in the three variables: race/ ethnicity, gender, and trauma type. These variables analyzed using means-descriptive analysis, and basic ANOVAs on SPSS software. Several studies have shown that social support is crucial to the effectiveness of treatment after the development of PTSD. Some support has been found indicating that certain populations (women, minorities, and those who experienced childhood sexual assault) may be more vulnerable to experiencing low or negative social support. The result show womens' low levels of social support were congruent with our hypothesis and previous research that alludes to the idea that women

have a harder time finding positive social support than men. Although we found no statistical significance in the relationship between social support and minority status.

Furthermore, Brookmeyer et al. (2011), study investigates how social support may protect Israeli early adolescents who have witnessed community violence from engaging in violent behavior when they have also witnessed terror violence. The study examines how support from parents, school, and friends could serve as protective, despite the interactive risk effects of witnessing community and terror violence. This study was cross-sectional, the sample totaled (N= 179) from Dimona and Sderot. 24.6% of students were from the town of Sderot (n= 44), located 1 km from the Gaza Strip, and 75.4% of students were from the town of Dimona (n= 135). Nearly 60% of students sampled were girls. The majority of students recruited were in the age group of 13 to 15 years (96.0%). Students' families can generally be described as low income and working, as 73.2% of students' parents were both employed. Results Of the 179 participants with demographic data, a few (<4%) were missing data on one or more of the continuous measures.Girls were victimized less by community violence, witnessed less community violence, and engaged in less violent behavior. Girls also reported more social support from parents, friends, and school. Older students reported more friend support and were less likely to witness terror violence. There was a positive correlation between parent employment and social support from parents and friends. Study findings indicated that facets of social support in the social ecology varied in the extent and the conditions in which they appeared to protect youth from witnessing community violence. In general, support from parents operated as a protective factor, whereas support from friends acted mainly as a risk by increasing the likelihood of violent behavior. Support from school had both a protective and risk effect, depending on the type of violence witnessed.

Also, Odah (2010), study aimed to identifying the relationship between the degree of exposure to traumatic experience and methods to adapt to the stresses and the level of social support, level of mental toughness, to the children the border areas of the Gaza Strip, and to identify whether there are differences in these variables attributable to some demographic variables are the following: (type, place of residence, age, educational level of parents). The researcher used descriptive analytical approach. And The sample consisted of the exploratory study (100) boys and girls, in order to verify the validity and reliability study tools, as the actual sample consisted of the study (600) boys and girls of the children

border areas of the Gaza Strip. To achieve these objectives, the researcher conducts four questionnaires to measure variables of the study are: traumatic experience, ways to adapt to the stresses, social support. Also the researcher used the following statistical methods to verify the results of the study: Duplicates, averages and percentages, to find a relationship between variables researcher used Person correlation coefficient (person), and to find the differences between the variables, the researcher used a T-test, and to find the differences between the averages of three or more researcher used a unilateral analysis of variance (One Way ANOVA). So the results of this study are: there is high level of traumatic experience to the children in the Gaza Strip border areas, as well as a high level of adaptation methods with stress, social support, and psychological toughness. There was a positive correlation between the positive experience of traumatic and all methods of adaptation with stress, social support, and psychological toughness. And the study showed that there were no differences in the traumatic experience, methods to adapt to stress, and psychological toughness due to the variable type, found that while there are differences in social support in favor of females. Also, the study showed that there were no differences in the methods of adaptation to stress, and psychological toughness due to the variable place of residence, while the differences found in the traumatic experience and was in favor of the governorates of the north, and Khan Younis, and that there differences in social support for the middle one. Also, the study showed that there were no differences in the traumatic experience, methods to adapt to stress, and psychological toughness due to the variable educational for level of parents, while those found differences in social support for children who have studied them in high school.

But, Schiff et al. (2010), study investigated the role that social support plays in posttraumatic stress (PTS), and depressive symptoms among Israeli adolescents with high or low exposure to terrorist acts. This study use 585 Jewish students (221 girls and 364 boys) in grades 7 to 12 from areas extensively versus slightly exposed to terrorist attacks. The results found that PTS levels and depressive symptoms were higher among adolescents residing in areas highly exposed to terrorism. Adolescents in high exposure areas reported lower perceived levels of support than adolescents in low exposure areas when gender, age and religiosity were controlled. Social support was found to be a-significant predictor for PTS and depressive symptoms, but no evidence for a buffering role of social support was obtained.

And, Thabet et al. (2009). Study aim to establish the relationship between perceived positive parenting support and PTSD symptoms in children exposed to war trauma. The study used a random sample of 412 children aged 12-16 years was selected from the Gaza Strip and was assessed using the Gaza Traumatic Events Checklist (GTEC), the SCID (DSM-IV) and the Perceived Parenting Support Scale (PPSS). The results show that Palestinian children were exposed to different types of war-traumatic events. The number of exposed traumatic events was independently associated with the severity of post-traumatic symptoms scores or the diagnosis of PTSD, while perceived parenting support was found to act as a protective factor in this association.

However, Diab (2006), study seeks to explore the role of social support as a protective factor mediating the impact of the negative effect of life's stressful events on individuals' mental health. The purpose of the study was to identify the role of social support as a-protective variable (mediating variable) from the psychological impact resulting from exposure to stressful events. The aim also is to determine the negative impact of stressful events on the mental health of adolescents. The study sample consisted of 550 secondary school students between the age of 15-19 years, with average age 16.3 years and standard deviation of 0.60. Males represented 48.9% and females 51.1% of the sample. The researcher used the following tools to conduct the study procedures: mental health questionnaire, questionnaire for social support was also used, also used the stressful events questionnaire. The researcher used a number of statistical methods that can be summarized in the following: percentages, repetitions, mathematical averages, standard deviations, relative weights, one-way ANOVA, Pearson Correlations coefficient, T-Test. Study results indicate the following: Palestinian adolescents are exposed to various forms of stressful events (familial, economical, social, emotional, health, personal, and academic), Palestinian adolescents enjoy good mental health, and social support received by adolescents is considered average. Also there are significant statistical differences in the degree of social support related to gender (sex) of the adolescents. And there are no significant statistical differences between adolescents in terms of social support provided based on the size of the family, there are significant statistical differences between adolescents on the scale of social support related to the birth order of the individual, and there is an inverse statistical relationship between the degrees of stressful events that adolescents are subjected to and social support. And there are significant statistical differences between the average scores of adolescents with low stressful events and those

with high levels of stressful events in terms of social support provided, in favor of those with low stressful events scores. Also, there is a statistical correlation between the scores of adolescents' mental health and social support, and significant statistical differences between the average scores of adolescents with low levels and high level of social support in terms of their mental health, in favor of those with high levels of social support. There is a strong inverse statistical relationship between the scores of mental health and the scores of stressful events of adolescents. And significant statistical differences between adolescents with low and high levels of stressful events in terms of their mental health, in favor of those with low levels of stress full events. There is no statistical relationship between the scores of mental health and social support for adolescents, and there are no significant statistical differences between adolescents with low and high social support and mental health, and is no statistical relationship between mental health and stressful events scores for adolescents. There are no significant statistical differences between adolescents with low and high levels of stressful events and their mental health. Social support is a mediating factor between stressful events and mental health.

Moreover, Lincoln et al. (2005), study used to examine the relationships among stress, social support, negative interaction, and mental health in a sample of African American men and women between ages 18 and 54 (N= 591) firo the National Comorbidity Study. The study findings indicated that social support decreased the number of depressive symptoms, did not mitigate the effects of stress, and was reduced in response to financial strain. Financial strain and traumatic events were associated with in- creased negative interaction with relatives and depressive symptoms. The findings verify that stressful and traumatic events have direct influences on levels of depressive symptoms and affect the quality of social interactions and suggest how social interaction processes contribute to mental health.

Also, Hassanein (2004), study discusses the psychological trauma, family support and its relation to the psychological well-being. This study aims to uncover the relation between the traumatic experiences, family support and its role in protecting children and helping them to enjoy a good mental health. It aims to give some ideas about the traumatic experiences, family support and its relation to the child’s mental health to help in Planning to children and families Programs. The importance of this study comes of its being one of

the first studies which concerns about Al Aqsa Intifada. Also because of the importance of the sample. The number of the sample is 450 child (both sexes), and their families. The measures of the study were: Trauma test, Post-traumatic Stress Disorder test, Neurotism test, Family support test, Rutter test. The results show that there are differences between children who got a lot of family support and children who did get a little of family support concerning Psychological well-being on the behalf of children who got a lot of family support. The girls show a better mental health than boys .There are differences between children who were exposed to many traumas and those who were exposed to few traumas concerning neurotism on the behalf of the children who were exposed to many traumas. There are no differences between children who were exposed to many traumas and children who were exposed to few traumas concerning mental health.

2.2.9. Comments on the literature review

2.2.9.1. Trauma

Through reviewing previous studies, the researcher noticed that the studies addressed the issue on trauma, and relationship between mental health problem such as PTSD, anxiety and depression, used different ways and different variables. Some studies investigate the relationship between war trauma and mental health problems (trauma, PTSD, anxiety and depression) in 408 secondary school student (Qeshta, 2015), and the study of Thabet and Vostains (2015), aimed to investigate the impact of war trauma on child mental health in 462 children of 7 to 18 years, also study of thabet et al. (2015 a), aimed to investigate types of traumatic events due to war on Gaza experienced by Palestinian adolescents in relation to PTSD and anxiety and coping strategies in 358 adolescents, aged between 15-18 years. while study of Araya et al. (2007), aimed to an understanding of how quality of life is affected by severe trauma and mental distress among 1193 internally displaced Ethiopian adults, between the ages 18 and 60 years.

From the previous literature review, the researcher notice that most of previous study selected the sample randomly (Thabet et al.; 2015a, 2015b; Thabet &Vostanis, 2015; Thabet & Gannam, 2014), and some of the study used descriptive analytical design (Thabet et al., 2015a; Qeshta, 2015; Abu Sultan, 2012), While the Kiser et al. (2008), used qualitative study designed, structurd interview. Also Thabet et al. (2015), used stratified cluster random sample survey. So the researcher notice that this point as this study used cross sectional descriptive analytic random sample, but it used stratified type.

And the researcher notice that all of the previous study that studied the trauma, used the similar tools as sociodemographic scale, and traumatic event checklist. And used another instrument according the aim of the study. In this study the researcher used sociodemographic scale, traumatic event checklist, and post-traumatic stress disorder scale, this point as the similar of some previous study.

The researcher notice that the main result that children in the Gaza Strip found that children experienced variety of traumatic events including witnessing killing of relatives, demolition of homes, bombardment, and arrest of relatives was associated with post traumatic disorder, anxiety, and depression (Qouta et al., 2007), Palestinian adolescents mainly cope commonly by developing social support, and the adolescents experienced

traumatic experiences developed less social support (Thabet et al., 2015a; Araya et al., 2007). Children living in families with low family monthly income reported more emotional problems(Thabet & Vostanis, 2015; Thabet et al., 2015 b), and there was significant association between exposure to traumatic events and developing PTSD (Thabet & Vostanis, 2015). also mental distress increased and quality of life decreased with age (Araya et al., 2007).

2.2.9.2. Posttraumatic stress disorder

From reviewing previous studies, the researcher noticed that the studies addressed the issue on prevalence PTSD, and relationship between mental health, used different ways and different variables. Some studies aimed to assess the prevalence of PTSD among Palestinian school-age children, for 1,000 school age children, of whom 52.3% were males and 47.7% females, age from 12 to 16 years (Khamis, 2005). Also Thabet and Vostanis (2000), study aimed establish rates of PTSD reactions and general mental health problems in children who had experienced war trauma, for 234 children aged between 7 to 12 years, who had experienced war conflict. Until, Sattler et al. (2014), study examines variables associated with posttraumatic stress symptoms and posttraumatic growth, in two sample group (first= 248, second= 255), Strip, also Al ibwaini, (2015), study aimed to investigate PTSD and resilience among 408 students in the Gaza Strip, from 13-18 years old. But Scarpa et al. (2006), study aimed to tested the relationship of community violence victimization to severity of PTSD, and the roles of coping style and perceived social support in moderating that relationship, of 440 participants, age between 18 and 22 years.

From the literature review, the researcher notice that most of previous study use descriptive analytic (Al ibwaini, 2015; Abu Nada et la., 2012). And some study used stratified random sample (Khamis, 2005), also, Al ibwaini (2015), used cross sectional design. But Thabet and Vostanis (2000), used longitudinal study. So the researcher notice that some point as this study used cross sectional descriptive analytic stratified random sample.

And the researcher notice that all of the previous study that studied the PTSD, used the similar tools as PTSD scale, and some studies used socio-demographic characteristic questionnaire (Al ibwaini 2015; Abu Nada et al., 2012; Khamis, 2005), also used Gaza traumatic events checklist (Al ibwaini 2015; Abu Nada, et al., 2012; Thabet, et al., 2004).

In this study the researcher used sociodemographic scale, Gaza traumatic event checklist, and post-traumatic stress disorder scale, this point as the similar of some previous study.

Also the researcher notice that the main result in this previous studies are: adolescents did not differ significantly in PTSS despite exposure differences across gender, place of residency and family income (Abu Nada et la., 2012), but there were statistically significant differences in total PTSD, avoidance, and arousal symptoms according to place of residence in favor of adolescents from middle area (Al ibwaini, 2015), also PTSD in adolescence is associated with suicide, substance abuse, poor social support, academic problems, and poor physical health, and rates of PTSD in adolescence are related to type of trauma (Nooner et al., 2012). Low perceived social support from family and friends significantly predicted increased PTSD scores (Scarpa et al., 2006; Nooner et al., 2012).

2.2.9.3. Family and social support

Through reviewing previous studies, the researcher noticed that the studies addressed the issue on family and social support, and relationship between stressful event and mental health, used different ways and different variables. Some studies examine the relationship of social support and mental health, such as the study of Diab (2006), aimed to identify the role of social support as a protective variable from the psychological impact resulting from exposure to stressful events of 550 secondary school students between the age of 15-19 years. also, Odah (2010), study aimed to identifying the relationship between the degree of exposure to traumatic experience and methods to adapt to the stresses and the level of social support, level of mental toughness, to the children, of 600 boys and girls. while, Brookmeyer et al. (2011), study investigates how social support may protect Israeli early adolescents who have witnessed community violence from engaging in violent behavior of 179 student, from Dimona and Sderot.

And some studies examine the relationship of family support and mental health, such as the study of Hassanein (2004), study aimed to discusses the psychological trauma, family support and its relation to the psychological well-being, for 450 child and their families, also Thabet et al. (2009), study aim to establish the relationship between perceived positive parenting support and PTSD symptoms in children exposed to war trauma, of 412 children aged between 12-16 years. But Al-Kurd (2012), study aimed to identify the effect of family

and social support on posttraumatic stress disorder, among 434 secondary school students on 10th, 11th , and 12th classes, and the researcher notice that the aim of Al-Kurd, (2012) study similar as this study, that this study aim to investigate relationship between war trauma, PTSD, social and family support among adolescent, age between 13-18 years old.

Also, from the previous study, the researcher notice that most of previous studies used descriptive analytic as (Odah, 2010; Al-Kurd, 2012), and another studies used random sample as (Thabet et al., 2009; Al-Kurd, 2012), but Al-Kurd (2012), used stratified random sample design. So the researcher notice that all above point as similar of this study that it used cross sectional descriptive analytic stratified random sample.

But about the instruments, the researcher notice that most of the previous studies used social support scales (Diab, 2006; Odah, 2010; Delong, 2012; Al Kurd, 2012), and some of the study used family support scale (Hassanein, 2004; AL Kurd, 2012). In this study the researcher used sociodemographic scale, Gaza traumatic event checklist, and post-traumatic stress disorder scale, this point as the similar of some previous study.

The researcher notice that the main result that social support is crucial to the effectiveness of treatment after the development of PTSD (DeLong, 2012)., and the result show womens' low levels of social support (Hassanein, 2004; Odah, 2010; Brookmeyer et al., 2011; DeLong, 2012). And there are no significant statistical differences between adolescents in terms of social support provided based on the size of the family (Diab, 2006). Palestinian adolescents are exposed to various forms of stressful events (familial, economical, social, emotional, health, personal, and academic), Palestinian adolescents enjoy good mental health, and social support received by adolescents is considered average (Diab, 2006).

From the previous study the researcher reported that the type of traumatic events are:

1. Mild traumatic events
2. Moderate traumatic events
3. Severe traumatic event

Most of the studies were conducted in Palestine such as Thabet et al. (2015b), report that 134 of study sample have mild traumatic events due to war on Gaza (35.3%) , while 177 of study sample have moderate traumatic events (46.6%), and 69 of study sample have sever traumatic events (18.2%).

And, Qeshta (2015), study showed that 4.2% of boys reported mild traumatic events, 22.8% reported moderate traumatic events, and 23 % reported severe traumatic events, 7.1% of Female reported mild traumatic events, 29.4% reported moderate traumatic events, and 13.5 % reported severe traumatic events.

Also, Al ibwaini (2015), study showed that 10.6% of adolescents reported mild traumatic events, 40.9% reported moderate traumatic events, and 48.5% reported severe traumatic event, and the result found that 48.5% of the study sample experienced at least 11 traumatic events.

And from the previous study the researcher reported that the degree of PTSD are:

1. No PTSD
2. One symptoms
3. Partial PTSD
4. Full PTSD

Thabet et al. (2015a), study showed that 25 of study sample have no PTSD (6.7%), 74 of study sample have one symptoms (20.5%), 125 of study sample have partial PTSD (35.1%), while 134 of study sample have full in PTSD (37.6%) according to DSM-IV.
And Qeshta (2015), study showed that 129 of children (31.6%) showed no PTSD, 108 of children (26.5%) showed at least one criteria of PTSD (B or C or D), 104 showed partial PTSD (25.5%) , and 67 of children showed full criteria of PTSD (16.4%).

Also, Al ibwaini (2015), study reported that 20.1% of adolescents showed no PTSD, 31.1% showed at least one criteria of PTSD , 29.7% showed partial PTSD, and 19.1% of adolescents showed full criteria of PTSD.

While Thabet et al. (2014), study showed that 12.4% of the children and adolescents reported probable PTSD, and 22.37% filled the two criteria partial PTSD, and 26.7% the one criteria partial PTSD (re-experiencing or avoidance or hyperarousal) and more than a third (38.4%) of the children did not have PTSD.

Until, Thabet and Vostanis (2015), study reported that 32.5% had partial and 12.4% had full criteria of PTSD, Khamis (2005), study showed that PTSD was diagnosed in 34.1% of the children, most of whom were refugees.

Chapter (3)
Methodology

3.1 Introduction

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

3.2 Study design

The researcher used a descriptive analytic type, cross sectional survey design, to identify the relation between research variables and answer of the study questions. The researcher used this method because this study involve human subject, ethical consideration and difficult decline human to experimental intervention.

3.3 Study population

The study population include all adolescents aged from 13- 18 years old in the five governorates in the Gaza Strip. The total population in the Gaza Strip is approximately 1.8 million people (PCBS, 2014). According to PCBS (2012b), the whole number of the 13–18 years population represents about 17.5% of total population in the Gaza Strip, which mean that the study population number is about 315.000 adolescents aged from 13-18 years.

3.4 Study setting

This study included the five governorates of the Gaza Strip. And this study designed to be conduct on adolescent at school classrooms, the schools represent all area of the Gaza Strip regions (North Gaza zone, Gaza zone, Middle zone, Khan Younis zone, and Rafah zone).

3.5 Study sample

A random sample was selected from government and private schools This sample represented all the adolescent between the age of 13 -18 years in the Gaza Strip in order to avoid bias which may arise from sampling techniques. Annex 3 (The cover letter of UNARWA)

3.5.1. Sample calculation:

By using sample size calculator software at confidence level 95% and confidence interval 5%, the recommended sample equals 384 adolescents. The researcher increased the number of sample to 400 to cover for possible non-respondents.

3.5.2. Sampling process:

The researcher selected the study sample by using stratified random sample, in which:

1. The researcher prepared a list of number of student aged between 13-18 years, and name of schools, from all areas in the Gaza Strip, and divided them into five categories (According to five governorates in the Gaza Strip).
2. The population was divided in to homogeneous strata.
3. Then summation the number of the student.
4. The needed number of the sample from each governorate was calculated according to the density of the population in it "Proportional sample" (annex 6).
5. Then selected according to number of the student in the privet and governments schools, (one privet school, and two government schools), were selected by using simple random sampling.
6. After the number of the sample determined from each area, the selected schools were contacted and informed about the purpose of the study and asked to accept collected the data from the student.
7. Then selected the class by using simple random sample.
8. After that, selected the students from this class by simple random sample.

3.5.3. Distribution of the sample:

The whole number of study population was about 315.000 adolescents, the sample number was 400 (1.27%) adolescent of the total population, 200 (50%) of the participant were male, and 200 (50%) were female. According to PCBS (2014), the percentage of adolescents aged from 13- 18 years in North Gaza is about 17% of total population, 45% in Gaza, 10% in Middle area, 20% in Khan Younis, and 8% in Rafah. Then the distribution of the sample according to these percentages, in which 70 of the participant were from the North area, 180 were from Gaza, 40 were from the Middle area, 80 were from Khan Younis and 32 were from Rafah area. Table (3.1) shows the distribution of sample in Gaza's governorates according to area.

Table 3.1: Distribution of the sample according to area

Zone	Sample size	Percentage
North Gaza	68	17%
Gaza zone	180	45%
Middle zone	40	10%
Khan Younis	80	20%
Rafah zone	32	8%
Total	**400**	**100%**

The range of age was 13-18 years, 65 (16.3%) of the study sample were 13 years old, 65 (16.3%) were 14 years old, 67 (16.8%) were 15 years old, 68 (17.0%) were 16 years old, 68 (17.0%) were 17 years old and 67 (16.8%) were 18 years old. Table (3.2) shows the distribution of sample according to their age. Figure (3.1) show distribution of sample according to their age and sex.

Table 3.2: Distribution of the sample according to age

Variable	Frequency	%
13	65	16.3
14	65	16.3
15	67	16.8
16	68	17.0
17	68	17.0
18	67	16.8
Total	**400**	**100.0**

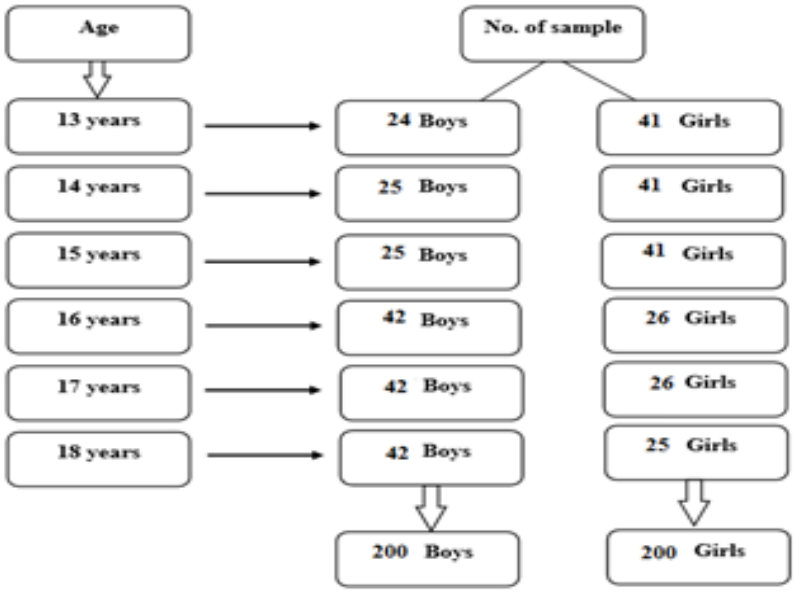

Figure 3.1: Distribution of sample according to age and sex

3.6 Study period

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

3.7 Eligibility criteria

Participants of this study were selected according to the following inclusion criteria.

3.7.1. Inclusion criteria:

- All Gazans adolescents aged from 13-18 years, from both gender, and who lived in war on the Gaza Strip.

3.7.2. Exclusion criteria:

- Adolescent who were outside the Gaza Strip during the war.
- Adolescent who diagnosed with mental disorder or disturbance.
- Adolescent who were diagnosed with mental illness and receive medical treatment.

3.8 Data collection procedure

Before starting data collection, the researcher developed a structural questionnaire for data collection. The researcher was trained 3 data collectors before collected the data about what must they do?, How collect the data?, and What did after collected the data?. Data collection was conducted through self-administered questionnaire by the student, after explained the aim of the study and procedures by the data collectors. A consent form will be available on the first page of the questionnaire. The researcher make supervision about this procedure when the data was collected.

3.9 Data entry and analysis

Data entry and analysis will use a statistical software statistical package for the social science (SPSS) version 22. Frequency and percent were used to express quantitative data of type of traumatic experience, post-traumatic stress disorder, family and social support of adolescent. For continuous variables means and standard deviation were reported. For differences between means of two groups parametric test were used such as t-test to compare sex of adolescents and mean of trauma, PTSD, family support and social support. While, ANOVA tests were used for measuring differences between more than two groups

of continuous variables such trauma and place of residence, PTSD and family support. The researcher was used least significant difference (LSD) test after one way ANOVA test, to explore further and compare the mean of one group with the mean of another. Pearson's correlation coefficient will use to test the association between traumatic experiences, PTSD, family support and social support. The 0.05 alpha levels was accepted as a sign for statistical significance for all the statistical procedures.

3.10 Study instruments

The researcher will use five instruments to implement her study, socio-demographic characteristic questionnaire, Gaza traumatic events checklist, PTSD scale for DSM-IV, family support scale and social support scale.

3.10.1. Socio-demographic characteristic questionnaire:

This questionnaire include educational level, type of school, age, sex, place of residence, number of family member, parents education, parents work, family income.

3.10.2. Gaza Traumatic Events Checklist (GTEC): (Thabet et al., 2014)

The checklist consisting of 29 items covering three domains of events typical for the of military escalation: (1) Witnessing personally acts of violence (e.g., killing of relatives, home demolition, bombardment, and injuries); (2) Having experiences of loss, injury and destruction in family and other close persons; and (3) Being personally the target of violence (e.g., being shot, injured, or beaten by the soldiers). In checklist respondent were asked whether they had been exposed to each of these events: (0) no (1) yes. In this study, the Cronbach's alpha coefficient was high and acceptable 0.93. (Table 3.3).

3.10.3. Posttraumatic stress disorder checklist:

This checklist contains 17 items adapted from the DSM-IV-TR PTSD symptom criteria. The 17 PTSD symptoms are rated by the participant for the previous month on a scale indicating the degree to which the respondent was bothered by a particular symptom from 1 (not at all) to 5 (extremely). Items can be categorized as follows: items 1-4, 17 are for criteria B (intrusive re-experiencing); items 5-11 are for criteria C (avoidance and numbness); and items 12-16 are for criteria D (hyperarousal). This scale was used in previous studies and showed high reliability and validity 27 (Thabet et al., 2008). In this study, the Cronbach's alpha coefficient was high and acceptable 0.87 (Table 3.3).

3.10.4. Social support scale: (Vivian Khamis)

Social support scale (SSS) contains 26 items and was designed to measure the three factors of social support. It contain three rank (11 items are support perceived from family and relatives, 10 items are Psychosocial support provided by friends, and 5 items are psychosocial support provided by the institutions). In checklist respondent were asked whether they had been exposed to each item: (1) never, (2) sometimes and (3) always. In this study, the Cronbach's alpha coefficient was high and acceptable 0.82 (Table 3.3).

3.10.5. Family coping: Family crisis oriented personal evaluation scales (F-COPES)

The family crisis oriented personal evaluation scales (F-COPES) is a self-report measure used to assess family coping strategies (McCubbin et al., 1991). The F-COPES was used in this study because coping as a contruct deals with plans or actions that ameliorate the experience of stress (e.g., McCubbin et al., 1991). The scale is composed of 30 items to assess effective problem solving coping attitudes and behavior used by families in response to problems or difficulties, which result in five subscale scores and a total score. The five subscales are: (a) requesting for social support; (b) restructuring; (c) request for spiritual (religious) support ; (d) positive evaluation; and (e) action of the family. Ascore is obtaind for each subscale and the total score by summing the respondents score for each of the items. In this study, the Cronbach's alpha coefficient was high and acceptable 0.82 (Table 3.3).

3.11 Questionnaire content

The questionnaire was provided with a covering letter explaining the purpose of the study, the way of responding, the aim of the research and the security of the information in order to encourage a high response. The questionnaire included multiple-choice question: which used widely in the questionnaire, the variety in these questions aims first to meet the research objectives, and to collect all the necessary data that can support the discussion, results and recommendations in the research.

3.12 Scientific rigor

3.12.1. Validity:

It refers to which a test measures what it is supposed to measure. The content of scales and questionnaires used were revised, modified and applied previously by many researchers on Gaza population (e.g. Thabet et al., 2008; 2014).

3.11.2. Reliability:

Refers to the consistency of measures. The extent to which a scale is free of random error and thus provides consistent results, and the scales was demonstrated in Gaza and achieve a good reliable results in any times.

Table 3.3: Cronbach alpha reliability to the used scales

Name of scale	No. of items	Cronbach alpha
Gaza traumatic events checklist	29	0.93
Posttraumatic stress disorder scale	17	0.87
Social support scale	26	0.82
Family crisis oriented personal evaluation scale	30	0.88

3.13 Ethical consideration

1. Approval Helsinki committee for apply this study.
2. Prepare consent form from ministry of the education about apply this study.
3. The participants need to be informed about the nature of the study.
4. verbal consent will obtained from the each participant before completion of questionnaire and confidentiality will be ensured.

3.14 Limitations and challenges of the study

1. Refuse UNARWA collect the data from it schools.
2. Refuse many of schools accept collect the data from it is student.
3. Frequent cuts of electricity.

Chapter (4)

Results

4.1 Introduction

This chapter presents the results of the study as following: first, the socio-demographic characteristics of the sample. Secondly, the prevalence of trauma, PTSD, family and social support, and the differences between these variables according to the socio-demographic characteristics of the study sample (sex, age, place of residence, monthly income, and number of family member). Finally, the relationships between trauma, PTSD and family and social support will be presented.

4.2 Socio demographic characteristics of the sample

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

Item	No.	%
Sex		
Male	200	50.0
Female	200	50.0
Age in years (mean age = 15.49 years**, SD = 1.71)**		
13	65	16.3
14	65	16.3
15	67	16.8
16	68	17.0
17	68	17.0
18	67	16.8
Type of school		
Private	28	7.0
Government	372	93.0
Class		
7	65	16.3
8	66	16.5
9	66	16.5
10	68	17.0
11	68	17.0
12	67	16.8
Place of residence		
North Gaza	68	17
Gaza	180	45
Middle area	40	10
Khan Younis	80	20
Rafah area	32	8
Number of the family member		
Less than 3	59	14.8
3 -6	82	20.5
More than 6	259	64.8

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

Item	No.	%
Father education		
Not educated	18	4.5
Preparatory	28	7.0
Elementary	73	18.3
Secondary	114	28.5
Diploma	29	7.3
University	97	24.3
Post graduate	41	10.3
Mother's education		
Not educated	19	4.8
Preparatory	18	4.5
Elementary	59	14.8
Secondary	163	40.8
Diploma	34	8.5
University	90	22.5
Post graduate	17	4.3
Father's job		
Unemployed	101	25.3
Worker	50	12.5
Skilled worker	34	8.5
Employee	168	42.0
Merchant	27	6.8
Other	20	5.0
Mother's job		
House wife	333	83.3
Employee	58	14.5
Other	9	2.3
Family monthly income (NIS)		
Less than 1700 NIS	227	56.8
1701-2400 NIS	80	20.0
2401-3500 NIS	52	13.0
3501-4001 NIS	6	1.5
More than 4001 NIS	35	8.8

Table (4.1) show that the number of sample was 400 adolescents, the sample consisted of 200 boys (50.0 %) and 200 girls (50.0%). According to the selection criteria, the age range was 13-18 years. And show that 16.3% of the study sample were 13 years old, 16.3% were 14 years old, 16.8% were 15 years old, 17.0% were 16 years old, 17.0% were 17 years old and 16.8% were 18 years old. The mean and standard deviation of the age was (mean=15.49 years), (SD= 1.71).

Regard type of school of the sample 7% learn at private schools, while 93.0% learn at government schools. 16.3% of the sample at seventh class, 15.6% at eighth class, also

16.5% at ninth class, 17% at tenth class, and 17% at eleventh class, while 16.8% at twelfth class.

Regard place of residence, 17% of adolescents were from North Gaza, 45% live in Gaza area, 10% live in Middle area, 20% live in Khan Younis, and 8% live in Rafah area. Also, regard number of the family member, 14.8% of the participating had Less than 3 members, 20.5% had 3 -6 members, and 64.8% had More than 6 members.

Regard fathers education, 4.5% fathers were uneducated, 7.0% had preparatory school education, 18.3% had elementary education, 28.5% had secondary education, 7.3% had diploma education, 24.3% had a university degree, and 10.3% had a post graduate degree. But for mothers education, 4.8% of mothers were uneducated, 4.5% had preparatory education, 14.8% had elementary education, 40.8% had secondary education, 8.5 % had a diploma degree, 22.5% a university degree, 4.3% had a post graduate degree.

Regard fathers job, 25.3% of fathers were unemployed, 12.5% were workers, 8.5% were skilled workers, 42.0% were employee and working, 6.8% were merchants, and 5% were other. Regard mothers job, 83.3% of mothers were housewives, 14.5% were employee and 2.3% were other.

Regard family monthly income, 56.8% of the families had a monthly income Less than 1700 NIS, 20% between 1701-2400 NIS, 13% had a monthly income 2401-3500 NIS,1.5% had a monthly income 3501-4001 NIS, 8.8% had monthly income more than 4001 NIS.

4.3 Frequencies of the study variables and differences in trauma, PTSD, social and family support.

4.3.1. Trauma

4.3.1.1. Frequency and severity of traumatic events checklist scale

The study showed that the most common traumatic experiences reported by adolescents were: Hearing shelling of the area by artillery (88.8%), Hearing the loud voice of Drones (81.3%), Watching mutilated bodies in TV (71.8%), and Hearing killing of a friend (68.5%). While, the least common traumatic experiences were: Personal threat if killing by the army (28.3%), and Physical injury due to bombardment of your home (28.8%). (Table 4.2).

Table 4.2: Frequency of traumatic events

No	Paragraph	Yes		No	
		No	%	No	%
1	Hearing killing of a friend	274	68.5	126	31.5
2	Hearing killing of a close relative	213	53.3	187	46.8
3	Hearing shelling of the area by artillery	355	88.8	45	11.3
4	Hearing the loud voice of Drones	325	81.3	75	18.8
5	Witnessing killing of a friend	142	35.5	258	64.5
6	Witnessing killing of a close relative	134	33.5	266	66.5
7	Witnessing shooting of a friend	148	37.0	252	63.0
8	Witnessing shooting of a close relative	137	34.3	263	65.8
9	Witnessing firing by tanks and heavy artillery at own home	140	35.0	260	65.0
10	Witnessing firing by tanks and heavy artillery at neighbors' homes	198	49.5	202	50.5
11	Witnessing arrest of a close relative by the army	138	34.5	262	65.5
12	Witnessing arrest of a friend	162	40.5	238	59.5
13	Watching mutilated bodies in TV	287	71.8	113	28.3
14	Witnessing bombardment of bog buildings by rockets	220	55.0	180	45.0
15	Witnessing assassination of people by rockets	168	42.0	232	58.0
16	Physical injury due to bombardment of your home	115	28.8	285	71.3
17	Shot by bullets, rocket, or bombs	117	29.3	283	70.8
18	Deprivation from water or electricity during detention at home	152	38.0	248	62.0
19	Threaten by shooting	130	32.5	270	67.5
20	Destroying of your personal belongings during incursion	134	33.5	266	66.5
21	Personal threat if killing by the army	113	28.3	287	71.8
22	Threaten of killing of your closed relative in front of you	129	32.3	271	67.8
23	Threatened with death by being used as human shield by the army to move from one home to home	133	33.3	267	66.8
24	Being arrested during the land incursion	130	32.5	270	67.5
25	Forced to leave you home with family members due to shelling	172	43.0	228	57.0
26	Exposure to arrest during invasion	175	43.8	225	56.3
27	Inhalation of bad smells due to bombardment	243	60.8	157	39.3
28	Threaten by telephone to leave the home for bombarment of home	210	52.5	190	47.5
29	Receiving pamphlets from Airplane to leave your home at the border and to move to the city centers	158	39.5	242	60.5

4.3.1.2. The severity of traumatic events

In order to find the severity of the traumatic experiences, total traumatic events were recorded in to mild trauma "0-4 events", moderate trauma "5-10 events" and severe trauma "above 10 events" (Thabet et al., 2014). The results show that 45.0% reported mild traumatic events, 32.5% reported moderate traumatic events, and 22.5% reported severe traumatic events. (Table 4.3)

Table 4.3: Severity of traumatic events

Traumatic events	No	%
Mild traumatic events	180	45.0
Moderate traumatic events	130	32.5
Severe traumatic events	90	22.5
Total	**400**	**100.0**

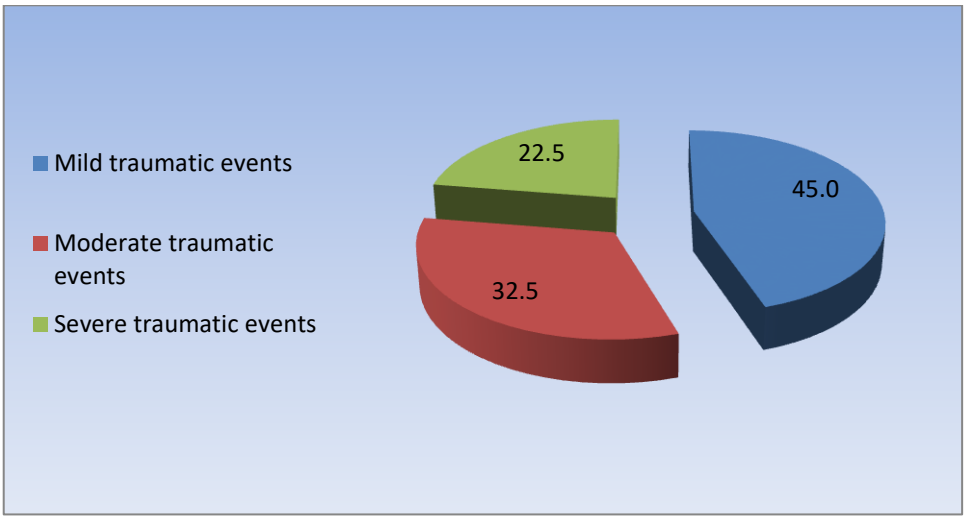

Figure 4.1: Severity of traumatic experiences

4.3.1.3. Means of total traumatic experiences

Table (4.4) shows that the mean of traumatic experience was 12.19 (SD = 7.96).

Table 4.4: Mean and standard deviation of the severity of traumatic experiences

Variables	No.	Minimum	Maximum	Mean	SD
Total traumatic experiences	400	0.00	28.00	12.19	7.96

4.3.1.4. Traumatic experiences according to socio-demographic variables

Table (4.5) shows that the mean of traumatic event in boys were 16.4 (SD=8.23) and 7.98 for girls (SD= 4.89). There were statistically significant differences toward boys (t= 12.388, p =0.001).

Table 4.5: t-test for traumatic experiences according to sex

Item	Sex	N	Mean	SD	T	P-value
Total trauma	Male	200	16.4	8.23	12.388	0.001**
	Female	200	7.98	4.89		

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

Table (4.6) demonstrates that the significant level was 0.001< (α=0.05), which means there were statistically significant differences in traumatic experiences resulting from the war on Gaza according to age.

Table 4.6: One Way (ANOVA) for the mean of trauma experiences according to age

Socio-demographic	Variance	Sum of Squares	DF	Mean Square	F	P- value
Age	Between groups	966.559	5	193.312	3.155	0.009*
	Within groups	243707.31	394	61.853		
	Total	25336.790	399			

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

It is indicated from the results in the table (4.6) the p-value (sig) corresponding to (One Way ANOVA) test less than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are differences in traumatic events due to age (F= 3.155, p = 0.009).

To detect these differences has been found LSD test posteriori comparisons in Table (4.7), it found that the study sample individual who their age (16) years saw that traumatic experience more than who their age (13, 14, 15) years, and who their age (17) years saw the traumatic experience less than who their age (15, 16) years.

Table 4.7: Results of LSD test for ddifferences in traumatic experience according to age

Age	mean	13	14	15	16	17	18
13	0.37		//	//	*	//	//
14	0.43			//	*	//	//
15	0.43				*	*	//
16	0.56					*	//
17	0.42						//
18	0.45						

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

Table (4.8) demonstrates that the significant level was 0.168 > (α=0.05), which means there were no statistically significant differences in traumatic experiences resulting from the war on Gaza according to type of school.

Table 4.8: Differences in traumatic experiences according to type of school

Type Of School	Mean	STD	T	P-value
Private	0.37	0.26	12.435	0.168
Government	0.44	0.28		

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

It is indicated from the results in the table (4.8) the p-value (sig) corresponding to (T) test more than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are no differences in traumatic events checklist due to type of school (t= 12.435, p = 0.168).

Table 4.9 demonstrates that the significant level was 0.172 > (α=0.05), which means there were no statistically significant differences in traumatic experiences resulting from the war on Gaza according to place of residence.

Table 4.9: One Way (ANOVA) for the mean of trauma experiences according to place of residence

Socio-demographic	Source of variation	Sum of Squares	DF	Mean Square	F	P- value
place of residence	Between groups	405.749	4	101.437	1.678	0.172
	Within groups	24931.041	395	63.117		
	Total	25336.790	399			

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

It is indicated from the results in the table (4.9) the p-value (sig) corresponding to (One Way ANOVA) test more than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are no differences in traumatic events checklist due to place of residence, (F= 1.678, p = 0.172).

Table (4.10) demonstrates that the significant level was 0.587 > (α=0.05), which means there were no statistically significant differences in traumatic experiences resulting from the war on Gaza according to monthly income.

Table 4.10: One Way (ANOVA) for the mean of trauma experiences according to monthly income

Socio-demographic	Source of variation	Sum of Squares	DF	Mean Square	F	P- value
monthly income	Between groups	4.337	4	1.084	0.708	0.587
	Within groups	605.253	395	1.532		
	Total	609.590	399			

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

It is indicated from the results in the table (4.10) the p-value (sig) corresponding to (One Way ANOVA) test more than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are no differences in trauma experiences due to family monthly income, (F= 0.708, p= 0.587)

4.3.2 Posttraumatic stress disorder symptoms

4.3.2.1. Frequencies of posttraumatic stress disorder symptoms

Table (4.11) shows that the most common post traumatic reactions were: Efforts to avoid activities, places, or people that arouse recollections of the trauma (16%), Efforts to avoid thoughts, feelings, or conversations associated with the trauma (14.8), Acting or feeling as if the traumatic event were recurring (12.3), Exaggerated startle response (12%), Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event (11%).

Table 4.11-a: Frequencies of posttraumatic stress disorder symptoms items

No	Paragraph	Never	Rarely	Sometimes	often	Always
1	Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.	23.8	15.5	42.8	11.8	6.3
2	Recurrent distressing dreams of the event	25.3	26.8	32.3	9.5	6.3
3	Acting or feeling as if the traumatic event were recurring	28.3	15.3	25.5	18.8	12.3
4	Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event	31.3	23.5	21.5	12.8	11.0
5	Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic even	37.3	20.5	18.8	14.5	9.0

Table 4.11-b: Frequencies of posttraumatic stress disorder symptoms items

No	Paragraph	Never	Rarely	Sometimes	often	Always
6	Efforts to avoid thoughts, feelings, or conversations associated with the trauma	28.0	20.5	26.8	10.0	14.8
7	Efforts to avoid activities, places, or people that arouse recollections of the trauma	28.3	19.3	25.0	11.5	16.0
8	Inability to recall an important aspect of the trauma	43.3	21.8	19.8	8.0	7.3
9	Markedly diminished interest or participation in significant activities	43.5	18.0	20.3	12.0	6.3
10	Feeling of detachment or estrangement from others	50.8	17.0	18.0	7.5	6.8
11	Restricted range of affect (e.g., unable to have loving feelings)	53.3	13.5	18.5	8.3	6.5
12	Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)	48.3	13.3	22.5	9.8	6.3
13	Difficulty falling or staying asleep	39.8	16.0	19.8	14.3	10.3
14	Irritability or outbursts of anger	38.3	15.0	25.5	12.0	9.3
15	Difficulty in concentration	36.3	18.8	23.0	11.5	10.5
16	Hyper vigilance (On edge been easily distracted or had to stay)	38.0	18.3	23.3	12.0	8.5
17	Exaggerated startle response	32.0	18.8	24.5	12.8	12.0

4.3.2.2. Mean and standard deviation of the posttraumatic stress disorder symptoms

Table (4.12) shows that mean total scores of PTSD was 40.53 (SD=12.68), mean Intrusion symptoms was 12.64 (SD= 4.25), mean avoidance was 15.81 (SD= 5.45), and mean arousal was 12.08 (SD= 5.19).

Table 4.12: Means and standard deviations of PTSD

Item	N	Minimum	Maximum	Mean	SD
Total PTSD	400	17	78	40.53	12.68
Intrusion	400	5	25	12.64	4.25
Avoidance	400	7	31	15.81	5.45
Arousal	400	5	25	12.08	5.19

4.3.2.3. Prevalence of posttraumatic stress disorder

According to DSM-IV diagnosis of PTSD of summing of (one re-experiencing, 3 avoidance, and 2 arousal symptoms). Table (4.13) shows that 133 of adolescents (33.3%) showed no PTSD, 130 of adolescents (32.5%) showed at least one criteria of PTSD (B or C or D), 100 showed partial PTSD (25%), and 37 of adolescents showed full criteria of PTSD (9.3%).

Table 4. 13: Prevalence of PTSD symptoms

PTSD	No	%
No PTSD	133	33.3
One symptoms	130	32.5
Partial PTSD	100	25.0
Full PTSD	37	9.3
Total	**400**	**100.0**

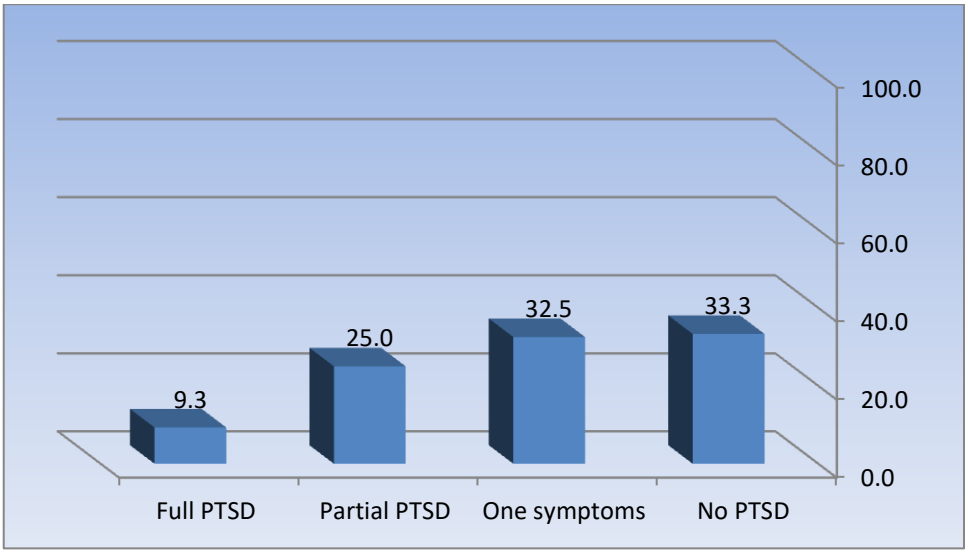

Figure 4.2: Prevalence of PTSD symptoms due to war on the Gaza Strip

4.3.2.4. Posttraumatic stress disorder symptoms according to socio-demographic factors

Table (4.14) shows that there were statistically significant for all subscales (Intrusion symptoms, avoidance, and arousal) and in total PTSD scores (Mean 37.7girls vs. 43.4 boys) (t= 4.630 , p= 0.001), thus it can be concluded that there are differences in PTSD due to sex. favor of male.

Table 4.14: Means and Standard deviations of the PTSD and sub scales according to sex

Dimension	Sex	Mean	STD	T	Sig
Intrusion	**Male**	13.1	4.1	4.593	0.017*
	Female	12.1	4.3		
Avoidance	**Male**	17.0	5.4	2.401	0.001***
	Female	14.6	5.2		
Arousal	**Male**	13.2	5.3	4.480	0.001***
	Female	10.9	4.8		
Total PTSD	**Male**	43.4	12.8	4.630	0.001***
	Female	37.7	11.9		

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

Table (4.15) shows that the p-value (sig) corresponding to (One Way ANOVA) test more than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are no differences in PTSD and subscales according to age group (13-18 years), in total PTSD (T= 0.702, P= 0.622).

Table 4.15 One Way (ANOVA) for the mean of PTSD symptoms of the study sample according to age

Dimension	Source of variation	Sum of Squares	DF	Mean Square	F	Sig level
Intrusion	**Between groups**	104.609	5	20.922	1.159	0.329
	Within groups	7109.828	394	18.045		
	Total	7214.438	399			
Avoidance	**Between groups**	152.133	5	30.427	1.025	0.402
	Within groups	11694.045	394	29.680		
	Total	11846.178	399			
Arousal	**Between groups**	148.881	5	29.776	1.108	0.356
	Within groups	10589.397	394	26.877		
	Total	10738.278	399			
Total PTSD	**Between groups**	566.590	5	113.318	0.702	0.622
	Within groups	63557.108	394	161.312		
	Total	64123.698	399			

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

Table (4.16) shows that there were no statistically significant differences in total PTSD, Intrusion ,avoidance, and arousal symptoms, according to type of school, thus it can be concluded that there are no differences in PTSD due to type of school, , in total PTSD (T= 1.654, P= 0.099).

Table 4.16: One Way (ANOVA) for the mean of PTSD symptoms of the study sample according to type of school

Dimension	Sex	Mean	STD	T	Sig
Intrusion	**Private**	12.07	4.07	-0.730	0.466
	Government	12.68	4.27		
Avoidance	**Private**	14.21	5.10	-1.608	0.109
	Government	15.93	5.46		
Arousal	**Private**	10.43	3.64	-1.754	0.080
	Government	12.21	5.27		
Total PTSD	**Private**	36.71	11.00	1.654	0.099
	Government	40.81	12.76		

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

Table (4.17) shows that there were no statistically significant differences in total PTSD, Intrusion, avoidance, and arousal symptoms according to place of residence, thus it can be concluded that there are no differences in PTSD due to place of residence, , in total PTSD (T= 1.273, P= 0.280).

Table 4.17: One Way (ANOVA) for the mean of PTSD symptoms of the study sample according to place of residence

Dimension	Source of variation	Sum of Squares	DF	Mean Square	F	Sig level
Intrusion	**Between groups**	108.366	4	27.092	1.506	0.200
	Within groups	7106.071	395	17.990		
	Total	7214.438	399			
Avoidance	**Between groups**	114.300	4	28.575	0.962	0.428
	Within groups	11731.878	395	29.701		
	Total	11846.178	399			
Arousal	**Between groups**	89.434	4	22.359	0.829	0.507
	Within groups	10648.843	395	26.959		
	Total	10738.278	399			
Total PTSD	**Between groups**	815.828	4	203.957	1.273	0.280
	Within groups	63307.869	395	160.273		
	Total	64123.698	399			

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

Table (4.18) shows that there were no statistically significant differences in total PSTD and subscales according to number of family member, , in total PTSD (F= 0.236, P= 0.790).

Table 4.18: One Way (ANOVA) for the mean of PTSD symptoms of the study sample according to number of family member

Dimension	Source of variation	Sum of Squares	DF	Mean Square	F	Sig level
Intrusion	**Between groups**	7.904	2.000	3.952	0.218	0.804
	Within groups	7206.533	397.000	18.152		
	Total	7214.438	399.000			
Avoidance	**Between groups**	44.331	2.000	22.165	0.746	0.475
	Within groups	11801.847	397.000	29.728		
	Total	11846.178	399.000			
Arousal	**Between groups**	3.045	2.000	1.522	0.056	0.945
	Within groups	10735.233	397.000	27.041		
	Total	10738.278	399.000			
Total PTSD	**Between groups**	76.202	2.000	38.101	0.236	0.790
	Within groups	64047.496	397.000	161.329		
	Total	64123.698	399.000			

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

Table (4.19) shows that there were no statistically significant differences in total PSTD and subscales according to family monthly income, thus it can be concluded that there are no differences in PTSD due to family monthly income, , in total PTSD (F= 0.534, P= 0.711).

Table 4.19: One Way (ANOVA) for the mean of PTSD symptoms of the study sample according to family monthly income

Dimension	Source of variation	Sum of Squares	DF	Mean Square	F	Sig level
Intrusion	**Between groups**	40.338	4	10.084	0.555	0.695
	Within groups	7174.100	395	18.162		
	Total	7214.438	399			
Avoidance	**Between groups**	40.478	4	10.120	0.339	0.852
	Within groups	11805.699	395	29.888		
	Total	11846.178	399			
Arousal	**Between groups**	45.864	4	11.466	0.424	0.792
	Within groups	10692.414	395	27.069		
	Total	10738.278	399			
Total PTSD	**Between groups**	345.006	4	86.251	0.534	0.711
	Within groups	63778.692	395	161.465		
	Total	64123.698	399			

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

4.3.3. Social support

4.3.3.1. Frequency of social support items

Table (4.20) shows that the most common social support were: First dimension, Support perceived from family and relatives were: My family members being with me when I need them (75%), my family give me advice when I need (68.5%),and My family helps me to overcome the problems that I face (68%). Second dimension, Psychosocial support provided by friends were: I feel that I am of interest to my colleagues who live close to me (54.8%), My relation with my friends make me feel important (50%), and I have sufficiency of the friends around me (47.8%). Third dimension, psychosocial support provided by the institutions were: There is institutions and programs with psychosocial support in my area that providing assistance to families in need such as family (29.5), and there institutions in my area which give us financial and moral support (28%).

Table 4.20: Frequencies of social support items

No.	Paragraph	No	Sometimes	Yes
First dimension: Support perceived from family and relatives				
1	my family members being with me when I need them	5.0	20.0	75.0
2	my relatives give me advice when I need	8.3	33.5	58.3
3	My family helps me to overcome the problems that I face	7.8	24.3	68.0
4	I have a sufficiency of friends around me	19.0	28.8	52.3
5	The friendship in my family is characterized by psychological support	13.3	29.3	57.5
6	my family give me advice when I need	9.8	21.8	68.5
7	relatives encourage us to overcome the psychological problems that I face	21.8	30.3	48.0
8	my family does not help me when I need	51.0	25.5	23.5
9	When i have a problem I can ask for help from my parents and my Relatives	12.0	27.5	60.5
10	my family made me feel satisfied and strong	6.5	26.5	67.0
11	I feel comfortable when I'm asking for support from my family	5.5	27.3	67.3
Second dimension: Psychosocial support provided by friends				
1	My friends always ready to listen to my problems	14.3	41.5	44.3
2	I have sufficiency of the friends around me	16.8	35.5	47.8
3	My friends help me financially when needed	25.3	37.8	37.0
4	my friends come to me alone when they need me	19.8	37.3	43.0
5	I feel that I am of interest to my colleagues who live close to me	10.8	34.5	54.8
6	When I'm in a problem that I relied on my close colleagues to help me	18.8	39.5	41.8
7	all my life I find whom helping me when I need help	14.5	45.3	40.3
8	I find it difficult to seek professional help	21.8	43.5	34.8
9	My relation with my friends make me feel important	14.3	35.8	50.0
10	I feel that there is no real support from my friends	38.8	34.3	27.0
Third dimension: psychosocial support provided by the institutions				
1	There is institutions and programs with psychosocial support in my area that providing assistance to families in need such as family	47.8	22.8	29.5
2	There institutions in my area which give us financial and moral support	42.8	29.3	28.0
3	i receive psychological help from the institutions that provide psychological counseling	48.0	30.5	21.5
4	There is at least one institution which provide me with financial support	53.5	27.5	19.0
5	I find it very difficult to get help from social institutions, which provide assistance to families in need such as family	44.8	31.3	24.0

4.3.2.2. Mean and standard deviation of the social support

Table (4.21) shows that mean total scores of social support was 83.98 (SD=16.199), mean support perceived from family and relatives was 34.87 (SD=7.592) mean psychosocial support provided by friends was 33.690 (SD= 6.764), and mean psychosocial support provided by the institutions was 15.407 (SD= 3.612).

Table 4.21: Means and standard deviations of social support

Social support scale	N	Minimum	Maximum	Mean	SD	Rank
First dimension: Support perceived from family and relatives	400	11.00	52.00	34.87	7.59	1
Second dimension: Psychosocial support provided by friends	400	13.00	47.00	33.69	6.76	2
Third dimension: psychosocial support provided by the institutions (NGOs)	400	5.00	24.00	15.407	3.61	3
Total social support	400	29.00	123.00	83.98	16.19	

It indicated of the show results on table (4.21) that the arithmetic mean of the social support scale was 83.98, and the standard deviation was 16.19, this indicates that adolescents in the Gaza Strip have social support with high degree.

As the social support has three dimensions ranked, support perceived from family and relatives dimension take first rank with 34.87 mean, then Psychosocial support provided by friends has second rank with 33.69 mean, and psychosocial support provided by the institutions has third rank with 83.98 mean.

4.3.2.3. Social support according to socio-demographic factors

Table (4.22) shows that the p-value (sig) corresponding to (One Way ANOVA) test less than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are differences in social support due to age, in total social support (F=2.598, P= .025).

Table 4.22: Differences in social support due to age

Dimension	Source of variation	Sum of Squares	DF	Mean Square	F	Sig level
Support perceived from family and relatives	Between groups	604.107	5	120.821	2.126	.062
	Within groups	22395.133	394	56.840		
	Total	22999.240	399			
Psychosocial support provided by friends	Between groups	550.295	5	110.059	2.449	.033*
	Within groups	17707.265	394	44.942		
	Total	18257.560	399			
psychosocial support provided by the institutions	Between groups	151.136	5	30.227	2.356	.040*
	Within groups	5055.442	394	12.831		
	Total	5206.578	399			
Total social support	Between groups	3341.904	5	668.381	2.598	.025*
	Within groups	101358.974	394	257.256		
	Total	104700.878	399			

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

To detect these differences has been found LSD test posteriori comparisons in Table (4.23), it found that the study sample individual who their age (13) years saw that social support less than who their age (15, 16, 17, 18) years.

Table 4.23: Results of LSD test for differences in social support due to age

Age	Mean	13	14	15	16	17	18
13	78.09		//	*	*	*	*
14	83.33			//	//	//	//
15	84.53				//	//	//
16	84.67					//	//
17	87.54						//
18	85.44						

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

Table (4.24) shows that the p-value (sig) corresponding to (T) test more than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are no differences in Social support due to sex, in total social support (T= -1.506, P= 0.133).

Table 4.24: Differences in Social support due to sex

Dimension	Sex	mean	STD	T	Sig
Support perceived from family and relatives	Male	34.3	8.6	-1.544	0.123
	Female	35.5	6.4		
Psychosocial support provided by friends	Male	33.0	7.6	-1.943	0.053*
	Female	34.3	5.8		
psychosocial support provided by the institutions	Male	15.3	4.0	-0.373	0.709
	Female	15.5	3.2		
Total social support	Male	82.8	18.9	-1.506	0.133
	Female	85.2	12.9		

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

Table (4.25) show that the p-value (sig) corresponding to (T) test more than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are no differences in social support due to type of school, in total social support (T= -0.198, P= 0.834).

Table 4.25: Differences in social support due to type of school

Dimension	type of school	mean	STD	T	Sig
Support perceived from family and relatives	Private	2.56	2.56	1.662	0.097
	Government	2.43	2.43		
Psychosocial support provided by friends	Private	2.26	2.26	0.550	0.582
	Government	2.22	2.22		
psychosocial support provided by the institutions	Private	1.38	1.38	-3.776	0.001***
	Government	1.80	1.80		
Total social support	Private	2.21	0.28	-0.198	0.834
	Government	2.23	0.31		

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

Table (4.26) show that the p-value (sig) corresponding to (One Way ANOVA) test more than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are significance differences in social support due to place of residence, in total social support (F= 4.865, P= 0.001).

Table 4.26: Differences in social support due to place of residence

Dimension	Source of variation	Sum of Squares	DF	Mean Square	F	Sig level
Support perceived from family and relatives	Between groups	818.689	4	204.672	3.645	0.006*
	Within groups	22180.551	395	56.153		
	Total	22999.240	399			
Psychosocial support provided by friends	Between groups	939.271	4	234.818	5.356	0.001***
	Within groups	17318.289	395	43.844		
	Total	18257.560	399			
psychosocial support provided by the institutions	Between groups	121.062	4	30.266	2.351	0.054*
	Within groups	5085.515	395	12.875		
	Total	5206.578	399			
Total social support	Between groups	4915.524	4	1228.881	4.865	0.001**
	Within groups	99785.354	395	252.621		
	Total	104700.878	399			

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

To detect these differences has been found LSD test posteriori comparisons in table (4.27), it found that the study sample individual who live in North Gaza had less social support than who live in Gaza, Khan Younis, and Rafah area, also, who live in Middle area had less social support than who live in Khan Younis, and Rafah.

Table 4.27: LSD test for differences in social support due to place of residence

Place	Mean	North Gaza	Gaza	Middle area	Khan Younis	Rafah area
North Gaza	77.8		*	//	*	*
Gaza	85.1			//	//	//
Middle area	79.8				*	*
Khan Younis	87.0					//
Rafah area	88.5					

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

Table (4.28) show that the p-value (sig) corresponding to (One Way ANOVA) test more than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are no differences in social support due to number of the family member, in total social support (F= 0.214, P=0.807).

Table 4.28: Differences in social support due to number of the family member

Dimension	Source of variation	Sum of Squares	DF	Mean Square	F	Sig level
Support perceived from family and relatives	Between groups	0.043	2	0.022	0.145	0.865
	Within groups	59.396	397	0.150		
	Total	59.439	399			
Psychosocial support provided by friends	Between groups	0.201	2	0.100	0.680	0.507
	Within groups	58.624	397	0.148		
	Total	58.825	399			
psychosocial support provided by the institutions	Between groups	0.314	2	0.157	0.467	0.627
	Within groups	133.378	397	0.336		
	Total	133.692	399			
Total social support	Between groups	0.041	2	0.021	0.214	0.807
	Within groups	38.219	397	0.096		
	Total	38.260	399			

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

Table (4.29) show that p-value (sig) corresponding to (One Way ANOVA) test more than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are no differences in social support due to family monthly income, in total social support (F=0.858, P= 0.489).

Table 4.29: Differences in social support due to family monthly income

Dimension	Source of variation	Sum of Squares	DF	Mean Square	F	Sig level
Support perceived from family and relatives	Between groups	227.117	4	56.779	.985	.416
	Within groups	22772.123	395	57.651		
	Total	22999.240	399			
Psychosocial support provided by friends	Between groups	189.153	4	47.288	1.034	.389
	Within groups	18068.407	395	45.743		
	Total	18257.560	399			
psychosocial support provided by the institutions	Between groups	51.570	4	12.893	.988	.414
	Within groups	5155.007	395	13.051		
	Total	5206.578	399			
Total social support	Between groups	902.025	4	225.506	.858	.489
	Within groups	103798.852	395	262.782		
	Total	104700.878	399			

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

4.3.4. Family support

4.3.4.1. Frequency of family support items

Table (4.30) shows that the most common family support were: We believe that this is the will of God (43%), ask the advice of relatives (e.g. grandparents) 22%, and face the problems and trying to find solutions to them immediately (20.5%). While, the least common family support were: share our problem with our neighbors (8%), ask for help from neighbors (8.3%) , and believe that if we wait enough time, the problem will end on its own (8.3%).

Table 4.30-a: Frequencies of family support

#	Item	sever disagree	disagree	neutral	agree	sever agree
1	We share our relatives difficulties	12.8	12.3	16.0	41.8	17.3
2	ask for encouragement and support from friends	8.0	12.8	19.0	41.3	19.0
3	we know that we have the power to solve the general problems	11.0	13.5	23.8	36.3	15.5
4	ask the advice of members of the families have faced similar problems	11.8	17.0	21.0	34.5	15.8
5	ask the advice of relatives (eg grandparents)	11.8	15.0	18.3	33.0	22.0
6	ask for help from institutions specializing in helping families	15.8	20.8	23.0	28.5	12.0
7	know that we have the ability to solve our problems	12.5	19.3	26.5	27.8	14.0
8	receive gifts and assistance from neighbors such as food and clothing ..	15.0	17.8	22.0	33.5	11.8
9	ask for advice and information from the clinic doctor	14.3	20.5	19.8	34.8	10.8
10	ask for help from neighbors	19.0	25.5	22.5	24.8	8.3
11	face the problems and trying to find solutions to them immediately	9.3	13.0	21.0	36.3	20.5
12	watch television	8.5	15.3	21.8	36.0	18.5
13	we show we are strong	13.3	16.3	20.8	31.0	18.8
14	attend religious seminars	9.5	13.0	23.5	35.5	18.5
15	accept the fact stressful events in life	12.5	13.8	26.3	34.5	13.0
16	share with close friends we are concerned	9.3	15.8	29.3	33.3	12.5
17	We know that luck can play a role as we do to solve our problems, family	13.8	18.3	25.3	30.5	12.3
18	practice exercises with friends to reduce tension	14.0	13.8	29.0	30.8	12.5
19	accept that these problems can occur without expecting	12.5	14.0	24.0	35.3	14.3
20	Participate our relatives in activities that are beneficial (family meetings, and invite them to dinner in)	11.8	16.0	24.5	33.5	14.3
21	ask for help from specialists in counseling to help families located in the problem	13.3	17.0	22.8	35.8	11.3

Table 4.30-b: Frequencies of family support

#	Item	sever disagree	disagree	neutral	agree	sever agree
22	believe that we can solve our problems ourselves	11.0	16.5	22.8	31.5	18.3
23	participate in religious seminars	10.0	15.3	24.0	33.5	17.3
24	put the problem in the a positive context of family so as not frustrated	8.8	20.0	22.3	33.3	15.8
25	We ask relatives about what they feel toward our problem	9.3	15.3	26.3	34.3	15.0
26	feel that it is important to the work of precautions to avoid problems, otherwise we will face difficulties in solving problems	10.5	17.3	24.5	35.3	12.5
27	ask the advice of religious leaders (Sheikh, a man of repair)	13.3	18.3	24.8	30.8	13.0
28	believe that if we wait enough time, the problem will end on its own	18.3	17.8	25.0	30.8	8.3
29	share our problem with our neighbors	22.3	25.3	20.8	23.8	8.0
30	We believe that this is the will of God	0.0	0.0	2.0	55.0	43.0

4.3.4.2. Mean and standard deviation of the family support

Table (4.31) shows that the arithmetic mean of the family support was 3.24, and the standard deviation was 0.63, this indicates that adolescents in the Gaza Strip have family support with moderate degree.

As the family crisis oriented personal evaluation has five dimensions ranked:

(1, 2, 5, 8,10, 16, 20, 25, 29): Requesting for social support

(3, 11,7, 13, 15, 19, 24, 22): Restructuring

(14, 23, 27, 30): Request for spiritual (religious) support

(12, 17 ،18, 26, 28): positive evaluation

(4, 6, 9, 21): Action of the family

Request for spiritual (religious) support dimension take first rank with 3.57 mean, then restructuring has second rank with 3.27 mean, requesting for social support has third rank with 3.18 mean, positive evaluation has fourth rank with 3.16 , and action of the family has final and fifth rank with 3.12 mean.

Table 4.31: Mean and standard deviation of family support

Family support	N	Minimum	Maximum	mean	STD	Rank
First dimension: Requesting for social support	400	9.00	45.00	3.18	0.72	3
Second dimension: Restructuring	400	8.00	39.00	3.27	0.76	2
Third dimension: Request for spiritual (religious) support	400	7.00	20.00	3.57	0.71	1
Fourth dimension: positive evaluation	400	4.00	20.00	3.16	0.76	4
Fifth dimension: Action of the family	400	4.00	20.00	3.12	0.78	5
Total FCOPE	**400**	**33.00**	**143.00**	**3.24**	**0.63**	

4.3.4.3 Family support according to socio-demographic factors

Table (4.32) show that the p-value (sig) corresponding to (One Way A NOVA) test less than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are differences in family support due to age, in total family support (F= 2.353, P= 0.040).

Table 4.32: Differences in family support due to age

Dimension	Source of variation	Sum of Squares	DF	Mean Square	F	Sig level
Requesting for social support	Between groups	249.640	5	49.928	1.186	0.315
	Within groups	16581.070	394	42.084		
	Total	16830.710	399			
Restructuring	Between groups	517.605	5	103.521	2.871	0.015*
	Within groups	14207.435	394	36.059		
	Total	14725.040	399			
Request for spiritual (religious) support	Between groups	83.112	5	16.622	2.112	0.063
	Within groups	3100.326	394	7.869		
	Total	3183.438	399			
positive evaluation	Between groups	73.102	5	14.620	1.505	0.187
	Within groups	3826.696	394	9.712		
	Total	3899.798	399			
Action of the family	Between groups	147.835	5	29.567	3.064	0.010*
	Within groups	3801.662	394	9.649		
	Total	3949.498	399			
Total family support	Between groups	4132.380	5	826.476	2.353	0.040*
	Within groups	138389.370	394	351.242		
	Total	142521.750	399			

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

To detect these differences has been found LSD test posteriori comparisons in table (4.33), it found that the study sample individual who their age (13) years saw that family support less than who their age (15, 16, 17, 18) years.

Table 4.33: Results of LSD test for differences in family support due to age

Age	Mean	13	14	15	16	17	18
13	3.03		//	*	*	*	*
14	3.21			//	//	//	//
15	3.28				//	//	//
16	3.26					//	//
17	3.38						//
18	3.30						

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

Table (4.34) show that the p-value (sig) corresponding to (T) test more than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are no differences in family support due to sex, in total family support (F= 2.379, P= 0.124).

Table 4.34: Differences in family support due to sex

Dimension	Source of variation	Sum of Squares	DF	Mean Square	F	Sig level
Requesting for social support	Between groups	94.090	1	94.090	2.237	0.135
	Within groups	16736.620	398	42.052		
	Total	16830.710	399			
Restructuring	Between groups	106.090	1	106.090	2.888	0.090
	Within groups	14618.950	398	36.731		
	Total	14725.040	399			
Request for spiritual (religious) support	Between groups	15.603	1	15.603	1.960	0.162
	Within groups	3167.835	398	7.959		
	Total	3183.438	399			
positive evaluation	Between groups	11.903	1	11.903	1.218	0.270
	Within groups	3887.895	398	9.769		
	Total	3899.797	399			
Action of the family	Between groups	.202	1	.202	.020	0.886
	Within groups	3949.295	398	9.923		
	Total	3949.497	399			
Total family support	Between groups	846.810	1	846.810	2.379	0.124
	Within groups	141674.940	398	355.967		
	Total	142521.750	399			

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

Table (4.35) show that the p-value (sig) corresponding to (T) test less than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are differences in family support due to type of school. Favor of private, in total family support (F= 1.548, P= 0.214).

Table 4.35: Differences in family support due to type of school

Dimension	Source of variation	Sum of Squares	DF	Mean Square	F	Sig level
Requesting for social support	Between groups	128.208	1	128.208	3.055	0.081
	Within groups	16702.502	398	41.966		
	Total	16830.710	399			
Restructuring	Between groups	103.681	1	103.681	2.822	0.094
	Within groups	14621.359	398	36.737		
	Total	14725.040	399			
Request for spiritual (religious) support	Between groups	5.212	1	5.212	0.653	0.420
	Within groups	3178.225	398	7.985		
	Total	3183.437	399			
positive evaluation	Between groups	.216	1	.216	0.022	0.882
	Within groups	3899.582	398	9.798		
	Total	3899.797	399			
Action of the family	Between groups	.593	1	.593	0.060	0.807
	Within groups	3948.904	398	9.922		
	Total	3949.498	399			
Total family support	Between groups	552.074	1	552.074	1.548	0.214
	Within groups	141969.676	398	356.708		
	Total	142521.750	399			

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

Table (4.36) show that the p-value (sig) corresponding to (One Way ANOVA) test less than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are differences in family support due to place of residence, in total family support (F= 4.300, P= 0.002).

Table 4.36: Differences in family support due to place of residence

Dimension	Source of variation	Sum of Squares	DF	Mean Square	F	Sig level
Requesting for social support	Between groups	638.256	4	159.564	3.892	0.004**
	Within groups	16192.454	395	40.994		
	Total	16830.710	399			
Restructuring	Between groups	510.812	4	127.703	3.549	0.007**
	Within groups	14214.228	395	35.985		
	Total	14725.040	399			
Request for spiritual (religious) support	Between groups	68.351	4	17.088	2.167	0.072
	Within groups	3115.086	395	7.886		
	Total	3183.438	399			
positive evaluation	Between groups	55.786	4	13.947	1.433	0.222
	Within groups	3844.011	395	9.732		
	Total	3899.797	399			
Action of the family	Between groups	159.458	4	39.865	4.155	0.003**
	Within groups	3790.039	395	9.595		
	Total	3949.497	399			
Total family support	Between groups	5946.574	4	1486.644	4.300	0.002**
	Within groups	136575.176	395	345.760		
	Total	142521.750	399			

To detect these differences has been found LSD test posteriori comparisons in table (4.37), it found that the study sample individual who live in North Gaza, family support for them less than who live in (Gaza, Khan Younis, Rafah area), and who live in Middle area, family support for them less than who live in (Khan Younis, Rafah area).

Table 4.37: LSD test for differences in family support due to place of residence

place of residence	mean	North Gaza	Gaza	Middle area	Khan Younis	Rafah area
North Gaza	2.99		*	//	*	*
Gaza	3.30			//	//	//
Middle area	3.06				*	*
Khan Younis	3.36					//
Rafah area	3.41					

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

Table (4.38) show that the p-value (sig) corresponding to (One Way A NOVA) test more than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are no differences in family support due to number of the family member, in total family support (F= 1.044, P= 0.353).

Table 4.38: Differences in family support due to number of the family member

Dimension	Source of variation	Sum of Squares	DF	Mean Square	F	Sig level
Requesting for social support	Between groups	3.213	2	1.607	.038	0.963
	Within groups	16827.497	397	42.387		
	Total	16830.710	399			
Restructuring	Between groups	36.262	2	18.131	.490	0.613
	Within groups	14688.778	397	36.999		
	Total	14725.040	399			
Request for spiritual (religious) support	Between groups	65.770	2	32.885	4.188	0.016
	Within groups	3117.668	397	7.853		
	Total	3183.438	399			
positive evaluation	Between groups	21.338	2	10.669	1.092	0.337
	Within groups	3878.459	397	9.769		
	Total	3899.798	399			
Action of the family	Between groups	34.663	2	17.331	1.758	0.174
	Within groups	3914.835	397	9.861		
	Total	3949.497	399			
Total family support	Between groups	745.882	2	372.941	1.044	0.353
	Within groups	141775.868	397	357.118		
	Total	142521.750	399			

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

Table (4.39) show that the p-value (sig) corresponding to (One Way ANOVA) test more than the significance level ($\alpha \leq 0.05$), thus it can be concluded that there are no differences in family support due to family monthly income, in total family support (F= 0.650, P=0.627).

Table 4.39: Differences in family support due to family monthly income

Dimension	Source of variation	Sum of Squares	DF	Mean Square	F	Sig level
Requesting for social support	Between groups	101.852	4	25.463	0.601	0.662
	Within groups	16728.858	395	42.352		
	Total	16830.710	399			
Restructuring	Between groups	247.238	4	61.809	1.686	0.152
	Within groups	14477.802	395	36.653		
	Total	14725.040	399			
Request for spiritual (religious) support	Between groups	42.507	4	10.627	1.336	0.256
	Within groups	3140.930	395	7.952		
	Total	3183.438	399			
positive evaluation	Between groups	25.922	4	6.480	0.661	0.620
	Within groups	3873.876	395	9.807		
	Total	3899.797	399			
Action of the family	Between groups	22.761	4	5.690	0.572	0.683
	Within groups	3926.737	395	9.941		
	Total	3949.497	399			
Total family support	Between groups	931.725	4	232.931	0.650	0.627
	Within groups	141590.025	395	358.456		
	Total	142521.750	399			

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

4.3.5 Relationships between traumatic events, PTSD symptoms, social and family support

Table (4.40) show that there is positive correlation with statistical significance between traumatic events experience and PTSD for adolescents in the Gaza Strip. But show that there are no correlation with statistical significance between traumatic events experience and social support. Also, show that there is positive correlation with statistical significance between traumatic events experience and family support, and positive correlation with statistical significance between PTSD and social support. Until, show that there is positive correlation with statistical significance between PTSD and family support, also, show that there is positive correlation with statistical significance between social support and family support.

Table 4.40: Pearson correlation coefficient to study the relation between PTSD, traumatic events, social support, and family support

Scale	Trauma	PTSD	Social support	Family support
Trauma	1	0.362*	0.026//	0.114*
PTSD	0.362*	1	0.200*	0.102*
Social support	0.026//	0.200*	1	0.156*
Family support	0.114*	0.102*	0.156*	1

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

Chapter (5)

Discussion

5.1 Introduction

This chapter presents a discussion of the results of the study as presented in chapter four, these findings are discussed in light of literature review that is important to clarify them in comparison of other studies conducted by other researchers. The chapter also presents recommendations regarding to trauma, PTSD, social and family support among adolescents in the Gaza Strip. This chapter also include the main recommendations and conclusion that the researcher reached after the discussion of the results.

5.2 Discussion

5.2.1. Trauma

5.2.1.1. Frequency of trauma

The study found that the highest traumatic events were: hearing shelling of the area by artillery (88.8%), hearing the loud voice of Drones (81.3%), watching mutilated bodies in TV (71.8%), and hearing killing of a friend (68.5%).

This study is consistent with Thabet et al., (2015a), the study revealed (90.8%) of study sample watching mutilated bodies on TV, and Thabet et al. (2015b), showed that the most common reported traumatic events due to the war on Gaza were: watching mutilated bodies and wounded people in TV (92.3%), and hearing shelling of the area by artillery (89.4%), also Qeshta (2015), showed that watching mutilated bodies in TV (93.1%), hearing shelling of the area by artillery (92.4%), and hearing the loud voice of drones (90.4%). And Thabet and Ghannam (2014), showed the most traumatic event was hearing shelling of the area by artillery (96.25%), watching mutilated bodies in TV (95.25%), and hearing the loud voice of drones that experienced by (92%). Also Abu Sultan (2012), revealed watching mutilated bodies on TV was the highest traumatic experience (92.73%). Until, Al ibwaini (2015), study found that the highest traumatic events were: watching mutilated bodies in TV (93.1%), hearing shelling of the area by artillery (92.4%), hearing the loud voice of drones (90.4%). Also, Al Kurd (2012), showed that Watching mutilated bodies in TV (96%).

Also, this study found that the least traumatic events were: Personal threat if killing by the army (28.3%), and physical injury due to bombardment of your home (28.8%), this result consistent with (Al ibwaini, 2015; Qeshta, 2015), study showed that physical injury due to bombardment of your home (10.3%), and Thabet et al. (2015 b), study show physical injury due to bombardment of your home (21.9%). But Abu Nada et al. (2012), show physical exposure (7% personal injury).

Many studies tried to find out the most traumatic events the individual may experience; Thabet et al. (2015a), study demonstrated the most events adolescents experienced were 86.6% of study sample did not feel safe at home, and 90.8% were unable to protect themselves, 81.8% of study sample were unable to protect their families during the war, while 79.6% don't think that others were able to protect them. But Thabet et al. (2015b), study demonstrated the most events adolescents experienced were watching mutilated bodies and wounded people in TV (92.3%), hearing shelling of the area by artillery (89.4%), and 89.2% heard the sonic booms from jetfighters.

Qeshta (2015), study found that watching mutilated bodies in TV (93.1%), hearing shelling of the area by artillery (92.4%), hearing the loud voice of drones (90.4%), , forced to leave you home with family members due to shelling (67.6%), and inhalation of bad smells due to bombardment (67.6%). While, the least common traumatic experiences were: Witnessing arrest of a close relative by the army (10.8%), witnessing arrest of a friend, and physical injury due to bombardment of your home (10.3%).

Thabet and Ghannam (2014), found in their study that the most prevalent types of trauma exposure were as follows: hearing shelling of the area by artillery (96.25%), watching mutilated bodies in TV (95.25%), (95%) experienced witnessing the signs of shelling on the ground, then hearing the sonic sound of the jetfighters (93.25%) and hearing the loud voice of drones that experienced by (92%).

Also Abu Sultan (2012), study found that watching mutilated bodies on TV was the highest traumatic experience (92.73%), then witnessing the shelling and destruction of another’s home (47.37%) and witnessing firing by tanks and heavy artillery at neighbors' homes (47.12%).

Al ibwaini (2015), study found that the highest traumatic events were: watching mutilated bodies in TV (93.1%), hearing shelling of the area by artillery (92.4%), hearing the loud voice of drones (90.4%), forced to leave you home with family members due to shelling (67.6%), and inhalation of bad smells due to bombardment (67.6%). While, the least common traumatic experiences were: witnessing arrest of a close relative by the army (10.8%), witnessing arrest of a friend, and physical injury due to bombardment of your home (10.3%).

While, Abu Nada et al. (2012), study found that the material exposure "such as witnessing bombardments" (85% to 96%) and media exposure (95%). Up to 17% of the adolescents experienced direct, physical exposure (7% personal injury).

And Al Kurd (2012), study found that the most traumatic events the study sample was exposed watching mutilated bodies in TV (96%), followed by Witnessed the shelling and destruction of another's home (70%), then expose you to force to leave your home with your family and relatives (69%). While, the least percent of traumatic events were being injured by burning phosphorous bombs and the regular bombs (52.5%). Then use as a human shield for the inspection of houses of the neighborhood or a neighbor to catch you (52%), and beaten and humiliated by the Israeli army (50%).

The researcher agrees with these studies about the diversity of traumatic events and attributes that to the nature and characteristics of surrounding environment. We noticed that watching mutilated bodies on TV was the highest traumatic events among adolescents in this study and in many other studies, this indicates the adolescents' attention-grabbing to follow the war events even through TV.

5.2.1.2. The prevalence and severity of traumatic experiences

This study found that 45% of adolescents reported mild traumatic events, 32.5% reported moderate traumatic events, and 22.5% reported severe traumatic event. And the result shows that the mean of traumatic experience was 12.19 (SD= 7.96).

Many studies were conducted in Palestine such as Thabet et al. (2015b), report that 134 of study sample have mild traumatic events due to war on Gaza (35.3%) , while 177 of study

sample have moderate traumatic events (46.6%), and 69 of study sample have sever traumatic events (18.2%).

Also Qeshta (2015), study showed that 4.2% of boys reported mild traumatic events, 22.8% reported moderate traumatic events, and 23 % reported severe traumatic events, 7.1% of female reported mild traumatic events, 29.4% reported moderate traumatic events, and 13.5 % reported severe traumatic events.

And Al ibwaini (2015), study showed that 10.6% of adolescents reported mild traumatic events, 40.9% reported moderate traumatic events, and 48.5% reported severe traumatic event, and the result found that 48.5% of the study sample experienced at least 11 traumatic events.

The study found that the total mean of traumatic experiences was 12.19, and found that the mean of traumatic event in boys were 16.4 (SD=8.23) and 7.98 for girls (SD= 4.89). This is consistent with Al-ibwaini (2015), study showed that the total mean of traumatic experiences was 10.91, and mean of traumatic event in boys were 11.79 , also 9.98 for girls.

And, Thabet et al., (2015a), showed that the mean traumatic events reported by adolescents was 13.34, also Thabet et al. (2015b), report that the mean number of traumatic events experienced by Palestinian adolescents was 14. While, Abu Nada et al. (2012), reported that number of traumatic events experienced by the adolescents was 9.9. Khamis (2005), study reported that a substantial number of children experienced at least one lifetime trauma (54.7%), and Al Kurd (2012), study showed that percentage of trauma was (61.5%), also Abu-Sultan (2012), study showed that the total mean of traumatic experience was 4.72.and Thabet and Vostanis (2015), study showed that children reported many traumatic events (mean = 4). But a study in New Zealand, showed that 61% of the sample experienced trauma events in their lifetime, with 9% experiencing events in the past year (Kazantzis et al., 2010).

The researcher agrees with studies of (Thabet et al., 2015b; Qeshta, 2015; Al ibwaini, 2015), which were conducted in Palestine, and demonstrated that all sectors of Palestine (especially the Gaza Strip) were exposed to the Israeli attacks and violence, which

increased the possibility to experience more traumatic events and increase these severity, and the researcher attributes these differences in severity and prevalence of traumatic events to the nature and severity of events (conflict or war and it is place).

5.2.1.3. The traumatic experiences and socio-demographic factors

The study found that there were statistically significant differences toward boys. Boys statistically significantly reported severe traumatic events than girls. This is consistent with Thabet et al. (2015a), showed there were significant differences in traumatic events according to sex in favor to males, and Thabet et al. (2015b), that showed boys reported significantly more traumatic events than girls, while Qeshta (2015), reported there were statistically significant differences toward boys, also Abu Sultan (2012), reported there was relation between traumatic events and sex of the students in favor of males. Until, Al ibwaini (2015), study found that there was relationship between trauma and sex, boys statistically significantly reported severe traumatic events than girls. In addition, Abu Nada et al. (2012), study reported boys were significantly more exposed than girls. But, AL Kurd (2012), study showed there were significant differences in traumatic events according to sex in favor to females.

And the results of this study found that there were statistically significant differences in traumatic experiences resulting from the war on Gaza according to age, it found that the study sample individual who their age (16) years saw that traumatic experience more than who their age (13, 14, 15) years, and who their age (17) years saw the traumatic experience less than who their age (15, 16) years. But Al ibwaini (2015), study reported that there were no statistically significant differences in traumatic experiences resulting from the war on Gaza according to age.

Until, the results of this study found that there were no statistically significant differences in traumatic experiences resulting from the war on Gaza according to type of school, place of residence, monthly income. This study is consistent with Qeshta (2015), study found that there were no statistically significantly differences in traumatic events and age of adolescents, there were no statistically significant differences in traumatic events according to adolescents children living, and there were no statistically significant differences in traumatic events according to families income.

Also Abu Sultan (2012), study showed that there were not any differences between traumatic events, and family income. Until, Al ibwaini (2015), study reported that there were no statistically significant differences in traumatic experiences resulting from the war on Gaza according to place of residence, family monthly income.

But Thabet et al. (2015b), study showed that there were significant differences between traumatic events and place of residence toward the group who live in North Gaza. that means the study sample who live in North Gaza had significantly greater level of traumatic events other than other groups which live in other places in (Gaza –Middle area –khan Younis – Rafah). And showed that adolescents from family with monthly income less than 150 US $ experienced more traumatic events than the other groups.

The researcher attributes these no statistically significance differences to severity of war trauma, which all the area of the Gaza Strip were exposed to the Israeli attacks and destruction. And all the population were experienced many types of traumatic events, without differentiating between any variable.

5.2.2. Posttraumatic stress disorder

5.2.2.1. Frequency of Posttraumatic stress disorder

The study found that the most common post traumatic reactions were: efforts to avoid activities, places, or people that arouse recollections of the trauma (16%), efforts to avoid thoughts, feelings, or conversations associated with the trauma (14.8), acting or feeling as if the traumatic event were recurring (12.3), exaggerated startle response (12%), intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event (11%).

Qeshta (2015), study showed that the most common post traumatic reactions in adolescents were: recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions (49%), acting or feeling as if the traumatic event were recurring (44.8%), intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event (34.8%).

Also, Al ibwaini (2015), study reported that the most common post traumatic reactions in adolescents were: recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions (43.6%), exaggerated startle response (41.4%), acting or feeling as if the traumatic event were recurring (40.7%), efforts to avoid activities, places, or people that arouse recollections of the trauma (40.2%), and efforts to avoid thoughts, feelings, or conversations associated with the trauma (40%).

And Al Kurd (2012), study found that the most symptoms were appearing of PTSD in the study sample was being upset by something which reminded (67.24%). Then, fell as though the event was re-occurring 65.62%. but the least symptoms was being unable to have sad or loving feeling 32.21%, and flowed by being unable to recall important parts of the event 25.02%.

The researcher proposed that people live in Gaza had been undergone many conflicts and wars in the last many years, and the majority of those people were affected due to these conflicts (by loss relative members, or have wounded member in the family, or have the home destructed, and many of traumatic events). That may explains why the most post traumatic reactions was recurrent and intrusive distressing recollections of the event, including "images, thoughts, or perceptions". It reflects a cumulative feelings and traumas in them after recurrent conflicts in last many years.

5.2.2.2. The prevalence of posttraumatic stress disorder

The study found that 133 of adolescents (33.3%) showed no PTSD, 130 of adolescents (32.5%) showed at least one criteria of PTSD (B or C or D), 100 showed partial PTSD (25%), and 37 of adolescents showed full criteria of PTSD (9.3%).

Thabet et al., (2015a), study showed that 25 of study sample have no PTSD (6.7%), 74 of study sample have one symptoms (20.5%), 125 of study sample have partial PTSD (35.1%), while 134 of study sample have full in PTSD (37.6%) according to DSM-IV.

And Qeshta (2015), study showed that 129 of children (31.6%) showed no PTSD, 108 of children (26.5%) showed at least one criteria of PTSD (B or C or D), 104 showed partial PTSD (25.5%) , and 67 of children showed full criteria of PTSD (16.4%).

Also, Al ibwaini (2015), study reported that 20.1% of adolescents showed no PTSD, 31.1% showed at least one criteria of PTSD (B or C or D), 29.7% showed partial PTSD, and 19.1% of adolescents showed full criteria of PTSD.

While Thabet et al. (2014), study showed that 12.4% (n=48) of the children and adolescents reported probable PTSD, and 22.37% (n=86) filled the two criteria partial PTSD, and 26.7% (n=103) the one criteria partial PTSD (re-experiencing or avoidance or hyperarousal) and more than a third (38.4%, n=149) of the children did not have PTSD.

Thabet and Vostanis (2015), study reported that 32.5% had partial and 12.4% had full criteria of PTSD, Khamis (2005), study showed that PTSD was diagnosed in 34.1% of the children, most of whom were refugees.

The researcher agrees with all previous mentioned studies that showed existence of PTSD symptoms in conflict and war areas. Most of these studies were conducted in Palestine except Kiser et al., 2008), and they found PTSD symptoms among Palestinian people, especially those live in the Gaza Strip. We noticed some differences of PTSD prevalence and severity, the researcher attributes these differences to nature of conflicts and the period they were conduct a studies.

Study from African American, Kiser et al. (2008), reported that 16 caregivers who were interviewed, 9 had children who met full and 7 who met partial diagnostic criteria for PTSD.

The researcher agrees with all previous mentioned studies that showed present of PTSD symptoms in conflict and war areas. Most of these studies were conducted in Palestine and they found PTSD symptoms among Palestinian people, especially those live in the Gaza Strip. We noticed some differences of PTSD prevalence and severity, the researcher attributes these differences to nature of conflicts and the period they were conduct a studies.

5.2.2.3. Posttraumatic stress disorder and socio-demographic factors

The study found that there were statistically significant for all subscales (Intrusion symptoms, avoidance, and arousal) and in total PTSD scores according to sex favor of male. This consistent with (Al ibwaini, 2015). But Qeshta (2015), study reported that there were no statistically significant differences in total PTSD scores, and also no significant for avoidance, and arousal subscales, but the girls reported more re-experiencing symptoms than boys, also Thabet et al., (2015a), study showed that girls reported more PTSD than boys. Until, Nooner et al., (2012) study showed that the adolescent females are twice as likely to develop PTSD following a significant trauma than males.

And this study found that there were no statistically significant differences in total PTSD, Intrusion ,avoidance, and arousal symptoms, according to age group, type of school, and number of family member. This consistent with Qeshta (2015), study that showed there were no significant differences between the total means of PTSD according to age group of children, and Al ibwaini (2015), study showed that there were no statistically significant differences in total PTSD scores and all subscales according to age, and number of sibling.

Also, this study found that there were no statistically significant differences in total PTSD, Intrusion ,avoidance, and arousal symptoms, according to place of residence. But Al ibwaini (2015), study showed that there were statistically significant differences in total PTSD, avoidance, and arousal symptoms according to place of residence in favor of adolescents from middle area.

Until, this study found that there were no statistically significant differences in total PTSD, Intrusion ,avoidance, and arousal symptoms, according to family monthly income. And this consistent with Al ibwaini (2015), study that showed there were no statistically significant differences in total PTSD scores and all subscales according to family monthly income. But Thabet et al., (2015a), study showed that there were significant differences between the total means of PTSD according to family income in favor of those who have less than 1700 NIS.

The researcher hypothesis that both girls and boys exposed to the same war traumatic events and in the same geographical area, but the differences come from the resilience of

the personality and the ability on adaptation in front of the traumatic events during crisis situations.

5.2.3. Social Support

5.2.3.1. Frequency of social support

The study found that the most common social support were: First dimension, support perceived from family and relatives were: My family members being with me when I need them (75%), my family give me advice when I need (68.5%), and my family helps me to overcome the problems that I face (68%). Second dimension, psychosocial support provided by friends were: I feel that I am of interest to my colleagues who live close to me (54.8%), my relation with my friends make me feel important (50%), and I have sufficiency of the friends around me (47.8%). Third dimension, psychosocial support provided by the institutions were: There is institutions and programs with psychosocial support in my area that providing assistance to families in need such as family (29.5), and there institutions in my area which give us financial and moral support (28%).

The study found that the mean support perceived from family and relatives was 34.87, mean psychosocial support provided by friends was 33.69, and mean psychosocial support provided by the institutions was 15.407, and mean of total score of social support scale was 83.93, it indicated adolescents in the Gaza Strip have social support with high degree.

As the social support has three dimensions ranked, support perceived from family and relatives dimension take first rank with 34.87 mean, then Psychosocial support provided by friends has second rank with 33.69 mean, and psychosocial support provided by the institutions has third rank with 83.98 mean.

In the result of Al Kurd (2012), study showed that the social support according to Vivian Khamis scale for social support, which divided into three sub scales are as the fowling: First, support perceived from family and relatives ,the average mean for all items equals 2.48, the weight mean equals 82.81% which is greater than 66.6%, this means that support perceived from family and relatives are very high. Second sub scale is psychosocial support provided by friends. The average mean for all items equals 2.26, the weight mean equals 75.27% which is less than 66.6%, this means that psychosocial support provided by friends is high. Third sub scale is psychosocial support provided by

the institutions, the average mean for all items equals 1.60, and the weight mean equals 53.47 % which is less than 66.6%, it means psychosocial support provided by the institutions is weak, and the weight mean of all sub scales equals 74.27 % which is less than 66.6, it means that social support provided to study sample are high and that can decrease the PTSD symptoms.

5.2.3.2. Social support and socio-demographic factors

The study found that there were statistically significance differences in social support according to age, who their age (13) years saw that social support less than who their age (15, 16, 17, 18) years. But Al Kurd (2012), study showed that there were no statistically significance differences in social support according to age.

The study found that there were no statistically significance differences in social support according to sex. This consistent with Al Kurd (2012), study showed that there were no statistically significance differences in social support according to sex. But DeLong (2012), study reported that women's low levels of social support were congruent with our hypothesis and previous research that alludes to the idea that women have a harder time finding positive social support than men. Until, Brookmeyer et al. (2011), study showed that girls reported more social support from parents, friends, and school. But Odah (2010), study found that there were differences in social support in favor of females. Also, Diab (2006), study reported that there are significant statistical differences in the degree of social support related to gender (sex) of the adolescents.

So the researcher proposed that this differences come from the type of social support, situation, and severity of the traumatic events.

And the study found that there were statistically significance differences in social support according to type of school, but no statistically significance differences according to number of the family member, and family monthly income. And this consistent with Al Kurd (2012), study showed that there were no statistically significance differences in social support according to number of family members, and family income. Also, Diab (2006), study showed that there are no significant statistical differences between adolescents in terms of social support provided based on the size of the family.

Also, the study found that there were no statistically significance differences in social support according to place of residence. But Al Kurd (2012), study showed that there were statistically significance differences in social support according to place of residences favor of North Gaza, also Odah (2010), study showed that the differences favor of the governorates of the North, and Khan Younis, and that there differences in social support for the middle one.

5.2.4. Family support

5.2.4.1. Frequency of family support

The study found that the most common family support were: We believe that this is the will of God (43%), ask the advice of relatives (e.g. grandparents) 22%, and face the problems and trying to find solutions to them immediately (20.5%). While, the least common family support were: share our problem with our neighbors (8%), ask for help from neighbors (8.3%) , and believe that if we wait enough time, the problem will end on its own (8.3%).

And the study found that the arithmetic mean of the family support was 3.24, this indicates that adolescents in the Gaza Strip have family support with moderate degree. And request for spiritual (religious) support dimension take first rank with 3.57 mean, then restructuring has second rank with 3.27 mean, requesting for social support has third rank with 3.18 mean, positive evaluation has fourth rank with 3.16 , and action of the family has final and fifth rank with 3.12 mean.

While, Al Kurd (2012), study reported that the family support provided to study sample according the (F–copes) was divided into 5 sub scales. First of all, requesting for social support the average mean for all items equals 3.66, and the weight mean equals 73.25 % which is greater than 60%, this means that requesting for social support is high. Second Restructuring, the average mean for all items equals 3.94, and the weight mean equals 78.8% which is greater than 60% that means restructuring is good. Third, requesting for spiritual (religious) support, the average mean for all items equals 4.29, and the weight mean equals 85.77 % which is greater than 60%, this means request for spiritual (religious) support is high. Fourth positive evaluation, the average mean for all items equals 3.63, and the weight mean equals 72.62 % which is greater than 60%, it means that the evaluation is positive. Fifth actions of the family, the average mean for all items

equals 3.69, and the weight mean equals 73.83 % which is greater than 60%, this means that the actions of the family are good. For all sub scale the average mean for all items equals 3.82, and the weight mean equals76.41% which is less than 60%, it means the family support is good, and it affects positively on the PTSD symptoms.

5.2.4.2. Family support and socio-demographic factors

The study found that there were statistically significant differences in family support according to age, it found that the study sample individual who their age (13) years saw that family support less than who their age (15, 16, 17, 18) years. But, Al Kurd (2012), study showed that there were no statistically significance differences in family support according to age.

The study found that there were no statistically significant differences in family support according to sex, to number of family member, and family monthly income. And Al Kurd (2012), study showed that there were no statistically significance differences in family support according to sex, number of family members, and family income.

The study found that there were statistically significant differences in family support according to type of school, favor of private school.

The researcher proposed that the most of the students in private schools have families with high income satisfied, and they were able to secure the basic life needs during the war, but the families with low income have intensified problems in addition to traumatic problems.

The study found that there were statistically significant differences in family support according to place of residence, it found that the study sample individual who live in North Gaza, family support for them less than who live in (Gaza, Khan Younis, Rafah area), and who live in Middle area, family support for them less than who live in (Khan Younis, Rafah area). Also, Al Kurd (2012), study showed that there were statistically significance differences in family support according to place of residences favor of North Gaza.

5.2.5. Relationships between traumatic events, PTSD symptoms, social and family support

The study found that there was significant correlation between total traumatic events total PTSD among the adolescents of the study sample. This consistent with Thabet and Vostanis (2015), study showed that there was significant association between exposure to traumatic events and developing PTSD. And Qeshta (2015), study showed that there was significant correlation between total traumatic events reported by children and total PTSD, re-experiencing, avoidance, and arousal. This means that traumatic experiences lead to post traumatic stress disorder. Also, Bensimon (2012), study showed that trauma increased PTSD and growth levels.

Another study, Al ibwaini (2015), showed that there was significant correlation between total traumatic events reported by adolescents and total PTSD, re-experiencing, avoidance, and arousal. And Nooner et al. (2012), study reported that trauma is associated with more shame and deviance, is associated with higher rates of PTSD, and rates of traumatic exposure peak in adolescence compared to adulthood, which is associated with correspondingly higher rates of PTSD. Al Kurd (2012), study reported that when the trauma is increased the symptoms of PTSD will increased.

But, the study found that there was no correlation between traumatic events experience and the social support for adolescents of the study sample. This consistent with Thabet and Vostanis (2015), study showed that trauma was negatively correlated with social support and wishful thinking, and positively correlated with self-criticism. But, Thabet et al. (2015a), study showed that adolescents experienced traumatic experiences developed less social support, and Odah (2010), study showed that there was a positive correlation between the positive experience of traumatic and all methods of adaptation with stress, social support, and psychological toughness. Also, Nooner et al. (2012), study reported that adolescents with less social support are more likely to experience trauma and develop PTSD.

Social support from parents, peers, and others has been found to be a protective factor both before and after a trauma (Lee et al., 2007).

Also, the study found that there was significant correlation between traumatic events experience and the family support.
Social support from parents, peers, and others has been found to be a protective factor both before and after a trauma (Lee et al., 2007).

Until, the study found that there was significant correlation between PTSD and social support of adolescents in the Gaza Strip. This consistent with Thabet et al. (2015a), study reported that adolescents with PTSD had coping by ventilating feelings, developing social support, however Nooner et al. (2012), study showed that the a dolescents with less social support are more likely to experience trauma and develop PTSD, also Scarpa et al. (2006), study showed that low perceived social support from family and friends significantly predicted increased PTSD scores. Until, Araya et al. (2007), study reported that coping strategies and perceived social support influenced mental distress and quality of life directly.

And, the study found that there was significant correlation between PTSD and family support of adolescents. This consistent with Thabet et al. (2015a), study reported that adolescents with less PTSD had looking more for solving his family problems, also Scarpa et al. (2006), reported that low perceived social support from family and friends significantly predicted increased PTSD scores.

Also, the study found that there was significant correlation between social support and family support. This consistent with Al Kurd (2012), study showed that positive correlation between family support and social support, it means when the social support increased the family support increased.

Our study is consistent with these studies that demonstrated the correlation between exposed to trauma, PTSD symptoms, social and family support. Exposed to trauma increase the possibility to develop PTSD, also the family and social support associated positively with PTSD (higher rates of PTSD associated with high rates of family and social support).

5.3 Conclusion

After the researcher presented the result of this study offered as possible, around the PTSD due to traumatic event, and the relationship between family and social support, and the researcher was discuss the objectives, the researcher saw this study will be the reference to another studies. Also, the researcher saw this study have special characterize by studied the Palestinian population that they have special character, as Palestinian adolescents experienced significant traumatic events due to the war on the Gaza Strip which were significantly associated with developing post-traumatic stress symptoms.

The study found that the highest traumatic events were: Hearing shelling of the area by artillery, then hearing the loud voice of Drones, then watching mutilated bodies in TV, and hearing killing of a friend. Also, this study found that the least traumatic events were: Personal threat if killing by the army and physical injury due to bombardment of your home.

And found that the most of the adolescents reported mild traumatic events, and found that there were statistically significant differences toward boys. Boys statistically significantly reported severe traumatic events than girls. And there were statistically significant differences in traumatic experiences resulting from the war on Gaza according to age. Until, there were no statistically significant differences in traumatic experiences resulting from the war on Gaza according to type of school, place of residence, monthly income.

Also, the study found that the most common post traumatic reactions were: efforts to avoid activities, places, or people that arouse recollections of the trauma, then efforts to avoid thoughts, feelings, or conversations associated with the trauma, acting or feeling as if the traumatic event were recurring, exaggerated startle response, and intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

The study found that the most of the adolescents show no PTSD, then show at least one criteria of PTSD (B or C or D). And found that there were statistically significant for all subscales (Intrusion symptoms, avoidance, and arousal) and in total PTSD scores according to sex favor of male. And no statistically significant differences in total PTSD,

Intrusion ,avoidance, and arousal symptoms, according to age group, type of school, place of residence, number of family member, and family monthly income.

And the study found that the most common social support were: First dimension, support perceived from family and relatives were: my family members being with me when I need them, then my family give me advice when I need, and my family helps me to overcome the problems that I face. Second dimension, psychosocial support provided by friends were: I feel that I am of interest to my colleagues who live close to me, then my relation with my friends make me feel important, and I have sufficiency of the friends around me. Third dimension, psychosocial support provided by the institutions were: There is institutions and programs with psychosocial support in my area that providing assistance to families in need such as family, and there institutions in my area which give us financial and moral support.

And this study found that the mean support perceived from family and relatives have high score, then psychosocial support provided by friends, then psychosocial support provided by the institutions, it indicated adolescents in the Gaza Strip have social support with high degree.

As the social support has three dimensions ranked, support perceived from family and relatives dimension take first rank, then Psychosocial support provided by friends has second rank, and psychosocial support provided by the institutions has third rank.

Also, the study found that there were statistically significance differences in social support according to age, type of school, but found that there were no statistically significance differences in social support according to sex, place of residence, number of the family member, and family monthly income.

However, the study found that the most common family support were: We believe that this is the will of God, then ask the advice of relatives (e.g. grandparents), and face the problems and trying to find solutions to them immediately. While, the least common family support were: share our problem with our neighbors, ask for help from neighbors, and believe that if we wait enough time, the problem will end on its own.

And the study found that the arithmetic mean of the family support indicates that adolescents in the Gaza Strip have family support with moderate degree. And request for spiritual (religious) support dimension take first rank, then restructuring has second rank, requesting for social support has third rank, positive evaluation has fourth rank, and action of the family has final and fifth rank.

The study found that there were statistically significant differences in family support according to age, type of school favor of private school, and place of residence, found that the study sample individual who live in North Gaza, family support for them less than who live in (Gaza, Khan Younis, Rafah area), and who live in Middle area, family support for them less than who live in (Khan Younis, Rafah area). but no statistically significant differences in family support according to sex, to number of family member, and family monthly income.

The result show that there was significant correlation between total traumatic events, total PTSD and family support, but no significant correlation between traumatic events experience and the social support. Also there was significant correlation between PTSD, social support, and family support. Until, there was significant correlation between social support and family support.

Also, the findings highlight the urgent need for establishing community mental health school based programs to help adolescents with such symptoms and increase awareness about their nature and management. Also there is need for conducting training courses for teachers and school counsellors to increase their knowledge about general mental health problems in schools and ways of dealing with such problems.

Trauma can have long-standing impact on adolescents mental health. Community based intervention programs could enhance adolescents resilience. Family, social and specialist mental health practitioners have essential roles in the development and delivery of such programs. And these findings urge toward providing psychological support programs to Palestinian adolescents to enhance current wellbeing and limit further developmental risks. Furthermore, the findings suggest the need to investigate the role of appraisal and coping to understand the pathways through which differences in trauma exposure lead to similar

posttraumatic stress outcomes, and the results confirms the importance of assessing PTSD in schools settings.

5.4 Recommendations

5.4.1. Trauma

According to the results, there was a high prevalence of traumatic experiences, which affect the adolescents badly, so the researcher recommends :

1. Restriction of TV programs that display a violence and war reports through cooperation with the ministry of information.
2. Restriction of TV use especially mutilated bodies through the parents.
3. Purposefully selected programs by parents or caretakers are good for children and adolescents.
4. It is necessary to provide a therapeutic interventions and protective interventions for adolescents exposed traumatic events.
5. It is necessary to provide therapeutic intervention program such as crisis intervention for students who were affected directly from Israeli violence, or those who are at risk.
6. Generation counseling department in every school and the staff mission is to give lessons that talk about the psychological problems associated with the trauma. Those counselors work to educate and train students on how to deal with these conditions before, after and during the trauma.

5.4.2. Posttraumatic stress disorder

According to the results, there was a prevalence of PTSD symptoms, which may threatening the adolescents' life and future or develop other problems, so the researcher recommends :

1. To establish supportive and therapeutic programs that encouraged affected adolescents to share their feelings and thoughts, and to provide the appropriate therapy to them (by cooperation with ministry of education and ministry of health).
2. Train good mental health workers by ministry of health to focus on mental health services that can help affected adolescents.
3. Follow a good plan of therapeutic interventions especially for those with sever PTSD symptoms such as (psychodynamic and cognitive behavioral interventions).

4. Immediate intervention to children and their families in case of trauma that will decrease the consequence of PTSD.

5.4.3. Social and family support

1. Training of school social and psychological workers about PTSD, how to discover it early, and how to manage such disorders.
2. Put weekly lessons for students about dealing with hard situations by social and psychological workers.
3. Encourage Exercises and increase the sports lessons at every school that will decrease anxiety and lower the tension.
4. Modification of institutions Programs and plans which meet all generations and families and cover all levels of community.
5. Increases the community institutions witch provide social support.
6. Teach families about the importance of their roles in case of PTSD and how to deal with their children.

5.5 Suggestion for further researches

1. longitudinal and qualitative researches about PTSD due to war trauma
2. The effect of traumatic experiences resulting from the war on Gaza on self-esteem
3. The relationship between PTSD and teacher support
4. Evaluation of level of trauma among students
5. Comparative study between Gaza and West bank about PTSD and social and family support.
6. The relationship between family and social support and post traumatic growth.

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Annexes

Annex No.(1)

Diagnostic criteria for PTSD according to ICD–10

A. The patient must have been exposed to a stressful event or situation (either short or long-lasting) of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone.

B. There must be persistent remembering or 'reliving' of the stressor in intrusive 'flashbacks', vivid memories, or recurring dreams, or in experiencing distress when exposed to circumstances resembling or associated with the stressor.

C. The patient must exhibit an actual or preferred avoidance of circumstances resembling or associated with the stressor, which was not present before exposure to the stressor.

D. Either of the following must be present:

1. inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor.
2. persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor), shown by any two of the following:
    - difficulty in falling or staying asleep
    - irritability or outbursts of anger
    - difficulty in concentrating
    - hypervigilance
    - exaggerated startle response.

Criteria B, C, and D must all be met within 6 months of the stressful event or the end of a period of stress. (For some purposes, onset delayed more than by 6 months may be included, but this should be clearly specified).

Annex No.(2)

Diagnostic criteria for PTSD according to DSM IV

Diagnostic criteria for Posttraumatic Stress Disorder

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

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

(2) the person's response involved intense fear, helplessness, or horror.

Note: In children, this may be expressed instead by disorganized or agitated behavior

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

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) recurrent distressing dreams of the event.

Note: In children, there may be frightening dreams without recognizable content.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).

Note: In young children, trauma-specific reenactment may occur.

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

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

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

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

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

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

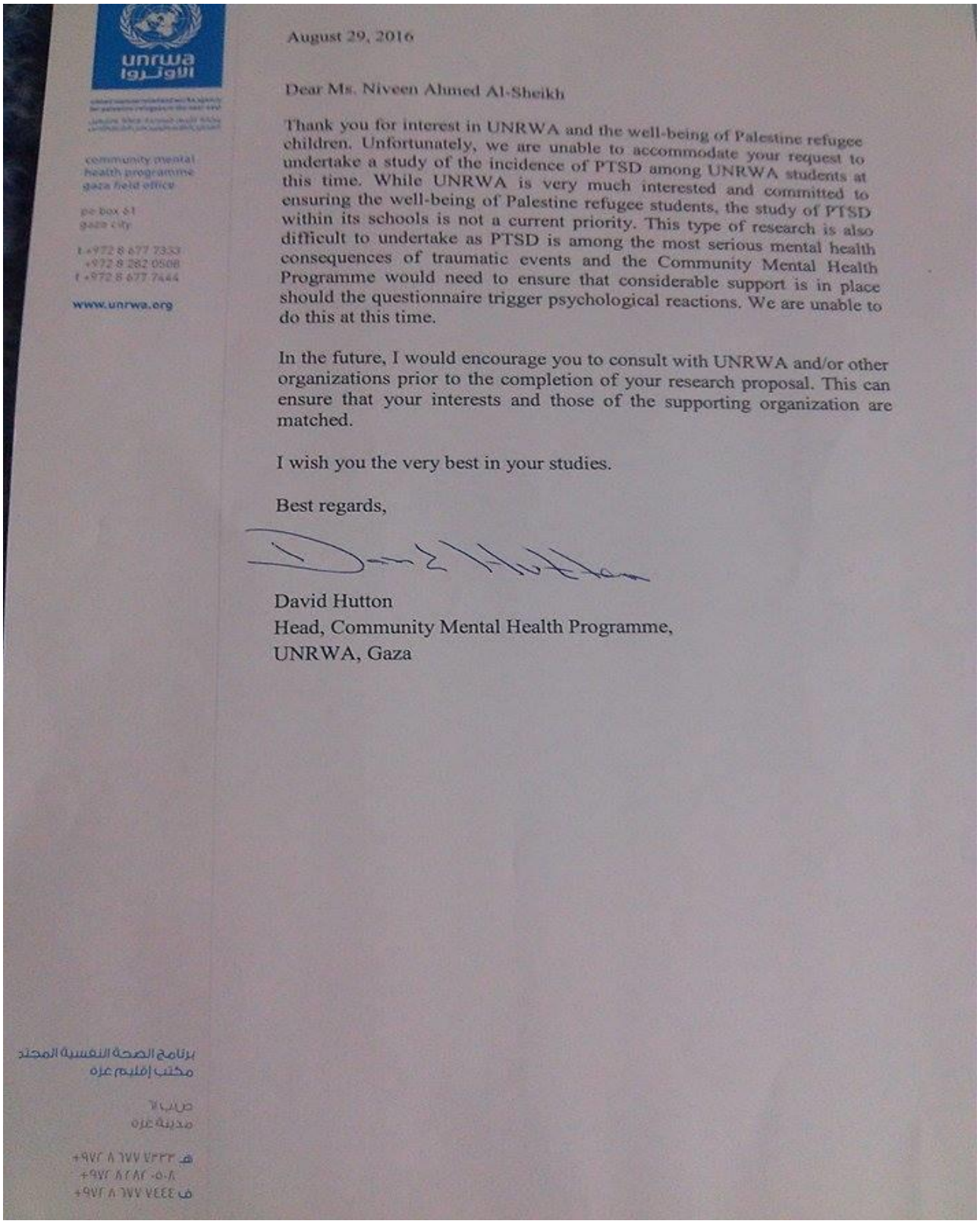
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response.

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more
With Delayed Onset: if onset of symptoms is at least 6 months after the stressor.

Annex No.(3)

Cover letter of UNARWA



unrwa
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community mental
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www.unrwa.org

August 29, 2016

Dear Ms. Niveen Ahmed Al-Sheikh

Thank you for interest in UNRWA and the well-being of Palestine refugee children. Unfortunately, we are unable to accommodate your request to undertake a study of the incidence of PTSD among UNRWA students at this time. While UNRWA is very much interested and committed to ensuring the well-being of Palestine refugee students, the study of PTSD within its schools is not a current priority. This type of research is also difficult to undertake as PTSD is among the most serious mental health consequences of traumatic events and the Community Mental Health Programme would need to ensure that considerable support is in place should the questionnaire trigger psychological reactions. We are unable to do this at this time.

In the future, I would encourage you to consult with UNRWA and/or other organizations prior to the completion of your research proposal. This can ensure that your interests and those of the supporting organization are matched.

I wish you the very best in your studies.

Best regards,

David Hutton
Head, Community Mental Health Programme,
UNRWA, Gaza

برنامج الصحة النفسية المجتمعية
مكتب إقليم غزة

ص.ب ٨١
مدينة غزة

هـ ٢٣٣٣ ٧٧٧ ٨ ٩٧٢+
٥٠٨٠ ٨٢٨٢ ٨ ٩٧٢+
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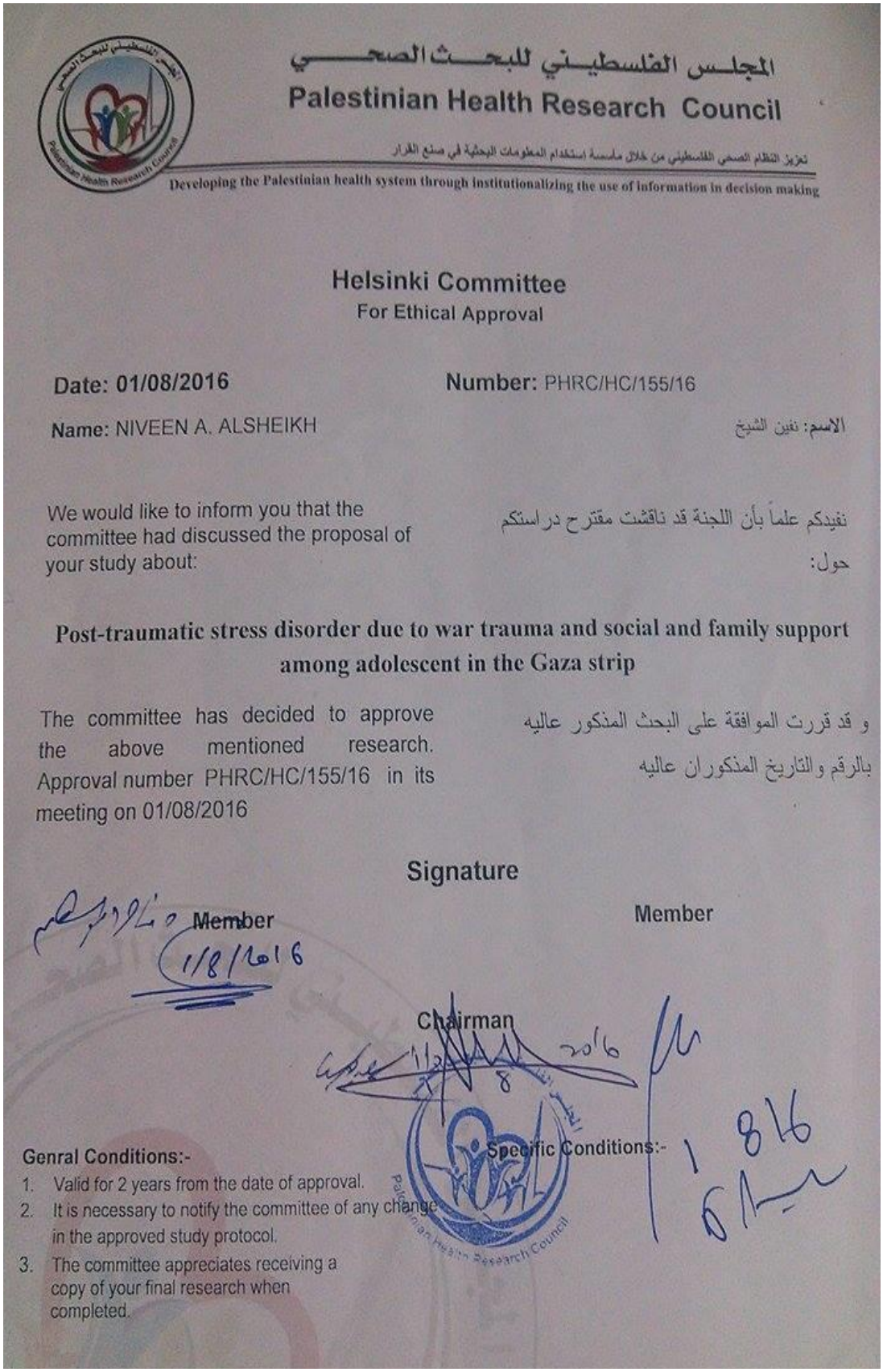
Annex No.(4)

Helsinki Committee for ethical approval



المجلس الفلسطيني للبحث الصحي

Palestinian Health Research Council

تعزيز النظام الصحي الفلسطيني من خلال مأسسة استخدام المعلومات البحثية في صنع القرار

Developing the Palestinian health system through institutionalizing the use of information in decision making

Helsinki Committee
For Ethical Approval

Date: 01/08/2016 **Number:** PHRC/HC/155/16

Name: NIVEEN A. ALSHEIKH **الاسم:** نفين الشيخ

We would like to inform you that the committee had discussed the proposal of your study about:

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:

Post-traumatic stress disorder due to war trauma and social and family support among adolescent in the Gaza strip

The committee has decided to approve the above mentioned research. Approval number PHRC/HC/155/16 in its meeting on 01/08/2016

و قد قررت الموافقة على البحث المذكور عاليه بالرقم والتاريخ المذكوران عاليه

Signature

Member 1/8/2016

Member

Chairman

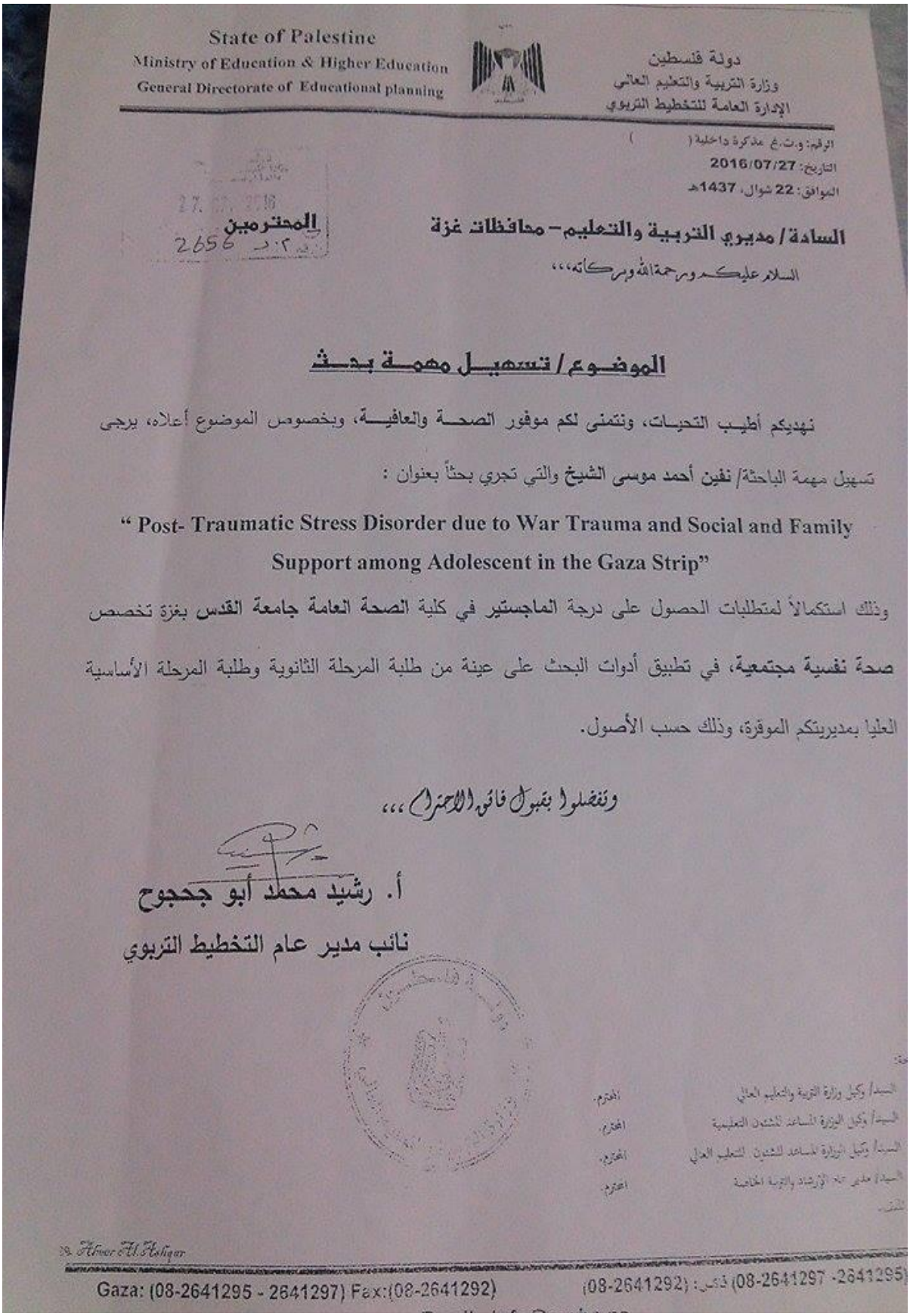
Genral Conditions:-

1. Valid for 2 years from the date of approval.
2. It is necessary to notify the committee of any change in the approved study protocol.
3. The committee appreciates receiving a copy of your final research when completed.

Specific Conditions:-

Annex No. (5)

Letter from ministry of education for mission facilitation



State of Palestine
Ministry of Education & Higher Education
General Directorate of Educational planning

دولة فلسطين
وزارة التربية والتعليم العالي
الإدارة العامة للتخطيط التربوي

الرقم: و.ت.ع /مذكرة داخلية/ ( )
التاريخ: 2016/07/27
الموافق: 22 شوال، 1437هـ

المحترمين

السادة/ مديري التربية والتعليم – محافظات غزة

السلام عليكم ورحمة الله وبركاته،،،

الموضوع/ تسهيل مهمة بحث

نهديكم أطيب التحيات، ونتمنى لكم موفور الصحة والعافية، وبخصوص الموضوع أعلاه، يرجى تسهيل مهمة الباحثة/ **نفين أحمد موسى الشيخ** والتي تجري بحثاً بعنوان :

" Post- Traumatic Stress Disorder due to War Trauma and Social and Family Support among Adolescent in the Gaza Strip"

وذلك استكمالاً لمتطلبات الحصول على درجة **الماجستير** في كلية **الصحة العامة جامعة القدس** بغزة تخصص **صحة نفسية مجتمعية**، في تطبيق أدوات البحث على عينة من طلبة المرحلة الثانوية وطلبة المرحلة الأساسية العليا بمديريتكم الموقرة، وذلك حسب الأصول.

وتفضلوا بقبول فائق الاحترام،،،

أ. رشيد محمد أبو جحجوح
نائب مدير عام التخطيط التربوي

السيد/ وكيل وزارة التربية والتعليم العالي المحترم.
السيد/ وكيل الوزارة المساعد للشئون التعليمية المحترم.
السيد/ وكيل الوزارة المساعد للشئون التعليم العالي المحترم.
السيد/ مدير عام الإرشاد والتربية الخاصة المحترم.

Gaza: (08-2641295 - 2641297) Fax:(08-2641292)

Annex No. (6)

Calculated the sample according to the density of the population

Area	No. of students		Total	Percent		No. of the students that needed from each area		Total
	privet	government		privet	government	privet	government	
North Gaza	1416	41633	43049	3.28%	96.71%	2	66	68
Gaza zone	11411	102373	113784	10.02%	89.97%	18	162	180
Middle zone	1861	23927	25788	7.21%	92.78%	3	37	40
Khan Younis	2707	46345	49052	5.51%	94.48%	4	76	80
Rafah zone	744	20614	21358	3.48%	96.51%	1	31	32
Total	18139	234892	253031			28	372	400
Percent						**7%**	**93%**	**100%**

Annex No. (7)

Participation invitation

No. of questionnaire ( )

Special for the researcher

Dear participant:

This study aims to investigate Post-traumatic stress disorder due to war trauma and social and family support among adolescent in the Gaza Strip- as a requirement to obtain a master degree in community mental health at Al-Quds University- Palestine, supervised by Prof. Dr. Abdel-Aziz Thabet.

The target of this study to investigate relationship between war trauma, PTSD, social and family support among adolescent in the Gaza Strip.

The researcher thanks you for your participation and collaboration in this study that we hope reduce the psychological problems and improve mental health among adolescents in the Gaza Strip .

The researcher would like to emphasize that information will remain confidential and for the purpose of scientific research that does not necessary to mention your name.

You have the right to refuse participate in this study.

Thank you for participation

Niveen Ahmed AL.Sheikh

Annex No.(8)

Socio-demographic data

First: Socio-demographic data

Name: …… Age: …… Sex: □Male □Female

School: ……... Class: …….

Type of school: □private □government □UNARWA

Place of residence: □North Gaza □Gaza □Middle area □Khan Younis □Rafah

Number of the family member: ……..

Father education: □Not educated □Preparatory □Elementary □Secondary □Diploma □University □Post graduate

Mother's education: □Not educated □Preparatory □Elementary □Secondary □Diploma □University □Post graduate

Father's job: □Unemployed □ worker □ Skilled worker □ employee □Merchant □Other

Mother's job: □House wife □ employee □Other ……..

Family monthly income (NIS): □Less than 1700 NIS □1701-2400 NIS □2401-3500 NIS □3501-4000 NIS □ More than 4001 NIS

Annex No.(9)

Gaza Traumatic events checklist

No.	Event and trauma	No	Yes
1.	Hearing killing of a friend		
2.	Hearing killing of a close relative		
3.	Hearing shelling of the area by artillery		
4.	Hearing the loud voice of Drones		
5.	Witnessing killing of a friend		
6.	Witnessing killing of a close relative		
7.	Witnessing shooting of a friend		
8.	Witnessing shooting of a close relative		
9.	Witnessing firing by tanks and heavy artillery at own home		
10.	Witnessing firing by tanks and heavy artillery at neighbors' homes		
11.	Witnessing arrest of a close relative by the army		
12.	Witnessing arrest of a friend		
13.	Watching mutilated bodies in TV		
14.	Witnessing bombardment of bog buildings by rockets		
15.	Witnessing assassination of people by rockets		
16.	Physical injury due to bombardment of your home		
17.	Shot by bullets, rocket, or bombs		
18.	Deprivation from water or electricity during detention at home		
19.	Threaten by shooting		
20.	Destroying of your personal belongings during incursion		
21.	Personal threat if killing by the army		
22.	Threaten of killing of your closed relative infront of you		
23.	Threatened with death by being used as human shield by the army to move from one home to home		
24.	Being arrested during the land incursion		
25.	Forced to leave you home with family members due to shelling		
26.	Exposure to arrest during invasion		
27.	Inhalation of bad smells due to bombardment		
28.	Threaten by telephone to leave the home for bombarment of home		
29.	Receiving pamphlets from Airplane to leave your home at the border and to move to the city centers		

Annex No.(10)

PTSD Scale

No.	Item	Never	Rarely	Sometimes	often	Always
1.	Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.					
2.	Recurrent distressing dreams of the event					
3.	Acting or feeling as if the traumatic event were recurring					
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 even					
6.	Efforts to avoid thoughts, feelings, or conversations associated with the trauma					
7.	Efforts to avoid activities, places, or people that arouse recollections of the trauma					
8.	Inability to recall an important aspect of the trauma					
9.	Markedly diminished interest or participation in significant activities					
10.	Feeling of detachment or estrangement from others					
11.	Restricted range of affect (e.g., unable to have loving feelings)					
12.	Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)					
13.	Difficulty falling or staying asleep					
14.	Irritability or outbursts of anger					
15.	Difficulty in concentration					
16.	Hyper vigilance (On edge been easily distracted or had to stay)					
17.	Exaggerated startle response					

Annex No.(11)

Social support scale

No.	Support perceived from family and relatives	Never	Some Times	always
1	my family members being with me when I need them			
2	my relatives give me advice when I need			
3	My family helps me to overcome the problems that I face			
4	I have a sufficiency of friends around me			
5	The friendship in my family is characterized by psychological support			
6	my family give me advice when I need			
7	relatives encarge us to overcome the psychological problems that I face			
8	my family does not help me when I need			
9	When i have a problem I can ask for help from my parents and my Relatives			
10	my family made me feel satisfied and strong			
11	I feel comfortable when I'm asking for support from my family			
Psychosocial support provided by friends				
1	My friends always ready to listen to my problems			
2	I have sufficiency of the friends around me			
3	My friends help me financially when needed			
4	my friends come to me alone when they need me			
5	I feel that I am of interest to my colleagues who live close to me			
6	When I'm in a problem that I relied on my close colleagues to help me			
7	all my life I find whom helping me when I need help			
8	I find it difficult to seek professional help			
9	My relation with my frinds make mee feel important			
10	I feel that there is no real support from my friends			
psychosocial support provided by the institutions				
1	There is institutions and programs with psychosocial support in my area that providing assistance to families in need such as family			
2	There institutions in my area which give us financial and moral support			
3	i receive psychological help from the institutions that provide psychological counseling			
4	There is at least one institution which provide me with financial support			
5	I find it very difficult to get help from social institutions, which provide assistance to families in need such as family			

Annex No.(12)

Family Crisis Oriented Personal Evaluation Scales (FCOPES)

1. Strongly disagree 2. Disagree 3. Don't know 4. Agree 5. Strongly agree

#	Item	1	2	3	4	5
1	We share our relatives difficulties					
2	ask for encouragement and support from friends					
3	we know that we have the power to solve the general problems					
4	ask the advice of members of the families have faced similar problems					
5	ask the advice of relatives (e.g. grandparents)					
6	ask for help from institutions specializing in helping families					
7	know that we have the ability to solve our problems					
8	receive gifts and assistance from neighbors such as food and clothing…					
9	ask for advice and information from the clinic doctor					
10	ask for help from neighbors					
11	face the problems and trying to find solutions to them immediately					
12	watch television					
13	we show we are strong					
14	attend religious seminars					
15	accept the fact stressful events in life					
16	share with close friends we are concerned					
17	We know that luck can play a role as we do to solve our problems, family					
28	practice exercises with friends to reduce tension					
19	accept that these problems can occur without expecting					
20	Participate our relatives in activities that are beneficial (family meetings, and invite them to dinner in)					
21	ask for help from specialists in counseling to help families located in the problem					
22	believe that we can solve our problems ourselves					
23	participate in religious seminars					
24	put the problem in the a positive context of family so as not frustrated					
25	We ask relatives about what they feel toward our problem					
26	feel that it is important to the work of precautions to avoid problems, otherwise we will face difficulties in solving problems					
27	ask the advice of religious leaders (Sheikh, a man of repair)					
28	believe that if we wait enough time, the problem will end on its own					
29	share our problem with our neighbors					
30	We believe that this is the will of God					

Annex No.(13)

دعوة

رقم الاستبانة ( ) خاص بالباحثة

عزيزي الطالب/ عزيزتي الطالبة :

تقوم الباحثة بإجراء دراسة بعنوان **"اضطراب كرب ما بعد الصدمة الناتج عن صدمة الحرب والدعم الأسري والاجتماعي لدى المراهقين في قطاع غزة"** حيث أن هذه الدراسة هي لاستكمال متطلبات بحث التخرج لدراسة ماجستير الصحة النفسية المجتمعية بجامعة القدس – أبو ديس تحت اشراف الاستاذ الدكتور عبد العزيز ثابت.
وتهدف الباحثة من خلال هذه الدراسة للتعرف على مدى تأثر المراهقين بالخبرات الصادمة التي تعرضوا لها و تأثير الدعم الأسري و الاجتماعي عليهم، ومن ثم الخروج بتوصيات تساعد في تخفيف العبء النفسي وتحسين الصحة النفسية لدى هؤلاء المراهقين.

لذا أمامكم عدة أسئلة لقياس الصدمات و المساندة الاجتماعية و الأسرية، فأرجو منكم الإجابة بصدق عن كل الأسئلة التالية وسوف تراعى السرية التامة في هذه الإجابات مع العلم أنها سوف تستخدم لغرض البحث العلمي فقط.
ملاحظة : المشاركة في البحث اختيارية وليست إجبارية ولا داعي لكتابة الاسم، ولذا أرجو أن تكون الاجابة دقيقة.

وشكـــرا لك/ي على حســن تعاونــك

الباحثة/ نيفين أحمد الشيخ

Annex No.(14)

البيانات الديموغرافية

أولا: البيانات الديموغرافية:

الاسم: ..... العمر: ..... الجنس: ذكر □ أنثى □

المدرسة: ..... الصف: .....

نوع المدرسة: خاصة □ حكومية □ وكالة □

مكان السكن (محافظة) □ الشمال □ غزة □ الوسطى □ خان يونس □ رفح

عدد أفراد الأسرة: .....

تعليم الأب □ أُمي □ ابتدائي □ إعدادي □ ثانوي □ دبلوم □ جامعي □ دراسات عليا

تعليم الأم □ أُمي □ ابتدائي □ إعدادي □ ثانوي □ دبلوم □ جامعي □ دراسات عليا

عمل الأب □ لا يعمل □ عامل عادي □ عامل حرفي (ذو حرفة) □ موظف □ تاجر □ أخرى

عمل الأم □ ربة بيت □ موظفة □ غير ذلك (حدد): .....

الدخل الشهري للأسرة (بالشيكل): □ أقل من ١٧٠٠ شيكل □ من ١٧٠١- ٢٤٠٠ □من ٢٤٠١ -٣٥٠٠

□ من ٣٥٠١– ٤٠٠٠ □ أكثر من ٤٠٠١ شيكل

Annex No.(15)

مقياس الخبرات الصادمة الناتجة عن الحرب علي غزة-2014

اعداد أ. د عبد العزيز موسى ثابت

استاذ الطب النفسي جامعة القدس

عزيزي/تي:

أمامك مجموعة من البنود التي توضح أنواع الخبرات الصادمة (الأحداث المؤلمة) التي قد يتعرض لها أي انسان في الظروف الصعبة مثل الحروب، الاحتلال، الكوارث الطبيعية والتي قد تشمل بعض ما تعرضت له خلال الحرب علي غزة-2014. نرجو أن تضع علامة صح في الخانة الصحيحة.

الرقم	الحدث أو الخبرة الصادمة	نعم (١)	لا(٠)
١	سماعك لاستشهاد صديق أو جار لك أثناء الحرب		
٢	سماعك لاستشهاد أب أو أخ أو أخت أو قريب لك أثناء الحرب		
٣	سماعك لأصوات القصف على المناطق المختلفة من قطاع غزة		
٤	سماعك لصوت الزنانة باستمرار		
٥	مشاهدة استشهاد صديق لك أمامك		
٦	مشاهدة استشهاد أب أو أخ أو أخت أو قريب لك أمامك		
٧	مشاهدة إصابة صديق لك أمامك بالشظايا أو الرصاص		
٨	مشاهدة إصابة أب أو أخ أو أخت أو قريب لك أمامك بالشظايا أو الرصاص		
٩	مشاهدة بيتكم و هو يهدم ، و يدمر من القصف أو الجرافات		
١٠	مشاهدة بيت جيرانكم و هو يهدم ، و يدمر من القصف أو الجرافات		
١١	مشاهدة أب/أخ/أخت/ أم/قريب لك وهو يعتقل أمامك		
١٢	مشاهدة صديق وهو يعتقل أمامك		
١٣	مشاهدة صور الجرحى و الأشلاء والشهداء في التلفزيون		
١٤	مشاهدة الابراج السكنية العالية و هي تقصف امام عينك و تسوى بالأرض		
١٥	مشاهدة عمليات الاغتيالات من قبل الجيش		
١٦	تعرضك للإصابة الجسدية نتيجة لقصف منزلك		
١٧	تعرضك للإصابة بشظية قنبلة أو صاروخ أو الرصاص		
١٨	تعرضك للاحتجاز في البيت و للحرمان من الماء و الأكل و الكهرباء		
١٩	تعرضك لإطلاق النار بقصد التخويف		
٢٠	تعرض إغراضك الشخصية في المنزل للتدمير و التكسير والنهب من الجيش		
٢١	تعرضك للتهديد شخصياً بالقتل		
٢٢	تعرضك للتهديد بقتل أحد أفراد الأسرة		
٢٣	تعرضك للخطر الشديد باستخدامك كدرع بشري للقبض على جار لكم		
٢٤	تعرضك للاعتقال أثناء الهجوم البري		
٢٥	تعرضك لترك المنزل مع عائلتك وأقاربك و النزوح لمناطق أخرى		
٢٦	تعرضك للاعتقال من الجيش أثناء الاجتياح		
٢٧	تعرضك لاستشاق غازات كريهه ناتجة عن القصف		
٢٨	تعرضك للتهديد بالتليفون لترك المنزل بغرض قصفه		
٢٩	تعرضك للتهديد بترك البيت في المناطق الحدودية و التوجه لوسط المدينة عن طريق منشورات من الطائرات		

Annex No.(16)

استبيان كرب ما بعد الرضح (الصدمة) الحرب

تقنين على البيئة الفلسطينية

أ. د. عبد العزيز موسى ثابت

استاذ الطب النفسي ـكلية الصحة العامةـجامعة القدس

عزيزي /تي

أمامك مجموعة من الأسئلة تبين ردود الفعل على الخبرات الصادمة التي تكون قد تعرضت لها من قبل، نرجو الإجابة على كل سؤال ووضح علامة (√) في الخانة الصحيحة. أما بالنسبة للخبرة الصادمة فيجب أن تكون محددا إلى الأحداث التي ذكرتها من قبل.

الرقم	الحدث (الخبرة الصادمة)	أبدا	نادرا	أحيانا	غالبا	دائما
١.	هل تعاودك صور و أحداث و ذكريات بما تعرضت له أثناء الحرب.					
٢.	هل تحلم أحلام مزعجة تذكرك بالحرب					
٣.	هل ينتابك شعور بأن ما تعرضت له في فترة الحرب سوف يحدث الآن مرة أخرى (أو تلعب بأشياء تذكرك بالحرب)					
٤.	هل تصاب بحالة من الضيق الشديد عند التعرض لأي موقف صعب خارجي أو داخلي من نفسك يذكرك بما تعرضت له أثناء الحرب					
٥.	هل تصاب بحالة من القلق والعصبية والتوتر (على شكل سرعة في ضربات القلب رعشة في اليدين، عرق غزير) عند تعرضك لأي موقف خارجي صعب أو داخلي من نفسك يذكرك بما تعرضت له أثناء الحرب					
٦.	هل تتجنب الأفكار، والأحاديث، والإحساسات التي تذكرك بالخبرات الصادمة التي تعرضت لها إثناء الحرب					
٧.	هل تتجنب الأشخاص و الأماكن ، والمواقف التي تذكرك بالخبرات الصادمة التي تعرضت لها إثناء الحرب					
٨.	أصبحت غير قادر على تذكر أشياء مهمة تتعلق بفترة الحرب و ما تعرضت له من مواقف صادمة					
٩.	منذ تعرضت للصدمة هل قل بشكل واضح اهتمامك بالمشاركة في النشاطات الاجتماعية، والمدرسية، و المشاركات السياسية المختلفة					
١٠.	هل تشعر بالغربة و الانفصال عمن حولك وأنه ليس لك بهم أي صلة					
١١.	هل أنت عاجز على حب الآخرين من حولك					
١٢.	هل تشعر بأنه ليس لديك مستقبل مثل أن تكمل تعليمك وتتزوج وتعيش حياة طويلة					
١٣.	هل تشكو من صعوبة في النوم أو البقاء نائما					
١٤.	هل تشعر بالتوتر وتنتابك نوبات من الغضب الشديد					
١٥.	هل لديك صعوبات في التركيز أثناء تأدية واجباتك المدرسية					
١٦.	هل تشعر بأنك دائما متيقظ ومتوقع للأسوأ وفي حالة انتظار دائم لما سيحدث					
١٧.	هل تجفل و تتفزز بشكل غير طبيعي لسماعك أقل صوت مزعج					

Annex No.(17)

مقياس الدعم الأسري و الاجتماعي لفيفيان خميس

الأسئلة التالية تصف مقدار الدعم الأسري و الاجتماعي الذي تتلقاه من الأقارب و الأصدقاء و كذلك من المؤسسات

أرجو منك /ي وضع صح إمام الإجابة بنعم أو أحيانا أو لا

الرقم	الدعم النفسي الاجتماعي المتلقي من الأقارب	نعم	أحيانا	لا
١	أفراد أسرتي يرافقوني عندما احتاج إليهم			
٢	أقاربي يقدمون لي النصيحة عندما احتاج			
٣	أسرتي تساعدني على التغلب على المشاكل التي أواجهها			
٤	لدي اكتفاء بمن حولي من أصدقاء			
٥	الصداقة الموجودة في عائلتي تتصف بالدعم النفسي			
٦	أسرتي تقدم لي النصيحة عندما احتاجها			
٧	أقاربي يشجعوني على التغلب على المشاكل النفسية التي أواجهها			
٨	أسرتي لا تساعدني عندما احتاج			
٩	عندما أكون في مشكلة يمكنني طلب المساعدة من والدي و أقربائي			
١٠	تشعرني أسرتي بالرضا و القوة			
١١	اشعر بالراحة عندما اطلب المساندة من أسرتي			
الدعم النفسي الاجتماعي المقدم من الأصدقاء				
١	أصدقائي دوما جاهزين للاستماع لمشاكلي			
٢	لدي اكتفاء بمن حولي من أصدقاء			
٣	أصدقائي يساعدوني ماديا عندما احتاج			
٤	أصدقائي يأتون لي وحدي عندما يحتاجون لي			
٥	اشعر أني محل اهتمام زملائي الذين يعيشون بالقرب مني			
٦	عندما أكون في مشكلة استطيع أن اعتمد على زملائي القريبين مني لمساعدتي			
٧	طوال حياتي أجد من يساعدني عندما احتاج للمساعدة			
٨	أجد صعوبة في البحث عن المساعدة المهنية			
٩	تعاملات أصدقائي القريبين مني تجعلني اشعر بأهميتي			
١٠	اشعر بعدم وجود مساندة حقيقية من أصدقائي			
الدعم النفسي الاجتماعي المقدم من المؤسسات				
١	يوجد مؤسسات و برامج خاصة بالدعم النفسي في منطقتي تقدم مساعدة للأسر التي تحتاج دعم نفسي مثل أسرتي			
٢	يوجد مؤسسات اجتماعية في منطقتي و التي تقدم الدعم المادي و المعنوي			
٣	أتلقى المساعدة النفسية من المؤسسات التي تقدم الإرشاد النفسي			
٤	يوجد مؤسسة واحدة على الأقل و التي تقدم لي المساعدة المادية			
٥	أجد صعوبة كبيرة في الحصول على المساعدة من المؤسسات الاجتماعية و التي تقدم مساعدات للأسر المحتاجة للمساعدة مثل أسرتي			

Annex No.(18)

مقياس التقييم الشخصي للأسرة اثناء الأزمات(F-COPES)

ترجمة د. عبد العزيز ثابت

عزيزي /تي يوجد أدناه قائمة تصف سلوك واتجاهات الأفراد نحو حل المشكلات أو الصعوبات ، أختار واحدة من الأرقام التي تصف وضعك فمثلا: إذا كانت تنطبق عليك عبارة تماماً فاختيار رقم ٥ وهذا يعني أنك توافق بشده ، وإذا كانت عبارة لم تنطبق عليك فاختار رقم ١ وهذا يعني انك غير موافق بشده ، وإذا كانت العبارة تصف استجابتك ببعض الموافقة فاختار ٢ أو ٣ أو ٤ وذلك للدلالة على مدى موافقتك أو عدم موافقتك على العبارة. عندما تواجه الأسرة مشكلات أو صعوبات فأننا نقوم بالتالي:

الرقم	الدعم الأسري	لا أوافق بشدة (١)	لا أوافق (٢)	لا اعرف (٣)	موافق (٤)	موافق بشدة (٥)
١	يشاركنا أقاربنا بالصعوبات					
٢	يقوم أصدقائنا بتقديم الدعم و النصيحة					
٣	نعرف أن لدينا القوة لحل المشكلات العامة					
٤	يقدم لنا أفراد من اسر واجهوا مشكلات متشابهة الدعم والنصيحة					
٥	يقدم لنا الأقارب مثل (الأجداد) النصيحة					
٦	تقدم لنا المؤسسات المتخصصة في مساعدة الأسر المساعدة المادية والمعنوية					
٧	نعرف ان لدينا المقدرة لحل مشكلاتنا					
٨	نتلقى الهدايا والمساعدة من الجيران مثل الطعام والملابس..					
٩	نطلب النصيحة والمعلومات من طبيب العيادة					
١٠	يقدم لنا الجيران المساعدة					
١١	نواجه المشكلات ونحاول ايجاد حلول لها فوراً					
١٢	نشاهد التليفزيون					
١٣	نظهر اننا أقوياء					
١٤	نحضر الندوات الدينية					
١٥	نتقبل الأحداث الضاغطة كحقيقة في الحياة					
١٦	يشاركنا أصدقائنا المقربين فيما يقلقنا					
١٧	يلعب الحظ دور بما سنفعله لحل مشاكلنا العائلية					
٢٨	نمارس تمارين رياضية مع الأصدقاء لتقليل التوتر					
١٩	نقبل بأن هذه المشاكل يمكن أن تحدث بدون توقع					
٢٠	يشاركنا أقاربنا في نشاطات مفيدة(جلسات عائلية، و دعوتهم للعشاء)					
٢١	يقدم لنا متخصصين في الإرشاد النفسي للعائلات المساعدة و الإرشاد					
٢٢	نؤمن بأننا يمكن أن نحل مشاكلنا بأنفسنا					
٢٣	نشارك في ندوات دينية					
٢٤	نضع المشكلة العائلية في إطار ايجابي حتى لا نصاب بالإحباط					
٢٥	نسأل الاقارب عما يشعروا به تجاه المشكلة					
٢٦	نشعر بأنه من المهم عمل احتياطات لتجنب المشاكل و إلا فأننا سوف نواجه صعوبات في حل المشاكل					
٢٧	نطلب النصيحة من رجال دين (شيخ، رجل إصلاح)					
٢٨	نؤمن بأننا إذا انتظرنا وقتا كافياً فإن المشكلة ستنتهي لوحدها					
٢٩	نشارك مشكلتنا مع جيراننا					
٣٠	نؤمن بأن هذه إرادة الله					

Annex No.(19)

Gaza Strip map

Annex No.(20)

ملخص باللغة العربية

عنوان الدراسة: اضطراب كرب ما بعد الصدمة الناتج عن الحرب والدعم الأسري والاجتماعي، لدى المراهقين في قطاع غزة.

- **اعداد: نيفين أحمد الشيخ**
- **اشراف : د. عبد العزيز ثابت**

هدفت الدراسة للكشف عن العلاقة ما بين كرب ما بعد الصدمة والدعم الاسري والاجتماعي، لدى المراهقين في قطاع غزة، تكونت عينة الدراسة من ٤٠٠ مراهق (٢٠٠ ذكور و ٢٠٠ اناث)، من محافظات قطاع غزة الخمس، وتتراوح أعمارهم ما بين ١٣- ١٨ سنة.

استخدمت الدراسة التحليل الوصفي، نظام الطبقية، واستخدمت أربعة مقاييس: قائمة الخبرات الصادمة للحرب على غزة، مقياس كرب ما بعد الصدمة للمراهقين، مقياس الدعم الاجتماعي، ومقياس التقييم الشخصي للأسرة أثناء الأزمات، وأيضا استخدمت استبيان البيانات الديمغرافية.

وجدت الدراسة أن متوسط الخبرات الصادمة ١٢,١٩، وهناك علاقة بين الخبرات الصادمة والجنس لصالح المراهقين الذكور، وهناك علاقة بين الخبرات الصادمة والعمر، وأيضا أظهرت عدم وجود علاقة بين الخبرات الصادمة ونوع المدرسة ، ومكان السكن و الدخل الشهري للأسرة.

وأظهرت الدراسة أن ١٣٣ (٣٣,٣%) من المراهقين لم تظهر عندهم أي أعراض كرب ما بعد الصدمة، ١٣٠(٣٢,٥%) لديهم على الأقل عرض واحد، ١٠٠(٢٥%) من العينة أظهرت كرب ما بعد الصدمة بشكل جزئي، بينما ٣٧(٩,٣%) من المراهقين انطبق عليهم التشخيص الكلي لكرب ما بعد الصدمة، وأظهرت الدراسة أن هناك علاقة بين مقياس اضطراب كرب ما بعد الصدمة والجنس لصالح الذكور، وأنه لا يوجد علاقة مع العمر ونوع المدرسة ومكان السكن وعدد أفراد الأسرة ، وبين الدخل الشهري للأسرة.

وأيضا أظهرت النتائج أن متوسط مجموع مقياس الدعم الاجتماعي ٨٣. وأظهرت النتائج أنه يوجد علاقة بين الدعم الاجتماعي والعمر، بينما لا يوجد علاقة بين الدعم الاجتماعي والجنس، ونوع المدرسة ، ومكان السكن ، وعدد أفراد الأسرة، وبين الدخل الشهري للأسرة.

وأظهرت النتائج أن متوسط الدعم الأسري ٣,٢٤، وأن هناك علاقة بين الدعم الأسري والعمر، ونوع المدرسة ومكان السكن ، بينما لا يوجد علاقة بين الدعم الأسري والجنس، وعدد أفراد الأسرة وبين الدخل الشهري للأسرة.

وأظهرت النتائج وجود علاقة ذات دلالة احصائية بين الخبرات الصادمة واضطراب كرب ما بعد الصدمة والدعم الأسري، بينما وجود علاقة سلبية بين الخبرات الصادمة والدعم الاجتماعي، ووجود علاقة بين اضطراب كرب ما بعد الصدمة والدعم الاجتماعي والاسري، وأظهرت النتائج وجود علاقة بين الدعم الأسري والاجتماعي. الخلاصة: النتائج تؤكد على أهمية تقييم اضطراب كرب ما بعد الصدمة في المدارس.