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The Effect of Family and Social Support on Posttraumatic Stress Disorder among Secondary School Students in Gaza Strip

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The Effect of Family and Social Support on Posttraumatic Stress Disorder among Secondary School Students in Gaza Strip

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بِسْمِ اللَّهِ الرَّحْمَٰنِ الرَّحِيمِ

يَا أَيُّهَا النَّاسُ اتَّقُواْ رَبَّكُمُ الَّذِي خَلَقَكُم مِّن نَّفْسٍ وَاحِدَةٍ وَخَلَقَ مِنْهَا زَوْجَهَا وَبَثَّ مِنْهُمَا رِجَالاً كَثِيرًا وَنِسَاء وَاتَّقُواْ اللَّهَ الَّذِي تَسَاءَلُونَ بِهِ وَالأَرْحَامَ إِنَّ اللَّهَ كَانَ عَلَيْكُمْ رَقِيبًا

النساء (1)

Dedication

I dedicate this work

To the pure souls of Gaza, war martyrs who were martyred in defense of the nation dignity

To all injured in Palestine.

To my beloved mother, who taught me how to be patient.

To my generous father, who supported me .

To my beloved wife who encouraged me.

To all my sisters especially Esraa, and Asmaa who help me in this work

To my lovely daughters ,Aseel….,Lamis….,Alma….,Meriam….,and…. Saba,

To my brothers,

Without their help, encouragement, and patience I will not complete this work.

Declaration

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

Alaaeddin S. Al Kurd

Signed ……

Date:

Acknowledgment

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Abstract

The study was performed to identify the effect of family and social support on posttraumatic stress disorder 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 10^{th}, 11^{th} , and 12^{th} 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 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%) and the most traumatic event was See injured and the remains of the martyrs in the television(96%) " While the trauma symptoms occur with the study sample (51.07%) .

The most symptoms were appearing of PTSD in the study sample was "being upset by something which reminded (67.24%). The level of social support equals (74.27 %).

On the other hand, the family support equals (76.41%),

There are no significant differences in all scales due to sex. However, the difference in Gaza Traumatic events checklist and the difference in female's favor. There are no significant differences in all scales due to Place of residence governorate; there is no significant difference at in all scales due to the amount of monthly home income.

The correlations, between each scale were there is a positive significant correlation between (Gaza Traumatic events checklist, and The Davidson Trauma Scale, 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).

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Least of abbreviation

ASD: Acute Stress Disorder

APA: American Psychiatric Association

C-PTSD: Complex Post Traumatic stress disorder

DSM IV and III: Diagnostic statistical and manual for mental disorders edition 4,3

DTS: Davidson Trauma Scale

ESK: Event-Specific Knowledge

F COPES: Family Crises Oriented Personal Evaluation Scale

GAS: General Adaptive Syndrome

GCMHP: Gaza Community Mental Health Program

GTEC: Gaza Traumatic Event Checklist

ICD: International Classification of Diseases

LSD: Lees Square Deference

PCBS: Palestinian Central Bureau of Statistics

PCOH: Palestinian Council of Health

PRCS: Palestinian Red Crescent Association

PTSD: Post Traumatic Stress Disorder

RHA: Refugee Health Assessment

SAM: Situationally Accessible Memory

SPSS: Statistical Package for The Social Sciences

SSS: Social Support Scale

UNRWA: United Nations Relief Work Agency

VAM: Verbally Accessible Memory

WHO: World Health Organization

Chapter I

1.1 Introduction

Posttraumatic stress disorder (PTSD) is one of the most common disorders seen by mental health workers around the world. Posttraumatic stress disorder affects children more than others, and produces many symptoms that indicate impairment in their ability to sleep well, to play, or to do school function. Posttraumatic stress disorders need immediate intervention in order to inhibit the bad consequences of the disorder. For many centuries, there has been some awareness that comes after experiencing an extreme event.
A person may develop a range of symptoms, which are not linked to any clearly defined somatic pathology. Although, it was not existed until the early nineteenth century, such reactions became the subject of professional medical interest and hence systematic studies. (Thabet et al 2004)

Palestinians are at high risk of exposure to traumatic events that have the capacity to produce traumatic stress reactions. Consequently, mental health practitioners and scholars have become increasingly interested in the psychological study of trauma, mainly post-traumatic stress disorder (PTSD) (Afana, Dalgard, Bjertness, Grunfeld, & Hauff, 2002; El Sarraj, Punamaki, Salmi, & Summerfield, 1996; Khamis, 1993, 2000 Thabet, Abed, & Vostanis, 2002, Thabet & Vostanis, 2000). More specifically, Khamis (1993) has investigated PTSD among Palestinian males who sustained serious bodily injuries during the Intifada, the Palestinian popular uprising in the Israeli-occupied the West Bank and the Gaza Strip that started in December 1987. The results indicated that the level of PTSD found is markedly high. However, there are no significant differences for demographic, situational, and trauma-related variables except for age. PTSD among adolescents is significantly higher than among adults. It is speculate that the injury itself is so intensely overwhelming while the other variables are overshadowed. On the other hand, researchers have investigated patients attending primary health care centers in the Gaza Strip (Afana et al., 2002). The prevalence of PTSD was found to be 29% whereas it was 36% in patients who were exposed to traumatic events. In addition, the results indicated that PTSD is more likely associated with the female gender as well as with those who had lesser educational attainment. Differences in PTSD symptoms among Male Palestinian political ex-prisoners

from the Gaza Strip have been found with respect to the degree of exposure to torture, to family and to economic difficulties (El Sarraj et al., 1996).

Lack of social support constitutes a major risk factor for psychopathology. These results suggest that social support may serve as a buffer during and after trauma. Moreover, children with more social support will have less Parents' support, which has been especially cited as the most important source of social support. Then, teachers' support can affects children coping through factors, such as, modeling, promoting adaptive, or coping psychological distress afterwards. (Pine &Cohen, 2002). Social support may also help to moderate the degree and severity of stressful reactions to trauma (Fremont, 2004) Also, it influences positively those affected by acting as a safeguard against imminent stressors (Green, Streeter, & Pomeroy, 2005). In a study of Palestinian families in the West Bank, Garbarino and Kostelny (1996) found that family functioning is critical in explaining the degree of PTSD experienced by children. Williams (2006) proposed interventions for enhancing coping mechanisms, stressing the importance of community in generating resilience among children. In his study regarding family stress and the psychological consequences, Sattler (2006) concurred with the assertion that social support is fundamental in ameliorating the impact of trauma. Intervention programs, emergency evacuation plans, informal community groups and recovery programs are all forms of social support that thought to reduce distress and restore feelings of control.

1.2 Study justification

When the researcher was working in the psychiatric mental health hospital, a new clinic of child psychiatry was opened. Thus, many families visit it to reassure about their children symptoms of restlessness, insomnia, nightmares and other symptoms. In fact, most of their complaints are from posttraumatic stress symptoms. We ask the families about their intervention with these symptoms, but a lot of them do not know how to deal with those symptoms. In addition, they do not know the important of the family members and the community in solving these problems and decreasing the trauma symptoms. Therefore, the researcher decided to make a research about the family and social support and how they affect (PTSD). In addition, when reviewing the articles and literature the researcher found that there are not many studies about this type of study, the social and family support together.

1.3 Research objectives

1.3.1 Main objective

To assess the effect of social and family support on the PTSD symptoms in children in Gaza Strip.

1.3.2 Specific objectives

1.3.2.1 To identify the level of social support among secondary school students in Gaza Strip.

1.3.2.2 To identify the level of family support among secondary school students in Gaza Strip**.**

135.2.3 To detect the most common traumatic events experienced by the secondary school students in Gaza Strip.

1.3.2.4 To explore the factors that possibly moderates the effects of PTS.

1.4 Research Questions

1.4.1 To identify what is the relationship among social and family support and the PTSD symptoms in children in Gaza strip?

Are there colorations between social support, family support and (PTSD)?

1.4.2 What is the level of social support among secondary school students in Gaza strip**?**

1.4.3 What is the level of family support among secondary school students in Gaza strip**?**

1.4.4 What are most common traumatic events experienced by the secondary school students in Gaza strip**?**

1.4.5 What are factors that possibly moderate the effects of PTSD?

1.4.6 Does the family and social support influence the PTSD symptoms?

1.4.7 What types of traumatic events are most likely to be associated with the development of PTSD?

1.5 Background

1.5.1 The Gaza Strip

The Gaza Strip is a narrow elongated piece of land, bordering on the Mediterranean Sea between Israel and Egypt, and covers 378 km2. It has high population density. There is high unemployment, socio-economic deprivation, and family overcrowding. Nearly two-thirds of the population are refugees, with approximately 55% living in eight crowded refugee camps. The remainder lives in villages and towns, the population is about 1.6 million people, as of July 2010, most of them descendants of refugee (PCBS, 2007).
Although the vast majority of them were actually born in Gaza Strip, the older generation fled to Gaza in 1948 as part of the Palestinian Nakba following the Israeli occupation. Israeli occupation has controlled the Gaza Strip since June 1967, after the six-day war. During the period of Israeli control, Israeli occupation created 21 settlements comprising 20% of the total territory. In September 1st, 2005, Israeli occupation removed the settlements and settlers from the Gaza Strip as part of Israel's unilateral disengagement plan, but maintains control of Gaza's airspace and territorial waters. In addition, they posed the siege on Gaza, so they do not allow any movement of people or goods in or out of Gaza via air or sea. On December 2008, the Israeli occupation forces conducted sudden and intensive air strikes on Gaza Strip. The operation continued for 23 days the blockade of The Gaza strip continued after the end of the war until now (PCBS, 2007).

In 27th of December 2008, the Israeli Forces launched large-scale air strikes on the Gaza Strip. After nearly three weeks of daily bombardment, air strikes and ground troop incursions by Israeli forces into Gaza, over 1,200 individuals from Gaza died. Hundreds of homes in Gaza have been destroyed, and many more have suffered damage. Internal displacement is high, with more than 90,000 individuals displaced. More than 40,000 Palestinians resided in UNRWA shelters while an estimated 50,000 resided with family and friends (OCHA, 2009).

1.6 Schools

1.6.1 Schools according to stage.

The number of propriety schools in Gaza strip is (260) with percentage of (66%) from all governmental schools in the Gaza strip, and the secondary schools are (134) with percentage of (34%) from all governmental schools in the Gaza strip.

1.7 Operational definition

1.7.1 Study variables

Dependent variable: posttraumatic stress disorder (PTSD).

Independent variables; are social and family support.

1.7.2 Post traumatic stress disorder:

(PTSD) is a disorder that develops after a person sees, involves in, or hears of an extreme, sudden, un-expected, un-avoidable traumatic event. The person reacts to this experience with intense fear, horror or helplessness, persistently relives the event, and tries to avoid being reminded of it **(**APA 1994)**.**

1.7.3 Social support:

Social support is usually denned as the existence or availability of people on whom we can rely on, people who let us know that they care about, value, and love us. Bowl by's theory of attachment (1969, 1973, 1980)

1.7.4 Family support:

Ensure that families are able to meet their needs and overcome stressors that impair effective parenting. By helping families to provide a nurturing environment, family support services play a critical role in fostering the healthy development and school readiness of

young children. Additionally, family support is seen as a crucial early intervention strategy for children who are at risk (Hawley Dale R. & DeHaan Laura 2004).

1.8 Chapter outline

This study consists of five chapters.

Chapter one served as an introduction to the study and provided the background to the Research aims, problem, objectives, and study questions.

Chapter 2 presents the theoretical framework and a review of relevant literature that is related to the study subject, which collected from scientific researches, published magazine, and other scientific ways.

Chapter three focuses on the research design and methodology employed. It also includes a discussion of the research instrument, and motivation of its use and details on sampling, data collection process and procedures, data analysis.

Chapter four presents the research results and its table.

In chapter five the results are related to the literature review and discussed in Terms of the research aims. Finely, the conclusions and recommendations for further research will be provided.

Chapter II

Theoretical framework and Literature review

2.1 Post traumatic stress disorder (PTSD)

2.1.1 Introduction

Since the beginning of Al Aqsa Intifada, children and adolescence have been exposed to various traumatic events, often reported by media across the world, particular events experienced. For example, bombardment of homes and military quarters, shooting, killing, arresting etc. After the exposure to traumatic events, Local and international psychiatric associations had published a lot of literatures and research talking about the stressful situation and posttraumatic stress disorders (PTSD). Mental health professional show increasing concern about developmental risks for adolescents who fall victim to political violence and war (Thabet et al, 2008)

2.1.2 Definition of (PTSD)

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

Internationally, the international classification of diseases (ICD), had recognized two reactions stress; an acute reaction to stress, which was transient, lasting only a few hours or days; and an adjustment reaction, which lasted slightly longer, in the tenth revision of ICD in (1992). World health organization (WHO), defined posttraumatic stress disorder along similar lines to the American DSM, albeit placing slightly different emphases on some of the symptoms. Posttraumatic stress disorder develops in persons who have experienced emotional or physical stress that would be extremely traumatic for virtually any person

such traumas include combat experience, natural catastrophes assault, rape, and disasters, such as building firs (Thabet 1996).

PTSD is a disorder that develops after a person sees, involves in, and hears of an extreme, sudden, un-expected, and un-avoidable traumatic event. The person reacts to this experience with intense fear, horror or helplessness, persistently relives the event, and tries to avoid being reminded of it.

To make the diagnosis, the symptoms must last for more than a month after the event and must significantly affect important areas of daily life such as family and work. The text revision of the fourth edition of Diagnostic and Statistical Manual Disorders (DSM-IV-TR) defines a disorder that is similar to PTSD called acute stress disorder (ASD), called by the ICD10 a cute stress reaction, which occurs earlier than PTSD (within 4weeks of the event and remits within 2 days to 4 weeks. If symptoms persist after the time, a diagnosis of PTSD is warranted. The events causing both ASD and PTSD are overwhelming enough to affect almost anyone. They can arise from natural or man made events like natural catastrophes, war, imprisonment, torture, assault, rape, and serious accidents. Persons re-experience the traumatic event in their dreams and their daily thoughts, they are determined to avoid anything that would bring the event to mind, and they undergo a numbing of responsiveness along with a state of hyper-arousal. Other associated symptoms are depression and cognitive difficulties such as poor concentration. Definitions of posttraumatic stress disorder according to (DSM - IV), is an event that is outside the range of usual human**.** Posttraumatic stress disorder is also associated with impairment of the person's ability to function in social or family life, including occupational instability, marital problems and divorces, family discord, and difficulties in parenting. Along with associated symptoms, there are a number of psychiatric disorders that are commonly found in and adolescents who have been traumatized. One commonly co-occurring disorder is major depression. Other disorders include substance abuse and other anxiety disorders such as separation anxiety, panic disorder, and generalized anxiety disorder; and externalizing disorders, such as attention deficit hyperactivity disorder, oppositional defiant disorder, and conduct disorder (Goldstein, 1995).

2.1.3 History of posttraumatic stress disorder

Much has been written about the impact of PTSD since it was first included in The Diagnostic and Statistical Manual of Mental Disorders in 1980. According to the psychiatrist Bessel Vander Kolk, a leading authority in this field, it is the second most commonly diagnosed psychiatric disorder. He has emphasized the way early trauma leads to cognitive impairment, behavioral reenactments, psychiatric illness, and loss of neuromodulation. Additionally, he has stated that one cannot overestimate the degree to which trauma warps character, (Kolk 1992). PTSD is a psychiatric disorder that occurs following the experience or witnessing, exposed to life threatening events. Such as, military combat, natural disaster, terrorist accident, and violent person assault like rape. people who suffer from PTSD often relive the experience through nightmares and flashbacks ,have difficulty sleeping and feel detached or estranged ,and these symptoms can be sever enough and last long enough to significantly impair the person's daily life (Berliner ,1997). PSTD is complicated by the fact that it frequently is co morbid with other disorders such as depression, substance abuse, anxiety, and other problems of physical and mental health. Posttraumatic stress disorder is associated with impairment of the person's ability to function in social or family life, including occupational instability, marital problems and divorces, family discord, and difficulties in parenting (Kulka et al, 1990).

2.1.4 Development of PSTD

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

2.1.5 People at risk

When an individual is exposed to life threatening traumatic event or circumstances, which are out of his usual range, he becomes victims of these events. In addition, it might develop psychological problems that might change his life. Those individuals could be as the following:

-Those that experience greater stressors magnitude and intensity, victimization, real or perceived responsibility, and betrayal.

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

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

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

2.1.6 Consequences of PTSD

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

Psych physiological alterations associated with PTSD include hyper-arousal of the sympathetic nervous system, increased sensitivity of startle reflex, and sleep abnormalities. People with PTSD tend to have abnormal levels of key hormones involved in the body's response to stress. Thyroid function also seems to be enhanced in people with PTSD. Some studies have shown that cortical levels in those with PTSD are lower than normal and epinephrine and nor epinephrine levels are higher than normal. People with PTSD also continue to produce higher than normal levels of natural opiates after the trauma has passed.

An important finding is that the neurohormonal changes seen in PTSD are distinct from, and actually opposite to, those seen in major depression. The distinctive profile associated with PTSD is seen in individuals who have both PTSD and depression, (Sack et al, 1993).

2.1.7 Categorizing of PTSD

After the exposure to unusual traumatic event, the reactions of posttraumatic stress disorder are started to arise on the victim. Four main groups of behaviors and attitude that are expressed by the victims manifest it. These groups of symptoms are as the following:

2.1.7.1 Reexperiencing symptoms

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

2.1.7.2 Avoidance symptoms.

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

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

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

2.1.7.3 Hyperarousal symptoms

Individuals with PTSD often act as though they were constantly threatened the trauma that caused their illness (Long, 1997). These symptoms most closely resemble those seen panic and generalized anxiety disorder. Although some symptoms such as irritability are generic anxiety symptoms, hypervigilance and startle are unique; the hypervigilance in PTSD may sometimes become so intense that it simply appears to be paranoia. The startle reaction of PTSD patients also has neurobiological implications for more on the neurobiological causation of PTSD (Friedman, 1996).

2.1.8 Associated features

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

2.1.9 PTSD in children and adolescent

PTSD is alarmingly high among school-age children. Clearly, there is an urgent need for policies aimed at identifying, preventing and treating childhood PTSD in schools. The most important thing is that there is an urgent need for the inclusion of professional screening and diagnostic procedures in schools. As a result, there is a need for well-trained mental health professionals, who are capable of identifying childhood disorders, and offering alternative strategies for early intervention and effective prevention,
(Khamis 2005).
There has been little study on the psychological sequel in children and adolescents. The Palestine Red Crescent Society estimates that during the period of Al-Aqsa intifada from

September 29, 2000, to April 30, 2007, Palestinians suffered more than 31,531 injuries of which many were injuries in children (PRCS, 2007).

PTSD occurs in children and adolescents but most studies of the disorder have focused on adults. DSM-IV-TR has a little to say about PTSD in young children except to describe symptoms; such as, repetitive dreams of the event, nightmares of monsters, and the development of physical symptoms such as stomachaches and headaches. The prevalence of PTSD is higher in children than in adults exposed to the same stressor. In certain situation, as war like situations, up to 90% of children will develop the disorder. Children in Palestinian Authority are living in war like situations, and they are exposing to continuous traumatic experiences. One study conducted by GCMHP showed that 32.4% of the Palestinian children living under severe conditions during the last years of the Al-Aqsa Intifada started to develop acute PTSD symptoms, while 44.4% of them suffered from moderate level of PTSD symptoms. Child risk factors include demographic factors (e.g., age, sex, socioeconomic status), other life events (positive and negative), social and culture cognitions, psychiatric co morbidity, and inherent coping strategies.

As in situations of disaster, war, or community violence, children, like adults, re experience the traumatic event in the form of distressing, intrusive thoughts or memories, flashbacks, and dreams. Children's nightmares may be link specifically to a trauma theme without details or may generalize to other fears. Flashbacks occur in children as well as in their adolescent or adult victim counterparts. Traumatic play, a specific form of re experiencing seen in young children, consists of repetitive acting out of the trauma or trauma-related themes in play. Older children may incorporate aspects of the trauma into their lives in a process termed reenactment. Fantasized actions of intervention or revenge are common; adolescent should be considered at increased risk for impulsive acting out secondary to anger and revenge fantasies. Related behaviors in child and adolescent victims of trauma include sexual acting out, substance use, and delinquency. Children often withdraw and show reduced interest in previously enjoyable activities. Habits like thumb sucking and nail biting and other regressive behaviors such as enuresis or fear of sleeping alone may occur. Virtually any person such traumas include combat experience, natural catastrophes, assault rape, and disasters such as building firs, (Thabet, 1996).

Trauma can be a formative, developmental influence in the ontogenesis of emotional, cognitive, arousal, and interpersonal systems (Pynoos, Steinberg, & Piacentini, 1999).

It is estimated that as many as 25% of all children experience a traumatic event by the age of 16 (Costello, Erkanli, Fairbank, & Angold, 2002).

Many children survive trauma, adaptively integrating the experience and developing normally (Pynoos et al., 1999; Yule, 2001). However, for some, post trauma Symptomatology reaches clinical levels manifesting a constellation of potentially life-disrupting and learning-impairing symptoms (Perry, 1999).

Between groups that constitute potential confounding variables and can distort research findings. For example, in a study that investigated PTSD reactions in children who had experienced war trauma (Thabet & Vostanis, 2000),

Few studies have investigated school age children in non-traumatic situations (Berna & Hyman, 1993; Motta, 1994), and as a result, the prevalence of PTSD in these children is unknown. Estimates of the prevalence rates of PTSD have varied from 2% in school—age children (Berna & Hyman, 1993) to 50% in children who have experienced war atrocities (Anthony, 1986). The discrepancy in these results may be attributed to the magnitude and severity of the stressors (Khamis, 1993; March, 1993; Pynoos, 1990). Many stressors have been identified as producing childhood PTSD, including child abuse (i.e., physical and sexual) in the family of origin (Bremner, Southwick, Johnson, Yehuda, &Charney, 1993; McCormack, Burgess, & Hartman, 1988).

In addition, it was hypothesized that children who exhibited PTSD symptoms would be more likely to report higher levels of anxiety in home environment, psychological maltreatment, gender inequities, harsh disciplining, and lower levels of parental support (Vivian Khamis 2002). Moreover, in a study to al Saraj and Quta of the prevalence of PTSD and other psychological suffering among Palestinian children living under sever condition during last tow and half years of Al Aqua Intifada. The results indicate that 32.7% of children started to develop acute PTSD symptoms that need psychological intervention while 49.2%of them suffered from moderate level of PTSD symptoms. Also, the results showed that the most prevalent types of trauma exposure fore children are for those who have witnessed funerals 94.6%, witnessed shooting 83.2%, saw injured or did who are not relatives 66.9% and saw family members who injured or killed 61.6% (Quta & al Saraj 2004). Posttraumatic stress disorder is associated with impairment of the person's ability to function in social or family life, including occupational instability, family discord, and difficulties in parenting. Since family, social cohesion and social support network decrease the dramatization level in an individual.

We have assumed that low perception of social support would result in development of posttraumatic symptoms. Especially, if there is a lack of family support. Social support and family is one of the most important protective factors for coping with trauma. Two recent 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, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003).

2.1.10 Theories of PTSD

2.1.10.1 Early Theory of trauma

2.1.10.1.1 Stress response theory Horowitz (1976, 1986)

In his theory Horowitz argued that when faced with trauma, people's initial
Response is outcry at the realization of the trauma. A second response is to try to assimilate the new trauma information with prior knowledge. At this point, many individuals experience a period of information overload during which they are unable to match their thoughts and memories of the trauma with the way that they represented meaning before the trauma. In response to this tension, psychological defense mechanisms are brought into play to avoid memories of the trauma and pace the extent to which is recalled. For example, the individual may be in denial about the trauma, feel numb, or avoid reminders of it. However, the fundamental psychological need to reconcile new and old information means that trauma memories will actively break into consciousness in the form of intrusions, flashbacks, and nightmares. These consciously experienced trauma memories provide the individual with an opportunity to try to reconcile them with pre trauma representations. It becomes apparent that, according to Horowitz, there are now two opposing processes at work: One to defend the individual by the suppression of trauma information, and the other to promote the working through of the traumatic material by bringing it to mind (e.g., Brewin, in press; Litz, 1992).

2.1.10.1.2 Theory of shattered assumptions

Although, the origins of this social-cognitive model also lie in the tradition of individual internal models or assumptive worlds and may be illusory, they help to sustain people in

their everyday lives and motivate them to overcome difficulties and plan. 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. When we have been obeying the rules of the road, and putting our own survival ahead of anything else when our life is threatened and all situations that have the potential to be traumatic. Thus, 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 experiencing and avoidance cycle described by (Horowitz 1986). 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. Although the research cited earlier has confirmed the importance of the basic assumptions described by Janoff-Bulman, other assumptions may be even more fundamental. Bolton and Hill (1996) proposed that for people to act in the world, they must have a set of beliefs that the self is sufficiently competent to act, that the world is sufficiently predictable, and that the world provides sufficient satisfaction of needs. Traumatic incidents are highly unpredictable and unpleasant and produce feelings of intense helplessness, thereby challenging these beliefs. Bolton and Hill suggest that in some cases, this produces intense conflict and feelings of unreality, since the experience of the trauma appears to contradict the person's core beliefs, but according to those beliefs, the experience cannot really have happened.

In fact, as several commentators have noted (e.g., Resick, 2001). The exact opposite is the case, with experience of previous trauma being a major risk factor for developing PTSD (Brewin et al., 2000).

2.1.10.1.3 Conditioning theory

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 arouses fear. Keane, Zimering, and Caddell (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 him or herself 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. In their application of conditioning theory to combat veterans, Keane et al. made further suggestions about the origin of specific symptoms. For example, they proposed that amnesia for aspects of the trauma could be due to avoidance of thinking or talking about it, as well as to being in a different mood state at recall than at the time of the trauma. Anger and irritability might reflect behaviors acquired during military training and reinforced during civilian life by the attainment of desired goals or a reduction in anxiety. More recent study by Orr et al. (2000) has shown that people with PTSD develop conditioned responses more readily to aversive events in general and that these responses are harder to extinguish. Although this could be a result of PTSD, it may also reflect genetic or acquired pre-trauma differences in condition ability. However, the conditioning approach does not clearly distinguish the etiology of PTSD from that of other anxiety disorders; it provides a powerful explanation of many prominent features of PTSD. Especially, the wide range of potential trauma reminders, physiological and emotional arousal elicited by these reminders, and the central role of avoidance in the maintenance of PTSD (Pitman, Shalev, & Orr, 2000).

2.1.10.1.4 Information-processing theories

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 (Chemtob, Roitblat, Hamada, Carlson, & Twentyman, 1988; Creamer, Burgess, &

Pattison, 1992; Foa, Steketee, & Rothbaum, 1989; Litz & Keane, 1989). The central idea is that there is something special about the way the traumatic event represented in memory. Thus, 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 attributed more to characteristics of the trauma memory itself than to conflict with preexisting beliefs and assumptions. According to Foa et al. (1989), PTSD reactions tend to persist when achieving exposure of sufficient length to all the various elements in the fear network is difficult. Under these circumstances, only some associations are weakened, leaving other elements of the fear network to continue being strongly associated with fear. This might come about because excessive arousal or thinking errors might interfere with attention to and integration of disconfirms Tory evidence, and because there might be a strong tendency to avoid reexposure to trauma cues. The strength of the various fear network models has been that they provided much clearer proposals about how, and what kind of cognitive architecture to use. Information about a traumatic event is processed, both at the time and afterwards. They offered adequate explanations of attention and memory processes, and vulnerability produced by the overturning of assumptions. Most importantly, they led to the development of highly successful, theoretically grounded treatment interventions. Among the limitations of the early fear network models is their difficulty in explaining how a memory can produce rapid responses such as flashbacks and physiological arousal. However, at the same time it is disorganized and contains gaps. They did not distinguish between flashbacks and ordinary trauma memories, or account for the wide range of other post trauma emotions and beliefs that are implicated in risk for PTSD. In addition, those memories can be activated and altered by the addition of contradictory information. It was inconsistent with a new understanding of fear conditioning arising from animal studies. Several lines of research suggested are more plausible that old memories remain intact and that fear reactions are inhibited by the creation of new memories (Bouton & Swartzentruber, 1991; Jacobs & Nadel, 1985; Ledoux, 1998).

2.1.10.1.4.5 Anxious apprehension model

Jones and Barlow (1990) argued that variables implicated in the etiology and maintenance of panic disorder is 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 and are hyperactive vigilant 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 hyperactive arousal 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 reexperiencing symptoms. To prevent the triggering of alarms, the person will tend to avoid emotional interceptive information. For example, through emotional numbing, as well as avoid external trauma-related stimuli. Jones and Barlow 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 (Bryant & Panasetis, 2001; Falsetti & Resnick, 1997; Nixon, Resick, & Griffin, in press).

Relatedly, Ehlers, Hackman et al. (2002) have proposed that the content of intrusive memories corresponds to moments that act as warning signals for the traumatic event. While Jones and Barlow's theory draws attention to a potentially important but neglected aspect of PTSD, it does not discuss in detail the role and variety of cognitions and emotions arising from the consequences of the event.

2.1.10.2 Recent theories

2.1.10.2.1 Emotional processing theory

Foa and Riggs (1993), Foa, and Rothbaum (1998) have elaborated the earlier network theory of Foa et al. (1989) 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, during, 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. This 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 (see also Dalgleish, 1999). Another development was an increased emphasis on negative appraisals of responses and behaviors, which could exacerbate perceptions of incompetence. Foa et al. 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. Foa & Rothbaum (1998) also elaborated a number of mechanisms thought to be involved in exposure treatment. First, repeated reliving should promote the habituation of fear, reducing the level of fear associated with other elements in the trauma memory as well as countering the belief that such anxiety is permanent. Second, it prevents avoidance of the trauma memory being negatively reinforced. Third, rehearsing the trauma memory in a therapeutic environment incorporates safety information into the trauma memory. Fourth, the trauma can be better discriminated from other potentially threatening events and seen as a specific case rather than as one among many examples of a dangerous world or an incompetent self. Fifth, exposure offers the possibility to experience the self as showing mastery and courage in the face of challenge. Sixth, by reflecting on events in detail, patients may reject previous negative evaluations as being inconsistent with the evidence. Seventh, the severity of the event frequently disrupts the cognitive processes of attention and memory at the time of the trauma and produces dissocialize states such as out-of-body experiences. This disruption leads to the formation of a disjointed and fragmented fear structure that is resistant to modification and to trauma, narratives that are relatively brief, simplistic, and poorly articulated. Repeated reliving generates a more organized memory record that is easier to integrate with the rest of the memory system. To sum up, exposure is thought to have a number of separate effects, some relatively automatic; such as reduction in anxiety and change in memory structures, and others more strategic such as positive reappraisals of actions and events Foa et al. (1989).

2.1.10.2.2 Empirical evidence theory

The treatment method associated with emotional processing theory, prolonged exposure, is well established as a highly effective treatment for PTSD (Foa et al., 1991, 1999). Several studies have investigated whether, as the theory predicts, the successful outcome of exposure treatment is related to the initial activation of fear and to within-session and between-session habituation. Two studies have supported the predicted relationship with initial activation of fear, as measured either by facial expressions (Foa, Riggs, Massie, & Yarczower, 1995) or by increased heart rate (Pitman et al., 1996). Jaycox, Foa, and Morral (1998) reported that initial fear activation was only associated with improvement when it was followed by sustained habituation, and Van Minnen & Hagenaars (2002) did not find a significant association between fear activation and improvement once initial symptom severity was controlled for. Improvement has been shown related to reductions in levels of fear between treatment sessions but not to reductions in fear within sessions (Jaycox et al., 1998; Van Minnen & Hagenaars, 2002).

2.1.10.2.3 Dual representation theory by Brewin (2003)

In contrast to the proposal of fear network theories, a traumatic memory is an ordinary memory that has a particular structure (more response elements, stronger inter-element associations, etc.) is the idea that trauma memories are represented in a fundamentally distinct way (Janet, 1904; Terr, 1990; van der Hart & Horst, 1989; van der Kolk & van der Hart, 1991). These authors suggested that pathological responses (for example, vivid and uncontrollable reexperiencing in the present) arise when trauma memories become dissociated from the ordinary memory system and that recovery involves transforming them into ordinary or narrative memories. However, they have not made clear whether ordinary memories of the traumatic event can exist alongside dissociated memories, and exactly how one form of memory is transformed into another.

One way of understanding this notion of a dissociated memory is to posit that there are two (or more) memory systems and that trauma information is better represented in one system than in the other. Several cognitive psychologists have proposed that there is separate perceptual memory system records information received little, if any, conscious attention. For example, even under ordinary conditions of antinational diversion, people frequently

fail to see highly visible but unexpected objects before their eyes, a phenomenon known as ‘‘intentional blindness’’ (Mack & Rock, 1998).

These unattended objects or items that are not consciously seen in their experiments are nevertheless encoded and analyzed in considerable detail and can unconsciously affect participants’ responses on tests of indirect memory. The findings appear to be very relevant to trauma victims, whose attention tends to be captured by the immediate source of threat and who may report that they simply failed to hear words that were shouted or shots that were fired in close proximity to them. Whereas in some models, the perceptual memory system is unable to support conscious experience (e.g., Tulving & Schacter, 1990), in others, it supports sensory images such as visual scenes (e.g., Brown & Kulik, 1977; Johnson & Multhaup, 1992; Pillemer, 1998). Although perceptual representations are usually thought to be transient or only detectable by indirect probes, it has been suggested that experiencing events with high levels of emotion or importance results in the storage of long-lasting, vivid traces. According to Brewin et al.’s (1996) version of dual representation theory, two memory systems continue to operate in parallel, but one may take precedence over the other at different times. Oral or written narrative memories of a trauma reflect the operation of a' verbally accessible memory’’ (VAM) system, so called to reflect the fact that the trauma memory is integrated with other autobiographical memories and the fact that it can be deliberately retrieved as and when required. Therefore, VAM memories of trauma are represented within a complete personal context comprising past, present, and future.

They contain information the individual has attended to before, during, and after the traumatic event, and that received sufficient conscious processing to be transferred to a long-term memory store in a form that can later be deliberately retrieved. These memories are available for verbal communication with others, but the amount of information they contain is restricted because they only record what has been consciously attended to Diversion of attention to the immediate source of threat and the effects of high levels of arousal greatly restrict the information that can be registered during the event itself. VAM memories register conscious evaluations of the trauma both at the time it is happening and afterwards, as the person considers the consequences and implications of the event, and asks them how it could have been prevented.

Thus, the emotions that accompany VAM memories include both ‘‘primary emotions’’ that happened at the time and ‘‘secondary emotions’’ generated by retrospective cognitive appraisals of those events. In contrast, flashbacks are thought to reflect the operation of a

‘‘situationally accessible Memory’’ (SAM) system, so called to reflect the fact that flashbacks are only ever triggered involuntarily by situational reminders of the trauma (encountered either in the external environment or in the internal environment of a person’s mental processes). The SAM system contains information that has been obtained from more extensive, lower level perceptual processing of the traumatic scene, such as sights and sounds that were too briefly apprehended to receive much conscious attention and hence did not become recorded in the VAM system. The SAM system also stores information about the person’s bodily response to the trauma, such as changes in heart rate, flushing, temperature changes, and pain. This results in flashbacks being more detailed and emotion-laden than ordinary memories.

2.1.10.3 Conclusion on theories of PTSD

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. In addition, have provided important insights, into PTSD. Conditioning theory provides a good account of how trauma cues acquire the ability to elicit fear and of the critical role-played by avoidance, but is limited by the absence of cognitive elements in explaining many of the symptoms and data concerning PTSD, especially those dealing with beliefs and perceived threat. Social-cognitive theories provide good accounts of the range of emotions and beliefs occasioned by trauma and of the process of long-term adjustment, without clearly differentiating between PTSD and other types of reaction such as neither depression, nor do they account for the nature of responses to trauma reminders. An information-processing theory offers clearer descriptions of the cognitive architecture by which the traumatic event may be represented, of effects on attention, and of how the overturning of assumptions increases the number of potential trauma reminders. However, they are less able to account for the importance of emotions other than fear and of beliefs extending beyond issues of danger to the wider social context. All these early theories were restricted by the small amount of published research on trauma, memory, and PTSD available at that time.

There is a high degree of overlap between the three recent models of PTSD reviewed in this article. All of them are able to incorporate a wide range of findings on the importance of factors affecting encoding, alterations in memory functioning, appraisals, coping strategies and cognitive styles, importance of prior beliefs and trauma exposure, and so on. The most important areas where they differ are their accounts of how trauma influences memory, the processes whereby changes are brought about in memory, and how these changes are related to recovery. In addition, memory disturbance and appraisal are treated largely as distinct aspects of PTSD in the two more recent theories than in emotional processing theory. Whereas Foa et al, emotional processing theory relies on the idea of a single associative network in memory, in which all information is represented in the form of propositions (i.e., logical relationships between concepts), both the others have explicitly considered that different types of memory may be involved. In the most recent version of dual representation theory (Brewin, 2001, in press), trauma stimuli receiving insufficient processing to form ordinary autobiographical memories are stored in a separate image-based SAM system where, in the context of trauma reminders. They give rise to intrusive images and physiological responses until their activation is blocked or inhibited by the creation of corresponding VAM representations.

The intrusive images produced by the SAM system consist of repressive, sensory representations, whereas intrusive images produced by the VAM system, like those of emotional processing theory are based on propositional knowledge. In Ehlers and Clark's cognitive theory, there is an autobiographical memory system consisting of higher order themes and personal times as well as more specific event related information. Poor incorporation of the event into the more general part of the autobiographical database is thought to result in a memory that is hard to retrieve intentionally. That is experienced as being without a context, and that is easily triggered by physically similar cues. There is an associative memory system can process preconscious information, prime the individual to respond to trauma reminders, and initiate reexperiencing directly in response to relevant cues. At present, Ehlers and Clark's cognitive model places more emphasis on the way in which stimuli are processed during trauma (i.e., the data-driven versus conceptual distinction) rather than on the specific way in which the output of these processes is represented in memory.

The model of autobiographical memory they employ (Conway & Pleydell-Pearce, 2000) distinguishes general autobiographical knowledge from specific sensory information,

called event-specific knowledge (ESK). To the extent that ESK involves imagery, it may behave in ways similar to Brewin's SAM system. Ehlers and Clark have not yet specified whether all reexperiencing is a product of this autobiographical memory system, of a separate associative memory system, or of both. One possibility that would align their approach more closely with dual representation theory is if ESK was represented in a form of analogue memory system that was specifically concerned with recording images. Although the dual representation, Ehlers, and Clark models are in many ways similar, they make different predictions in some areas. In the latter, data-driven processing during a trauma is a risk factor for developing PTSD.

For dual representation theory, the detailed processing of sensory information is only regarded as harmful if the information is overrepresented in the SAM system relative to the VAM system. Provided the processing is done with full attention and the information is being adequately encoded in the VAM system, no ill effects should ensue. Hippocampus processing in VAM will automatically assign a context, rather than this needing brought about by deliberate conceptual processing. The dual representation approach would suggest that some self-reports of high levels of data-driven processing may reflect a state of mind in which intentional resources are overstretched, leading to disproportionate encoding in the SAM rather than the VAM system. Under these conditions, VAM representations would be inadequate to prevent reexperiencing of the SAM representations in the form of vivid images. Dual representation theory also differs from the emotional processing and Ehlers and Clark models in that it does not assume disorganization or fragmentation in the trauma memory are in themselves risk factors for PTSD. Instead, it proposes that what is critical is to have stimuli that are associated with very high levels of arousal during the trauma represented within the VAM system where they are assigned a context. Memory disorganization may be related to difficulty in deliberately retrieving clear and detailed images of these critical moments in time, but according to dual representation theory, it is the contents of the memory rather than the degree of organization that is the risk factor.

All three theories agree that one of the benefits of reliving is the elaboration and contextualization of the trauma memory, but offer somewhat different explanations for why this process is helpful. Foa and Rothbaum proposed that it enables the trauma memory reintegrated with the rest of the memory network, so that the elements of the trauma memory are equally strongly associated with external elements as with each other. Ehlers and Clark suggested that contextualization sites trauma-related information within periods

and themes in a preexisting autobiographical database, and that this inhibits retrieval of sensory details and physiological responses in response to reminders of the trauma. According to Brewin, contextualization, particularly in time, results in the creation of new VAM memories that are able to prevent the amygdale from responding to trauma reminders. The three theories also differ in their account of how psychological treatment works.

Emotional processing theory emphasizes the importance of incorporating specific types of disconfirm Tory information into the trauma memory, but does not differentiate at a theoretical level between automatic changes in the trauma memory brought about. For example, by exposure and between-session habituation and deliberate changes brought about by cognitive reappraisal. In contrast, the dual representation and Ehlers and Clark models address separately the bringing about of modifications to the trauma memory and changes in problematic appraisals, for example, discussing the circumstances under which it might be helpful for cognitive restructuring to precede exposure work. Ehlers and Clark's focus on memory processes led them additionally to propose that it might be insufficient to carry out cognitive restructuring on its own and that the agreed reappraisals might have incorporated into reliving sessions.

Dual representation theory contains the additional notion that treatment creates new trauma memories that compete with the original representations retrieved by trauma cues; where particular representation is retrieved depends on their accessibility. In addition, it influenced by the match between those cues and information in the memory, by the amount retrieval of the representations has been practiced, and by the distinctiveness of the representations. Grey et al. (2002) applied the theory to explaining why patients might benefit from carrying out cognitive restructuring within reliving sessions. They suggested that this process led to the creation of particularly rich and detailed VAM memories in which positive reappraisals relevant to a variety of negative emotions were associated with a large number of sensory and physiological cues present during the trauma. In the presence of trauma reminders, these more detailed memories would have a retrieval advantage over VAM memories just containing information about the positive appraisals and would be better able to inhibit the activation of corresponding SAM memories.

2.2Family support

2.2.1 Introduction:

For adolescents and children, family support is the most important element in their lives, as part of their growth experience. Adolescents usually expect many 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 (Stice, Ragan, & Randall, 2004).

2.2.2 Definition of family

According to Bowen theory, 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. (Bowen 1978).

Bowen family systems theory is a theory of human behavior that views the family as an emotional unit and uses systems thinking to describe the complex interactions in the unit. It is the nature of a family that its members are intensely connected emotionally. Often people feel distant or disconnected from their families, but this is more feeling than fact. Family members so profoundly affect each other's thoughts, feelings, and actions that it often seems as if people are living under the same "emotional skin." People solicit each other's attention, approval, and support and react to each other's needs, expectations, and distress. The connectedness and reactivity make the functioning of family members interdependent. A change in one person's functioning is predictably followed by reciprocal changes in the functioning of others. Families differ somewhat in the degree of interdependence, but it is always present to some degree. The emotional interdependence presumably evolved to promote the cohesiveness and cooperation families require

protecting, shelter, and feed their members. Heightened tension, however, can intensify the processes that promote unity and teamwork, and this can lead to problems. When family members get anxious, the anxiety can escalate by spreading infectiously among them. As anxiety goes up, the emotional connectedness of family members becomes more stressful than comforting. Eventually, one or more members feel overwhelmed, isolated, or out of control. These people accommodate the most to reduce tension in others. It is a reciprocal interaction. For example, a person takes too much responsibility for the distress of others in relationship to their unrealistic expectations of him. The one accommodating the most literally "absorbs" anxiety and thus is the family member most vulnerable to problems such as depression, alcoholism, affairs, or physical illness. Dr. Murray Bowen, a psychiatrist, originated this theory and its eight interlocking concepts. He formulated the theory by using systems thinking to integrate knowledge of the human species as a product of evolution and knowledge from family research. A core assumption is that an emotional system that evolved over several billion years governs human relationship systems. People have a "thinking brain," language, a complex psychology and culture, but people still do all the ordinary things other forms of life do. The emotional system affects most human activity and is the principal driving force in the development of clinical problems. Knowledge of how the emotional system operates in one's family, work, and social systems reveals new and more effective options for solving problems (Bowen1978).

Greenberg and Keane defined family as mother, father, siblings, aunts, and grandparents. Seven studies reported family living arrangement of the youth (Alderfer et al., 2009; Barakat et al., 1997; Boyer, Ware, et al., 2003; Burton et al., 1994; Dixon, Howie, & Starling, 2005; Halloran, Ross, & Carey, 2002; Linning & Kearney, 2004).

2.2.3 Theories of family support

2.2.3.1 Psychoanalytical perspective:

Some psychologists think that the analytical psychological helped to enrich the quality of some of the assumptions related to the effects of socialization on personality. Bronvenbernr 1963 the basis of psychoanalytic theory led to this little Number of researchers to focus on the emotional nature of the relationship between parents and children as a Paved part for the growth of certain forms of behavior. As Freud, the process

of socialization was a Control process of the primitive evil incentives in order to try and protect human rights and Prevention of the primitive rule of selfish needs.

2.2.3.2 General systems theory

A general systems perspective examines the way components of a system interact with one another to form a whole; Rather than just focusing on each of the separate parts, a systems perspective focuses on the connectedness and the interrelation and interdependence of all the parts. A systems perspective permits one to see how a change in one component of the system affects the other components of the system, which in turns affects the initial component. The application of the systems perspective has particular relevance to the study of the family as families are comprised of individual members who share a history. Those have some degree of emotional bonding, and develop strategies for meeting the needs of individual members and the family as a group Family systems theory allows one to understand the organizational complexity of families, as well as the interactive patterns that guide family interactions. (Anderson and Sabatelli 1999).

2.2.3.3 Feministic theory

Nuclear family refers to a family unit consisting of two parents and their socially recognized children, either biological or adopted. The term nuclear family is most often used to describe a married husband and wife living with their children in one household, as opposed to living with other relatives in an extended family. Historically, it was familiar for households in many societies to consist of larger extended families. After the industrial revolution, there was a greater emphasis on the nuclear family. (Linda Napikoski 2001).

2.2.4 Types of families:

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

2.2.4.1 Nuclear family

A group consists of parents and their unmarried children as basic features of the nuclear family as a group. It is a temporary group, which ends by the death of one of the parents.

2.2.4.2 Extended family

Generations living in one house this type of family 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 their families in one house as in African and Arab communities.

2.2.5 Function of families

Family has functions and tasks created to do and that is-

1- Biological function, family is still essential system in the community and we cannot do anything without it. In addition, through it human being continues to remain and summarizes the biological function of family is in reproduction.

2- Psychological function, human does not need only food to grow but he/she needs to satisfy his-Psychological needs, such as, the need for love, security, and estimation. Those needs do not occur only through the family, where it is the first place where the individual finds affection and emotional warmth.

3- The social function , this function is reflected in the socialization process which influence seems to be in the first five years of a child's life, in particular, because it is the age in which children learn social roles such as, (nutrition ,modesty ,sex education And independence). In addition, it includes a social function to give the role and social status of the right of the child, the definition of the child and the development of his concept of himself. In addition to his conscience, building and teaching social norms that help him to adapt and achieve mental health.

4- Economic function, this function is important to the major development of family function. In addition, Most prominent of these developments is 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. (Anani 2000).

2.2.6 Definition of family support

Ensure that families are able to meet their needs and overcome stressors that impair effective parenting. By helping families to provide a nurturing environment, family support services play a critical role in fostering the healthy development and school readiness of young children. Additionally, family support is seen as a crucial early intervention strategy for children who are at risk, or those with special needs. The concept of family support, while initially encompassing only income support, has evolved over time to include a more comprehensive and often integrated set of services. These include: “material supports"; such as cash assistance, tax credits, child care, family leave; and “instrumental supports”; such as parenting education, health and mental health services, employment services, family court services, resource and referral services. (Hawley Dale R. & DeHaan Laura 2004).

2.2.7 Family emotional process

Family emotional system describes the family’s emotional system during a single generation, but this pattern has already replicated for generations. Father and mother interaction will follow the patterns of their parents and will pass the patterns on to their children. Murray Bowen considered marriage to be the beginning of the nuclear family relationship and he discounted other living arrangements. He felt that the true fusion does not begin if there is the option to terminate the relationship. Bowen does not consider that exceptions to the rules, which are always present, are sufficient to disprove his conclusions. At some time in the wedding process, be it the engagement, the ceremony, or the first home, the fusion will inevitably be initiated. It is critical that the spouses be at an equal level of differentiation. Note the point made above that it is not the behavioral manifestation, but the emotional control of the intellectual process, that determines the level of differentiation. There is an inverse relationship between the level of differentiation and emotional fusion; that is, high differentiation equals low fusion and vice versa. Bowen does not elaborate on possibilities of marriages between unbalanced levels of spouses. Too much fusion in the couple can result in anxiety for one or both parties. The most common way of dealing with this stress is emotional distance or emotional divorce. Other methods of compensation are common such as, martial conflict, sickness or dysfunction in one of the spouses, and projection of the problem into one of the children. These are means to

dampen energy. Compensation strategies exist uniquely or in various combinations, but usually sickness of a spouse is outwardly harmonious and a relatively placid situation. Dysfunction of one spouse provides an effective means of absorbing anxiety and produces enduring marriages, but it does require one of the pair to sacrifice his or her health. With a triangle, the third member absorbs extra energy that arises between the primary dyad, thereby allowing the couple to maintain closeness. A key point is that the conflict tends to localize in the weakest and most inadequate person in the triangle Conflicting spouses are unable to adapt, but have periods of intense closeness. Impairment of the children is important enough to be considered a separate working concept as it eventually may progress from mild neurosis to severe psychopathology (Carl V 2008)

2.2.8 Family support and PTSD

As with other anxiety disorders, children's trauma reactions are influenced by parental reactions. In addition to, modeling their parents' reactions (social influence), there are probably inherited dispositions to react adversely to traumatic events (genetic influence). This has not been adequately studied in relation to PTSD in children. Some traumatic events, such as the sudden loss of a parent or sibling can dramatically affect the caring environment surrounding the child. In addition, it can potentially result in a complicated mix of trauma and grief with both PTSD and complicated grief reactions as a result (Dyregrov, 1993).

Children are very sensitive to their parents' reactions – both to the event itself and to talking about it afterwards. It is common that children will refrain from discussing a traumatic event and its consequences as they soon register that doing so upsets their parent. This partially may explain why parents underestimate the degree of stress reactions experienced by their children. Thus, one cannot rely solely on parental report when making diagnoses or estimating prevalence. (Smith et al., 2001). Parents may avoid discussion of a traumatic event because of their own distress involved in such discussions; they may limit discussions as a means of protecting their child, or because of cultural taboos against such discussions. From many studies it is also, known that adults underestimate the severity of children's reactions and they may therefore be unaware of children's needed to process their experience. Parents' own symptoms may reduce their capacity to support children as well as to avoid reminders. It has been found that children of parents (especially mothers)

who harbor an elaborative narrative style in contrast to a restrictive narrative style provide more detailed narratives of events (Harley & Reese, 1999). The parental climate of communication may be instrumental in helping the child cope following traumatic events.

(Salmon and Bryant (2002), outlines the following important aspects that talking with adults can have for children.

a) Reinstate the experience in memory and prevent forgetting.

b) Help the child to appraise and interpret the experience.

c) Correct misconceptions.

D) Help the child manage and regulate his or her emotions.

e) Provide information about coping strategies and facilitate their enactment.

It is clear from this that loss and trauma impact parental communicative functioning can seriously reduce children's coping potential if such communication is not sustained by the child's social environment. For adolescents, family support is the most important element in their lives. As part of their growth experience, adolescents usually expect many 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 (Stice, Ragan, & Randall, 2004).

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 (Bateson, 1978; Cummings, Davies, & Campbell, 2000; Watzlawick et al., 1967). 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 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 (Danieli, 1980; Figley, 1989; Harkness & Zador, 2001; Weine 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 (Davidson & Mellor, 2001; Davidson, Tupler, Wilson, & Connor, 1998) and in community samples (Ozer, Best, Lipsey, & Weiss, 2003; Punamäki, Komproe, Qouta, El Masri, & de Jong, 2005).

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 (Westerink & Giarratano, 1999). Research among families living under war conditions shows correlations between the mothers' and their children's depressive symptoms (Smith, Perrin, Yule, & Rabe-Hesketh, 2001; Qouta, Punamäki, & El Sarraj, 2005). Thus, suggesting similarity or symmetry between family members' responses to trauma and this is the reasons for symmetric symptom expression have been explained by contamination of fear, generalization of anxiety and worry about each other's safety (Laor et al., 1997; Qouta et al., 2005).

Traumatized and persecuted families tend to assume clear roles and strict share of work in showing strengths and weaknesses in order to survive and maintain a balance in turmoil. In "the emotional share of work", each family member's response is regulated by other members' distress or strength (Almqvist, 2000; Punamäki, 1987; Weine et al., 2004). The asymmetries may further occur between parental and child subsystems. In traumatized families, both parents and children intensively worry about each other's security. Thus, generational boundaries can diffuse (Jaffa, 1993; Montgomery, Krogh, Jacobsen, & Lukman, 1992; Weine et al., 2004). For instance, the wife and children of a torture survivor may dedicate all their efforts to protect the father from further stress and hide their own anxiety. Jaffa (1993) described a "parental child" that assumes the role of a suffering adult and becomes responsible for nurturing and caring for siblings in the traumatized families. "Prettification" is an extreme form of change of family roles, where children take over the caring and supporting tasks of parents, who are incapable of doing so due to their mental health or other problems (Chase, 1999; Zahn- Waxler & Radke-Yarrow, 1990). In war-traumatized families, children have witnessed the humiliation of their parents and felt their inability to protect them. It may explain the children's engagement in political struggle and willingness to compensate for the familial humiliation by the enemy (Baker, 1990). Similarly, refugee children tend to take the responsibility for their persecuted

families and guide their parents in facing new stressors and demands for adjustment. Parents in turn perceive their children as the exclusive source of hope for a better life and live through the children's achievements (Almqvist, 2000; Weine et al., 2004).

The motive for the strict hierarchies and role reversals in traumatized families are to maintain balance and secure survival and wellbeing. When one family member is weak and suffers from psychological distress, others compensate by showing resiliency and positive adaptation. These asymmetries pose a risk for mental health and child development because of their inadequate timing and inflexibility. Observations among war veterans and refugee families show that responses that were functional in the time of life danger turn out to be dysfunctional in family life, because it demands intimacy and sharing rather than hardiness and numbing of emotions (Almqvist & Hwang, 1999; Catherall, 1997; Riggs et al., 1998). There is ample evidence that traumatic events of war and military violence are associated with PTSD and depressive symptoms among children (Kuterovac-Jagodic, 2003; Sack, Clarke, & Seeley, 1995; Thabet & Vostanis, 1999; Weisenberg, Schwarzwald, Waysman, Solomon, & Klingman, 1993) and adults (Solomon, Kotler, & Mikulincer, 1988; De Jong et al., 2001). Similarly, traumatic experiences increase negative family characteristics such as poor parenting (Barber, 2001; Punamäki, Qouta, & El Sarraj, 1997), marital conflicts (Riggs et al., 1998) and dysfunctional family communication (Garbarino & Kostelny, 1996).

Less research is available about families' strengths and resources under traumatic stress. There are, however, observations that trauma victims make great efforts to improve their resources in order to maintain wellbeing and integrity. They report positive changes in themselves, such as deepened spirituality, appreciation of life and human relationships, which conceptualized as posttraumatic growth (Garbarino2001; Tedeschi, 1999). Evidence is available of resilient children who successfully adapt despite of stressors and adversities (Rutter, 1985), overcome hardships and trauma, achieve developmental competences and even blossom in harsh conditions (Luthar, 1993; Masten, & Coatsworth, 1998). Family characteristics, such as social support, open communication and emotional sharing (Beardslee & Podorefsky, 1988; Olsson, 2003). Some observations are available showing that traumatic experiences can result in positive family developments such as increased feeling of cohesion and appreciation of family life (Catherall, 1997; Punamäki, 1988).

Five studies found that elements of family functioning and environment correlated with PTS in youth (r strength = 0.22–0.64; directionality of relationship depended on phenomena measured; trauma exposure included spinal cord injury, violence, trauma, and SCUD missile attack. (Boyer, Hitelman, et al., 2003; Boyer, Ware, et al., 2003; Burton et al., 1994; Laor et al., 2001; Overstreet et al., 1999). Parental support for children also provides much needed social support. Parents must provide a child with unconditional love and care, and must set boundaries and regulations. By creating rules for the child to follow, the parent helps to shape the child's social actions and to acquaint the child with the way the world operates. Without these bounders a child may gain a peer social support but with inappropriate actions may lose them rather quickly. For parents who provide care for disabled children, economic status is a major factor that affects the physical health of the caregiver and the child. For childhood disabilities that may cost a great deal of money to treat, the parent's social well-being can be affected by the parent's help which is afford to the child. Parental caregivers in the U.S. tend to have less social support system than that in Canada, mainly because of Canada's universal health plan, and the mother is less focused on money for treating her child. This is provided by the government (Brehaut et al., 2004).

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).

2.3 Social support

2.3.1 Introduction

Human is social creature by nature, Allah made him always in need of continuing to draw support from his brother. In addition, social support 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 pressures of life. Therefore, social support linked with mental and health happiness and that absence are associated with the increasing of depressive symptoms (Cutronal, 1996).

2.3.2 Definition of Social Support

Social support has received increasing attention as an important variable, which intervenes between the trauma and PTSD (American Psychiatric Association, 1994). 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, friends, neighbors etc. (Sarason et al 1983).

Social support consists of the others who will assist individuals to deal with emotional problems and their participation in their functions, and provide them with money, materials, tools, skills, information, and advice. Thus, they will help them deal with stressful situation that they exposed to it. (Caplan, 1981).

Social support is usually denned as the existence or availability of people on whom
We can rely, people who let us know that they care about, value, and love us. Bowlby's theory of attachment (1969, 1973, 1980).

Coheh define Social support is the individual requirements for support from Surrounding environment, whether from individuals or groups reduce the stressful of life events experienced by Them, and enable social activity to participate and face of these events (ali.1997).

Defined by (Cob, 1976) as, the desire to get close-to-close people who can provide information, facts, and guidance, which refers to the mutual love and affection?

(1978 moss, defined it as self-feeling of belonging, a sense of acceptance, love, and express empathy and emotional support in difficult situations.

As defined by (Ezra Abdel-Hamid, 1996), the degree of individual's sense of the availability of participation and emotional support material and the process by others such as family, relatives, friends, coworkers, and bosses. As well as the presence of the furnish advice and guidance from these individuals and have deep social relations with them, and this degree is equal to the total of the individual responses on a scale of social support. (Ali Abd el-Salam, 2005).

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

The concept of social support has been a reoccurring theme throughout the stress and mental health literature (for examples, see Cohen and Syme, 1985 and Vaux, 1988).

Moreover, the social support carries the meaning of support, severity, strengthening, and assistance to cope with situations. Also, may be the beginnings of the emergence of the term social support in modern human sciences while addressing the social scientists of this concept in the framework of social relations. Here, they form the definition of social relations network , which is the real beginning for the emergence of social support, called (social provisions) (Mohamed and Mohamed Mahrous Shenawi Mr. Abdul-Rahman, 1994).

(Cassel, and, Kaplan, and cob) have put in the seventies of the last century the basis of work in the field of social support, and proposed a vision of the types of social relations. In addition to the various activities included in the process of social support which made the value clear , and importance of social support in alleviating negative effects of the harmful effects of stressful life events on physical and psychological aspects of the individual (Ali abed elsalam2005).

2.3.3 The importance of social support

Social support is one of most important factors in predicting the physical health and well-being of everyone, ranging from childhood through older adults. The absence of social support shows some disadvantage among the impacted individuals. In most cases, it can predict the deterioration of physical and mental health among the victims. The initial social support given is also a determining factor in successfully overcoming life stress. The presence of social support significantly predicts the individual's ability to cope with stress. Knowing that others value them is an important psychological factor in helping them to forget the negative aspects of their lives, and thinking more positively about their environment. Social support not only helps to improve a person's well-being, but also it affects the immune system. Thus, it also a major factor in preventing negative symptoms such as depression and anxiety from developing. (Cutrona, Russell, & Rose, 1986).
Turner & Marino (1994) saw that social support affects directly on the happiness of the individual (well-being) by the important role that played when the stress level is high, or for mental health which independent from the level of pressure, or as a variable and a mediator diluted from the negative effects resulting from high-pressure level (Turner & Marino, 1994**).**

As well as, both of (Cohen & wills 1985, and Kessler & Wethington, 1986) saw that social support plays an important role for the Continuation and survival of human being, they are like the heart that pumps blood to other organs of the body, which confirms the individual entity through his sense of support and support from those around him. In addition to appreciation and respect from the community to which he belongs, and of belonging and compatibility with the social norms within the society, which help him to cope with life events stressful. It also helps him to respond in positive and effective ways that support the individual to keep his mental and psychological health (Ali Abdel- Salam, 2005).

In their opinion (1991 Downey & Coyne,) the social support of trusted others have main importance in the pressure-oriented events and social support can reduce or exclude the effects of these events on health. However, the importance of social support as a key independent variable has received little attention in criminology. In a presidential address to the Academy of Criminal Justice Sciences, Cullen (1994) argued that social support could possibly be an organizational link for the theories of disorganization, control, and

cultural values. Yet, Cullen (1994) also points out that. . In criminology, the insights linking social support to crime remain disparate, and are not systematized so far as to direct theoretical and empirical investigation the concept of social support in criminological research has not been given adequate attention thus far. Social support can take on different meanings to different researchers. While concept of family attachment in social control theory can be loosely conceptualized as one form of social support, assuming a traditional family relationship of nurturing and caring, a strong attachment to the family provides the individual with a basic social support group. An individual's social network may also be examined in relation to social support. An individual's network is made up of other people with whom he or she has contact. These other people all have the potential to aid the individual with some form of social support, yet the forms of social support can be numerous (Vaux, 1988). This can lead to a disparity in measuring the concept of social support. Without a clear definition and valid, reliable indicators to measure the concept, research on social support would be imprecise (Theist, 1982).

This study defines social support as the degree to which a person's basic social needs (e.g., affection, esteem, approval, belonging, identity, and security) are gratified through interaction with others (Thoits, 1982). It implies important dimensions of social support: descriptions of available support, supportive behavior, descriptions of enacted support, and support appraisals (Vaux, 1988).

Thus, the concept of social support includes; the perceived availability of support, the behavior that occurs during support, the support that is actually given, and whether the support is useful or not. In addition, support could be one of three different types: instrumental, emotional, and informational. Instrumental support entails the physical and economical support an individual receives from social support. Emotional support entails the affection, empathy, and acceptance gained from social support. Informational support involves advice and information conveyed from social support. Esteem/approval, belonging, identity, and security (Thoits, 1982).

Social support phenomena have been examined at almost every stage of the life cycle. Large bodies of empirical literature have developed somewhat independently regarding late adulthood, (Chapman and Pancoast 1985; Heller and Mansback 1984).

adulthood(Gore 1978; Lin, Dean, and Ensel 1986; Wilcox 1981),late adolescence (Procidano and Heller 1983; Sarason et al. 1983), early and middle adolescence(Barrera 1981; Burke and Weir 1978; Cauce, Felner, and Primavera 1982; Hotaling, Atwell, and Linsky 1978; Hunter and Youniss 1982; Unger and Wandersman 1985; Vaux 1981), and childhood (Sandler 1980; Felton 1985).

Professionals from the fields of social work, community mental health, public health, and community psychology (Gottlieb 1983; Whittaker and Garbarino 1983) have implemented social support programs and interventions. These interventions have varied in scale, complexity, specification of process, correspondence to theory or research findings, and clarity of objectives. In general, applied efforts have reflected the confusion found in analytic research and theory. Programs that clearly identify which point of the support process is the target of change are the exception; those that place such changes in the larger context of the support process are a rarity (Alan Vaux 1988).

Recently, a social-cognitive processing model was developed by Lepore (2001) to explain the role of social interactions on emotional adjustment to cancer, a life-threatening illness that can induce posttraumatic stress reactions. As so Joseph and colleagues (1997), Lepore suggests that social and contextual variables have an important impact on the cognitive processing of traumatic events. After the announcement of a cancer diagnosis, most people talk about their experience with their significant others, a strategy that can facilitate their cognitive processing. However, the emotional benefits of confidence are dependent on the reactions of others (Lepore, Silver, Wortman, & Wayment, 1996).

Social support and physical health are two very important factors help the overall well-being of the individual. A general theory has been drawn from many researchers over the past few decades postulation that social support essentially predicts the outcome of physical and mental health for everyone. There are six criteria of social support that researchers can use to measure the level of overall social support available for the specific person or situation (Cutrona, Russell, & Rose, 1986). First, they would look at the amount of attachment provided from a lover or spouse. Second, measuring the level of social integration that the individuals involved with, it usually comes from a group of people or friends. Third, the assurance of worth from others such as positive reinforcement that could inspires and boosts the self-esteem. The fourth criterion is the reliable alliance support that

provided from others, which means that the individual knows they can depend on receiving support from family members whenever it was needed. Fifth, the guidance of assurances support which is given to the individual from a higher figure of person such as a teacher or parent. The last criterion is the opportunity for nurturance. It means the people would get some social enhancement by having children of their own and providing a nurturing experience. Research has produced evidence that certain kinds of social support contribute to developing resilience and personal growth (Neill, 2006). (Ullman & Filipas, 2001).

2.3.4 Social Support Processes

Social scientists have long theorized about the association between social support and mental health outcomes (Cohen & Wills, 1985; Pearlin, Lieberman, Menaghan, & Mullan, 1981; Wethington & Kessler, 1986). The main effects model (Wheaton, 1985) assumed that social support has a direct effect and serves a health-restorative role by meeting basic human needs for social contact, regardless of the level of stress present. This generalized beneficial effect of social support occurs because social networks provide positive interactions, support, and affirmation that lead to an overall sense of self-worth, self-esteem, and positive affect. Social support has also been studied widely as a psychosocial resource that potentially mitigates or buffers the deleterious psychological effects of stress on mental health outcomes. Cohen and Wills's theory of the stress process proposes that social support buffers or protects individuals from the deleterious effects of stress. In the event of a stressful situation, supportive network members can variously help individuals reappraise the stressor as something that is within their ability to manage, help provide a solution to the problem, or encourage healthy coping behaviors. Social networks can also help one avoid potentially stressful situations such as financial problems or problematic relationships that would otherwise increase one's risk of psychological problems. The process of social stress theory (Pearlin et al., 1981) combines components of stress-the sources, editors, and manifestations of stress-into a conceptual framework that takes into account both structural and individual factors. The underlying proposition of this theory is that stressful life events (e.g., unemployment, death of a loved one) disrupt an individual's psychological equilibrium and potentially have adverse effects on mental health outcomes by eroding one's sense of self. Resources such as social support, however, can intervene in this process to effective mediate the effects of stress on psychological outcomes. Reflecting the influence of structural factors, the theory suggests that exposure to both

stressors and resources are influenced by the social structure (e.g., experiences of racism and discrimination). Accordingly, the hypothesis follows that the relationship between stress and mental health is influenced by differences in social statuses, such as race and socioeconomic status. This is consistent with previously noted findings indicating that African Americans are at higher risk of exposure to stress because of their position in the social structure (Lincol, et al, 2005)

2.3.5 Social Support and PTSD

It is essential in the psychology of health. This hypothesis, which texts on social support from trusted others have great importance in the face of significant life events and social support. In addition, it can reduce or exclude the consequences of these events on health (Coune & Dawney, 1991). The relationship between social support and the severity of PTSD symptoms may vary from one type of trauma to another (Valentiner, Foa, Riggs, & Gershuny, 1996). Both of Shenawi and Abdel-Rahman, (1994) pointed that social support have dilute effect to the results of stressful events. People who are going through painful events vary their negative responses (psychological symptoms) for these events depending on the availability of these friendly and supportive relations, which increase the risk of mental disorders as the lack of the amount of support social development. (Bowlby) said that, the individual who enjoys the social support which have affection from others since the first years of his life then becomes a person with highly self confident. In addition to being able to provide social support to others, and becoming less vulnerable to mental disorders. Moreover, adding that the social support increases an individual's ability to resist and overcome frustrations and make it able to resolve its problems in a new way (Bowlpy, J, 1980). The Joseph and colleagues model (1997) underlined that social support influences PTSD symptoms mainly through cognitive processes and the inhibition of processing of traumatic thoughts and expression of emotions. Second, the Lepore (2001) modeled proposes that the nature and quality of social interactions influence the frequency of intrusive thoughts that maintain the ill-adapted chronic responses to the traumatic events and the tendency to avoid disclosing or thinking about the event. The quality of social relationships also affects negatively the level of psychological distress among cancer patients (Lepore & Helgeson, 1998; Manne, 1999). Nevertheless, it is difficult to infer exactly what specific type of PTSD-related cognitive process (attribution style, core beliefs, appraisals of thoughts, etc.) is affected by social support. Some researchers pointed

to the potential mediating role of “perceived Control” over the trauma and adjustment in the relationship of support to PTSD (Frazier, Steward, & Mortensen, 2004)

(Rutter, 1990) Indicated that the protective variables of pressure effect are "the personal and social variables, which would decrease the impact of pressure events on the cognitive, emotional and social aspects". In addition, these variables play an important role in recognition the stressful events, as well as affect the individual assessment to the effectiveness of his psychological and social sources to face the pressures events. (Rutter) sat protective variables that reduce the negative effects of stressful events. They are as the following:

- Personality traits, which are independent and self-esteem.
-Family support, which are interdependent and emotional warmth.
- Social support which encouraging, and motivating the individual to cope with stressful events of life and self-protection (Rutter, 1990).

(Sarason, 1986) had been assumed that once the individual's awareness that he can rely on someone to help; this would reduce the pressure on him. (Buunk & Verhoeven) Pointed that social support plays an important role in reducing stress; individuals who are under high pressure are always looking for help from others. If the support have a positive impact in reducing the pressure on the individual, an increase in pressure have a negative impact on social support .especially, as people who try to stay away from individuals who are under serious and severe pressure. (Hussein Fayed, 2006).

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 a social system believed to provide love, caring, or a sense of attachment to a valued social group” (Hobfoll, 1988). Perceived social support, then, is the belief that these helping behaviors will occur when needed (Norris&Kaniasty, 1996). In general, greater social support is associated with better psychological outcomes, and perceived rather than actual received social support seems particularly predictive of better psychological health in times of stress (Cassell, 1976; Cobb, 1976). In regards to coping with trauma, it appears that support from family and friends has a positive influence. In fact, social support was the strongest predictor found in a meta-analysis by Brewin, Andrews, and Valentine (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. For example, Solomon et al. (1988) found that number of social contacts was negatively related to PTSD in a sample of combat veterans. The perceptions of social support are also important in the prediction of PTSD. It has been suggested that survivors of trauma who perceive inadequate social support may be more at risk of negative outcomes (Raphael & Wilson, 1993). The literature on the effects of social support in victims of violence, however, is not without controversy. In a study of adolescents who were abused. For example, the number and satisfaction of social supports were related to less sociality in adolescents who were sexually abused, but not in those who were physically abused (Esposito & Clum, 2002). In a study of survivors of rape, social support was also found to buffer victims of sexual assault from poor physical health (Kimerling &Calhoun, 1994). Despite these positive findings, the literature has been inconsistent. In addition, it has been suggested that some support providers can unintentionally be unhelpful and negative in their attempt to be supportive to Social reactions that include emotional support, validation, and listening can be positive. However, others include responses such as blame, disbelief of the victim, taking control, or distraction can be quite detrimental. For example, using a checklist of 40 possible social reactions, (Ullman 1996) found that such negative social reactions were related to poorer recovery in victims of sexual assault, despite coming from individuals described as "support providers." Thus, social networks that are normally perceived to be supportive may actually provide ineffective social support at the time it is needed most. Moreover, for various reasons, actual and perceived social support may decrease after an individual has been victimized or has experienced a traumatic stressor (Golding, Wilsnack, & Cooper, 2002; Norris & Kaniasty, 1996). As such, social support, even when individuals believe it will occur, may be less helpful in periods of high stress. In summary, perceived social support seems to play an overall protective role in recovery from stress and trauma, 450 Journal of Interpersonal Violence though similar to the coping literature; findings have not been entirely consistent and need further clarification. In particular, the meta-analysis by Brewin et al. (2000) suggests that risk and/or protective factors such as social support may not be uniform across different kinds of samples (e.g., military vs. civilian) and thus deserve further scrutiny in the general population. Posttraumatic stress disorder is also associated with impairment of the person's ability to function in social or family life, including occupational instability, family discord, and difficulties in parenting. Since family, social cohesion and social support network decrease the dramatization level in an

Individual, we have assumed that low perception of social support would result in development of posttraumatic symptoms, especially if there is a lack of family support. Social support and family is one of the most important protective factors for coping with trauma. Two recent meta-analysis studies examining the risk/protective factors related to posttraumatic stress disorder (PTSD) revealed social and family support to be among the strongest predictive factors of PTSD (Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003).

2.4 Literature review

2.4.1 Introduction

In this chapter, the researcher discussed and searched the recent and old litterateur to identify the trauma (PTSD), social and family support. In addition to finding other studies, which explained the importance of this, study, and he tied them with other studies.

2.4.2 Literature review concerning PTSD

Thabet et al (2008) Exposure to war trauma has been independently associated with PTSD and other emotional disorders in children and adults. The aim of this study was to establish the relationship between ongoing war traumatic experiences, PTSD and anxiety symptoms in children, accounting for their parents' equivalent mental health responses. Methods of the study were conducted in the Gaza Strip, in areas under ongoing shelling and other acts of military violence. The sample included 100 families, with 200 parents and 197 children aged 9–18 years. Parents and children completed measures of experience of traumatic events (Gaza Traumatic Checklist), PTSD (Children's Revised Impact of Events Scale, PTSD Checklist for parents), and anxiety (Revised Children's Manifest Anxiety Scale, and Taylor Manifest Anxiety Scale for parents). Results both children and parents reported a high number of experienced traumatic events, and high rates of PTSD and anxiety scores above previously established cut-offs. Among children, trauma exposure was significantly associated with total and subscales PTSD scores, and with anxiety scores. In contrast, trauma exposure was significantly associated with PTSD intrusion symptoms in parents. Both war trauma and parents' emotional responses were significantly associated with children's PTSD and anxiety symptoms. On the other hand the situation before and after the trauma cans affect the consequences of trauma. That appears in a study to Vivian Khamis (2008) was designed to assess the occurrence of post-traumatic stress disorder (PTSD) and psychiatric disorders (i.e., anxiety and depression) in Palestinian adolescents following intifada-related injuries. It was hypothesized that a combination of pre-trauma variables (e.g., age, geographic location), trauma-specific variables such as trauma recency, type of trauma (deliberately violent vs. accidental), and post-trauma variables (e.g., social support, coping strategies, belief in fate) would be predictive of these psychological squeal. The participants were 179 boys who were injured during Al-Aqsa

intifada and as a result sustained a permanent physical disability. They ranged in age from 12 to 18 years (M¼ 16.30, SD ¼ 1.64). Questionnaires were administered in an interview format with adolescents at home. Approximately 76.5% of the injured victims qualify as having PTSD and that the disorder had a heterogeneous course, with excess risk for chronic symptoms and co morbidity with other psychiatric disorders such as anxiety and depression. Among all the predictors in the PTSD, anxiety and depression models, only geographical location, fatalism, and negative coping were significant predictors. However, in Orla study, (2003), of 160 children 8- years- old of Northern Ireland, he found that, children's perception of negative stressful events related to the political conflict in the northern Ireland over times one and two girls perceived three events as considerably more stressful than boys. In addition, children's perception of stressful events is related to host of social factors. Personal, social and situational factors differently determine children perception of negative life experience. That was constant with Vivian Khamis study (2002); it was performed 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 Participants were 1,000 children aged 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. Questionnaires were administered in an interview format with children at school, and with the available parent at home, .and the Results A substantial number of children experienced at least one lifetime trauma (54.7%). Post-traumatic stress disorder (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 (Vivian Khamis2002).

However, in an interesting study conducted in Palestine by Thabet et al, (2002). On 91 children exposed to home bombardment and demolition during AL – Aqsa Intifada and 89 controls that had been exposed to other types of traumatic events related to political violence completed self – report measures of posttraumatic stress, anxiety and fears. He found that, more children exposed to bombardment and home demolition reported symptoms of PTSD and fear than controls group. By contrast, children exposed to other events, mainly through the media and adults, reported more anticipatory anxiety and

cognitive expression of distress than children who were directly exposed. In one of the studies of the Middle East, 20 Kurdish children aged 6_16 years were assessed. Four (20%) fulfilled PTSD criteria according to DSM III – R, but these subsided at follow – up (Ahmed, 1992). The same researcher assessed a different sample of 45 Kurdish children of Anfal families, five years after the uprising operation and relocation in two camps in North of Iraq. Eighty seven percent 87% of children reported PTSD (Ahmed et al, 2000). Children's trauma scores were positively correlated with posttraumatic stress disorder (Ahmad 2000).

Derek, et al (2000) in a study on 216 teenagers had survived a shipping disaster and 87 young people as matched controls were interviewed found that, the survivors showed raised rates of diagnosis in a range of anxiety and affective disorders during the follow-up period. The highest rates were among the survivors who had developed posttraumatic stress disorder, and those survivors who had not were generally similar to the controls. Onset of anxiety and affective disorders varied between being indefinitely close to the disaster to years later. Differences in rates of disorder between the survivor and control groups had lessened by the time of follow-up but were still apparent, due to continuing disaster among the survivors still suffering from PTSD, and to a lesser extent among those who had recovered from PTSD. That was constant with Orlee, et al, (2000). In study of 217 children found that, developing PTSD following the disaster was significantly associated with being female. With pre- disaster factors of the learning and psychological difficulties in the child and violence at the home, severity of exposure to the disasters, survivors subjectively appraisal of the experience, adjustment in the early post disaster period, and life events and social support subsequently. When all these factors were considered together, they measures of the degree of exposure to the disaster add subjective appraisal of life threat. Those survivors who developed PTSD, its duration and severity were best predicted not by objective and subjective disasters – related factors, but by pre-disaster vulnerability factors of social, physical, and psychological difficulties in childhood.

Paul, L. (2000). In his survey sample on 31 Bosnian, refugee children in 1996 at the International Clinic of Boston Medical Center found that, only one family expressed interest in psychosocial services of any kind. Large numbers of Bosnian refugee are likely to have experienced traumatic war violence and are at risk of behavioral symptoms. The refugee health assessment (RHA), affords opportunities to screen for behavioral problems

but not to intervene. Primary care provides and other clinicians should be aware of likely recurrences of symptoms in high-risk children. On another study to Thabet et al (1999) in his study of 234palestinian children found that, the rate of children who reported moderate to severe PTSD reactions at follow-up had decreased from 40.6%(N=102) to 10.0% (N=74). 49 children (20.9%), were rated above the cut-off for mental health problems on the Rutter A2 (parent) Scales, and 74 children (31.8%) were above the cut-off on the Rutter B2 (teacher) Scales. The total scores on all three measures had significantly decreased during the one-year period. The number of traumatic experiences recalled at the first assessment best predicted the total CPTS-RI score at follow-up. In a useful study, Betty et al, (1999) in the study of 3,208 students found that more than 40% of the students reported knowing someone injured and more than one-third reported knowing someone killed in the blast. Post traumatic stress symptoms at 7 weeks significantly correlated with gender, exposure through knowing someone injured or killed, and bomb-related television viewing. Pfefferbaum, (1999). Found that, PTSD has been described in children exposed to variety of traumatic experience is. Partial symptomatology and co-morbidity is common.

A variety of factors influences response to trauma and effect recovery.

They include characteristics of the stressors and exposure to it; individual factors such as gender, age and developmental level, and psychiatric history; family characteristics; and cultural factors. Since the condition is likely to occur after disaster situations, much of the literature describes the child's response to disaster and interventions tend to include efforts within schools and/or communities. A number of clinical approaches have been used to treat the condition. While assessment has been studied extensively, the longitudinal courses of PTSD and treatment effectiveness have not been biological correlates of the condition also warrant greater attention. In another study of Pefferbaum, et al (1999) of 3,220 students found that, more than one third of the sample knew someone killed in the explosion. Bereaved youths were more likely non-bereaved peers to report immediate symptoms of arousal and fear, changes in their home and school environment, and posttraumatic stress symptoms. Retrospective measures of initial arousal and fear predicted posttraumatic stress symptoms at 7 weeks. The result supports the literature addressing the role of initial response in post – traumatic stress symptoms development. The study raises concern about the impact of television, and traumatized youths' reactivity to it.

However, Paul, et al, (1999) in study of 170 children confirmed that, 39, (22.9%) fulfilled the DSM-IV criteria for PTSD. There were significant differences between children with and without PTSD on each individual component of screening battery. Various criteria for

casernes were evaluated and at 6 weeks, post trauma the screen identified up to 90% of children diagnosed with PTSD and 37% with borderline conditions. A sample of 36 children was re – assessed 8 months post trauma and initial screen scores correctly identified all children with persistent PTSD. Croatia and Bosnia were areas of ethnic cleansing; findings have arisen from a number of studies following the war in Croatia and Bosnia. In 1992, Bosnia Serb and Serbian forces launched a campaign of ethnic cleansing against Muslim and Croat civilians in Bosnia – Herzegovina. Military and paramilitary forces, along with local unit, attack non – Serbs in their homes, thought villages and cities across Bosnia. In a study of Bosnian adolescents, posttraumatic stress disorder reactions were weakly present in 19%, moderately present in 28.6% of the adolescent (Ajdukovic, 1998).

In study conducted in Russia, Vladislav, (1998), in study of 156 subjects, (42%) fulfilled partial criteria and 87 (25%) fulfilled full DSM-IV criteria for posttraumatic stress disorder. They found that, Russian juvenile delinquents represent a severely traumatized population; mainly due to high levels of violence exposure. those with full posttraumatic stress disorder are the most severely traumatized and have highest rates of psychopathology, as compared to those with no or partial PTSD, and they require the most clinical attention and rehabilitation. Both exposure to violence and levels of posttraumatic stress are related to personality traits, which influence degree of exposure and individual perception of stress. The latter should be considered in individualized approaches to rehabilitation. In other Bosnian study, Richard et al, (1997), in a study of 364 Bosnian children found that, the children were exposed to virtually all of the surveyed war-related experiences. The majority had faced separations from family, bereavement, close contact with war and combat and extreme deprivation. The prevalence and severity of experiences were not significantly related to child's gender, wealth, or age, but were related to their region of residence, with children from the region of Sarajevo having the highest prevalence of experiences. Almost 94% of children met Diagnostic and Statistical Manual of Mental Disorders, 4^{th} ed., criteria for posttraumatic stress disorder. 90, 6%and 95.5% of the children reported significant life activity affecting sadness and anxiety, respectively. High levels of other symptoms surveyed were also found. Children with greater symptoms had witnessed the death, injury, or torture of member of their nuclear family, was older, and came from a large city. (Qouta et al, 1995) Posttraumatic stress disorder develops in persons who have experienced emotional or physical stress that would be extremely

traumatic for virtually any person such traumas include combat experience, natural catastrophes, assault rape, and disasters such as building firs.

In another significant study for, Garbarino et al (1996), in his study of 150 Palestinian children and their mothers living in cities and villages in the West Ban, he founds that; boys were more vulnerable to risks than girls were. Moreover, boys were especially susceptible to multiple risks. Older children were better able to use cognitive processes to seek resources outside the family and to find refuge and take action than younger children. Furthermore, older children were more likely to have had a longer period before facing the extended crisis of political violence. That was constant with in Thabet study at the same year but in the Gaza Strip Thabet study (1996) in a study of 150 Palestinian adolescents and their mothers living in cities and villages in the West Bank. He found that; boys were more vulnerable to risks than girls were. Moreover, boys were especially susceptible to multiple risks. Older adolescents were better able to use cognitive processes to seek resources outside the family and to find refuge and take action than younger adolescents. Furthermore, older adolescents were more likely to have had a longer period of normal times before facing the extended crisis of political violence. (Garbarino et al 1996) in his study of 234palestinian adolescents found that, the rate of adolescents who reported moderate to severe PTSD reactions at follow-up had decreased from 40.6% (N=102) to 10.0% (N=74). 49 adolescents (20.9%), were rated above the cut-off for mental health problems on the Rutter A2 (parent) Scales, and 74 adolescents (31.8%) were above the cut-off on the Rutter B2 (teacher) Scales. The total scores on all three measures had significantly decreased during the one-year period. The number of traumatic experiences recalled at the first assessment best predicted the total CPTS-RI score at follow-up. (Garbarino et al, 1996, Thabet, 1996)

In another Palestinian studies performed by, (Qouta et al, 1995). In study of 108 Palestinian children found that, exposure to political traumatic experiences increases children's psychological suffering, neuroticism and increases children's active participation in national struggle. However, this activity does not save children from suffering from psychological symptoms when the exposure to traumas is overwhelming. The first Gulf War between Iraq and Iran led to great loss in human and properties in both sides. A large number of families fled from both countries to find save place for themselves and their children. Thos children who exposed to organized violence during war and persecution put them at risk of developing chronic PTSD.

The second Gulf War affected a large number of children especially Kuwaiti children, who experienced a large number of traumatic events ranging from witnessing killing of others to being hurt themselves, Nader et al (1993) assessed Kuwaiti children following the Gulf crisis, and found that 70% reported moderate to sever PTSD reactions. In another sample of Kuwaiti children and adolescent after the Iraqi invasion, prevalence rates were 48.1% for mild 40.6% for moderate, and 11.4% for sever or very sever posttraumatic stress disorder (Abdin et al, 1994). Thus, as Khames showed in her study that an evidence of high prevalence of PTSD among the injured significant differences in PTSD prevalence for demographic, situational, and trauma related variables were found except for the age factor. Prevalence of PTSD among adolescents was significantly higher than among adults. It seemed that the injury itself was so intensely overwhelming that the other variables were overshadowed (Vivian Khamis1993). The trauma here is bonded to serous body injury. However, in Maksoud study on 2220 Lebanese the trauma was bonded to many traumatic events children found that on average, a Lebanese child has experienced five to six different types of war related traumatic events during his or her life, and some events were experienced several times. Exposure to shelling or combat, displacement, extreme poverty and witnessing violent acts were the most common traumatic experience faced by Lebanese children. In contrast, involvement in military activities, being a victim of violent acts, and suffering from serious physical injuries were less common experience. In addition, the number and types of traumatic experiences varied significantly by age, gender, socioeconomic status and region of residence (Maksoud, 1992). In another study in Lebanon. (Maksoud, Lawrence, 1992). In study of 224 Lebanese children found that, the number and type of children's war trauma varied meaningfully in number and type by their age, gender, father's occupational status, and mother's educational level. The number of war trauma were experienced by a child was positively related to PTSD symptom's and various type of war traumas were differentially related to PTSD, mental health symptoms, and adaptation outcomes. For example, children who were exposed to multiple war were bereaved, became victims of violent acts, witnessed violent acts, and were exposed to shelling or combat exhibited more PTSD symptoms. Children who were separated from parents reported more depressive symptoms and children who experience bereavement and were not displaced reported behavior that is more painful. Lastly, children who were separated from parents and who witnessed violent acts reported behavior that is more parochial.

2.4.2.1 Conclusion on PTSD litterateur

In recent years, a number of studies have started to assess the levels of PTSS or PTSD among Palestinian youth given their widespread exposure to trauma. Indeed, between September 2000 and November 2005, over 26000 Palestinians under the age of 18 years, representing about 7.5% of the child and adolescent population, were injured in the context of the Al-Aqsa Intifada. Approximately 12% of the injured youngsters are now suffering from a permanent disability (PCBS, 2006). Overall, PTSS levels seem to range from 10% to 70% among the youth from the Gaza strip (Thabet et al., 1999; Qouta, Punamaki, and El Sarraj, 2003). In a study on 1000 school-aged Palestinian children, 54.7% reported experiencing at least one intense traumatic event in their lifetime and 34% were diagnosed as having full PTSD (Khamis, 2000). In child populations from relatively comparable contexts, levels of PTSS ranged from 22 to 25% among Israeli and 27% among Lebanese children, through 48% among Cambodian refugee children and 52% among Bosnian youth (Kinzie, Sack, Angell, Manson, and Rath, 1986; Smith, Perrin, Yule, and Rabe 2001). Iraqi children whose shelter was destroyed by shelling showed the highest posttraumatic stress levels (78-88%) (Dyregrov et al., 2002). The few studies specifically pertaining to Palestinian adolescents (aged 11 to 19 years) suggest that 11 to 16% suffer from low to mild, 33% to 49% from moderate and 33 to 54% severe levels of PTSS/D (e.g. Qouta et al., 2003). Other Previous studies have also investigated PTSD in Palestinian families who experienced Intifada-related trauma. Among the various variables studied, PTSD was more associated with women, Gaza's, families who had a member killed, and with trauma-induced stress (Khamis, 2000). Recently, there were few studies, which investigated PTSD in Palestinian children (Thabet et al., 2002, 2004; Thabet & Vostanis, 2000). Viewed collectively, these studies have not been successful in addressing demographic and other differences

2.4.3 Literature concerning family and social support

On study to Grills et al 2011, Social support world be assumptions, and exposure as predictors of anxiety and quality of life followed by a mass trauma_ on a university students examined the influence of a mass trauma (the Virginia Tech campus shootings) on anxiety symptoms and quality of life. In addition to the potential vulnerability/protective roles of world assumptions and social support. Pre-trauma adjustment data, collected in the six months prior to the shooting, was examined along with two-month post-shooting data in a sample of 298 female students enrolled at the university at the time of the shootings. Linear regression analyses revealed consistent predictive roles for world assumptions pertaining to control and self-worth as well as family support. In addition, for those more severely exposed to the shooting, greater belief in a lack of control over outcomes appeared to increase vulnerability for post-trauma physiological and emotional anxiety symptoms. Alicia A. Ellis et al 2011 study showed the lend support to recent cognitive and developmental models of the etiology of post-traumatic stress disorder, and the possible shared cognitive vulnerability between trauma symptoms and depression. Clinically, the results indicate that, appraisals, social support, and depression symptoms should be assessed in addition to trauma symptoms following single-incident traumatic events. The findings also suggest that when depression symptoms are present following trauma Exposure. It may be useful to ensure children have adequate social support. Thus other study found that in case of assess the trauma .and appraisals, social support ,can reduce the bad consequences of (PTSD) that was appear in a study was conducted by (Armando A. Pina and Ian K. Villalta 2008). It examined the influence of aspects of the post–Hurricane Katrina recovery environment (i.e., discrimination, social support) and coping behaviors on children's posttraumatic stress reactions (symptoms of posttraumatic stress disorder (PTSD), anxiety, and depression). Data corresponding to 46 youth (M¼11.43 years; 39% girls; 33% African American, 67% European American) revealed that greater helpfulness from extra familial sources of social support predicted lower levels of child-rated symptoms of PTSD, anxiety, and depression. A positive predictive relation was found between helpfulness from professional support sources and PTSD, perhaps suggesting that parents whose children were experiencing higher PTSD symptom levels sought professional support and reported it to be helpful. Youths' avoidant coping behaviors predicted both PTSD and anxiety symptoms. Discrimination, active coping, and familial

support did not predict any of the posttraumatic stress reactions assessed in this study. In a study of post-war Kosovo,

Ahern et al. (2004) found that men with low levels of social support and high levels of traumatic exposure exhibited the highest rate of PTSD symptoms. However, they argued that the concept of social support might be too general for useful measurement. The nature of social support, its impact over time and the needs of the recipients are factors that may determine its efficacy in stressful situations. Ghazi Al-Otaibi (2001) conducted a study (PhD Thesis) titled [disorder Posttraumatic stress and its impact on achievement motivation and future orientation of young Kuwaitis people. The sample was 1200 students and students from the University of Kuwait and from the General Science and employees of the Ministry of Education of teachers and their parameters (583) man, and (617)woman their ages between(18-25). The results of the study include: 1) there is a negative correlation between the dimensions of the disturbance pressure scale after shock and most of the dimensions of achievement motivation and future orientation. This refers to the negative impact of trauma on the motivation, achievement and future direction. There is statistically significant effect of the interaction of presence during the aggression on the social situation. Beside a group of (married in Kuwait), which refers to the suffering of individuals who were inside married. They are the most suffering, fear and concern for their families. There is statistically significant effect of exposure to an insult, where they were more exciting of physical, social, emotional, and behavioral side and View the humiliation to have negative effects. There is statistically significant effect of the type, (as well as women were more affected than men of Stress disorder were, PTSD was). This is due to their emotional nature and their sense of disappointed to see the aggression and the inability to do something towards him and vent their pent-up feelings.

Barbarin et al. (2001 Zoellner, Foa, & Bartholomew, 1999) completed a study of South African children exposed to violence that explored the extent to which coping resources protected the children from negative psychological adjustment. They found that the children's experiences of violence depended on their families' ability to act as barriers to the violence and the quality of family relationships and other social support resources available. In contrast, they indicated that the buffering effect became less powerful as the children matured. Episodes of chronic, enduring interpersonal violence put children at higher risk for developing symptoms of PTSD. The purpose of this study was to use a

culturally based perspective (Africentric worldview) to analyze social supports as a source of coping in African American children who were chronically exposed to community violence. Although living in violent communities. In Schuster et al.'s (2001) study of adult reactions to the September 11 attacks, the most commonly employed coping mechanism was talking to others. On a study was conducting on police men in New Zealand (1999) following the experience of trauma. Information processing theories of traumatic stress and empirical evidence suggest a model of social support and Posttraumatic Stress Disorder (PTSD) etiology, in which emotional support and disclosure moderates the effects of trauma. This model was tested using survey data from 527 New Zealand Police officers. The results showed that all support variables had significant negative main effects on PTSD symptoms. Trauma was positively related to PTSD symptoms and this relationship was moderated by police officers' attitudes to expressing emotions at work and emotional support from peers. These results have implications for the provision of support for workers whose job places them at risk of experiencing multiple traumas (Zoellner, Foa, & Bartholomew, 1999).

Wolff & Ratner, (1999) in the absence of social support, however, victims are more likely to blame themselves for the event, have ruminating thoughts, and express their feelings in maladaptive ways. Such as, anger, withdrawal, or depression. Further, social relationships that are strained, involve social friction and isolation, or discourage discussion of trauma-related feelings, may increase depressive symptoms (Nolen-Hoeksema & Davis, 1999).

In a study conducted by (Ali Abdel-Salam, 1997) about the role of social support in the face of stressful events of life, as understood by married women . Its results explained that there are significant differences between married women who enjoy the social support and women who do not enjoy the social support in the methods of facing the stressful events of life for the married women who enjoy social support. On a Study of social support and face, the stressful life events understood by married workers by Ali Abdel Salam Ali (1997). This study aimed to compare the married women with high social support, and married women with low social support in the face of stressful events of life in the incidence of mental disorders. The study sample consisted of the first groupp which is experimental group of (50) married women who supported of social support from family and work group. The second group is the control group of (50) of working married women who are not supported of social support whether from family or work group. The results showed the existence of significant differences between the two methods in the face of life events, and the incidence of mental disorders. In addition, there are significant differences

between married women working with high social support and married women working with low social support in the following dimensions:

Work through the event pays attention to trends and other activities and social relations development and self-efficacy by a group of married women with high social support.

The results of the study of (Over Holse et al.1995) show the existence of a negative correlation between the size of social support, and stressful life events have received social support among the psychosocial. In addition, social variables with great interest by researchers Based on the premise that "the social support received by the individual through the groups to which he belongs. Such as, family, friends and colleagues in work and study, or club play a major role in reducing the negative effects of the events and bad attitudes that he did not exposed. The result of the study of (Hisham Abdullah, 1995) consistent with the results of a study of (Hetherington & martin, 1986), they also agreed with the results of a study of (Pattrrson et al. 1989) to emphasize the importance of the availability of social support through parental pattern of sons. In addition, to take the size of predictable a standard of social support for social relations development of a network of individuals who suffer from severe stressful life events.

Some studies have addressed the relationship of social support and its impact on the prevention and decreased of the effects of stress such as studying (Imad Mukhaimar, 1997; Nabil Dokhan and Basher Hajjar, 2006; Emad Abdel-Razek, 1998(,and (Vitaliano's study and his colleagues (vitaliano et al. 2001).

Fadel Abu Hein (1991) has a study on violence and Psychological trauma and its impact on psychological situation of children. Most of the result was- the study sample 2779 children. The age of 8 – 15 years Palestinian children was subjected to one or more of the difficult situations that have Psychological traumatic affect on their lives. such as, 92% inhaled the gas in their homes, 42% saw a family being beaten, 85% of the children came home for the night raids, 50% of children Had been personally insulted, and 19% of children were detained personaly.

In a study for (Hisham Abdullah, 1995), entitled the social support and its relationship to depression and despair among a sample of students and staff". The study aimed to examine the relationship between the size of social support and the degree of satisfaction from one hand and all of the depression and despair from the other hand.

This is among a sample of students and staff in Egyptian society and the impact of the study. In addition to mutual interaction of sex, section, accommodation, type of work on social support, depression and despair. The study have been formed of (328) people (169)

male (159) females and a sample of students consisted of (242) male and female students between the ages of 19-25 years, a sample staff included (86) members of whom (60) factor, (26), the worker, working in different points of the Eastern province between the ages of 13-50 years. the Results of the study where that the lower of the social support level in terms of its size and degree of satisfaction reported more depression and hopelessness among students and staff in the sample of the study and vice versa. The result of the study suggests that as well as to the human standing and facing parking the pressures of life alone without being there supported. In addition, cares, and sponsored, increases the intensity of that pressure, and feel lonely and the social support improved and modify their methods in facing the pressures of life and deal with the higher level of depression increased the degree of despair and vice versa. Also, it resulted in three essential results dealing with differences between members of the total sample of different sex in Social support, and type of residence and work, and the effect of interaction between these variables on social support. In addition, results of a study of Research linking social support and mental health among trauma victims (Davidson, Hughes, Blazer, & George, 1991) indicated hat access to a supportive network is crucial for recovery. Specifically, victims of trauma who can discuss their feelings with someone are more able to cope with their experience and less likely to experience psychological problems. (Katrona, Rasel, and Rose, 1986) showed that social support was essential prediction of physical and mental health state, which associated with the interaction between stress and social.

2.4.3.1 Conclusion of social and family support litterateur

The research suggests that social support and negative interactions are distinct dimensions of social relationships that have unique effects on mental health status (Lincoln et al., 2003; Okun & Keith, 1998; Rook, 1990). The majority of studies indicate that, across a variety of samples and indicators, negative interactions have more potent effects on mental health than doe's social support (Rook, 1984; Swindle et al., 2000). The harmful effects of negative interactions with network members may. In fact, offset or even cancel out the benefits of social support on well-being (see Lakey et al., 1994; Lepore, 1992; Vinokur, Price, & Caplan, 1996, for a different perspective). The more social and family support provided by family and the friends the less symptoms and distress and other mental problems (Hisham Abdullah, 1995; vitaliano et al. 2001 ; Pattrrson et al. 1989 ; Over Holse et al.1995; Abdel-Salam, 1997 ; Zoellner, Foa, & Bartholomew, 1999).

A recent analysis among Black women (Gray & Keith, 2003) found that negative interactions with family and friends increased psychological distress. Whereas, social support decreased distress. Negative interactions, however, had a stronger effect on distress than did social support in sum. Although social support is recognized as an important resource that helps individuals confront stressful situations, the researcher knows little about the possible role of negative interactions within this context. Further, the lack of research on both social support and negative interactions and their potential influence on the mental health status of African Americans limits our understanding of how these factors function in relation to stressful and traumatic events, given the prominence of informal social support networks.

Chapter III

3.1 Methodology

This chapter describes the methodology that the researcher used in this research. The adopted methodology to accomplish this study uses the following techniques: the information about the research design, research population, questionnaire design, statistical data analysis, and content validity and pilot study.

3.2 Study Design

This study used a cross sectional approach to evaluate the effect of social and family support on the secondary school students. The researcher used this methods because it is achievable and less time wasting and easier than other types.

3.3 Target population

The population of the study consisted of school students at tenth, eleventh and twelfth classis they ware 96595 students in secondary schools 51858female, 44737meal (The Ministry of Education, and Higher Education annual report year 2010 – 2011).

3.4 Sample

The sample was calculated using the IPA info program and it was 384 then the sample was selected more than the calculated sample in case of exclusion or losing of any case.
The study sample was random stratified sample wear the strata was the 10^{th} ,11^{th} ,and 12^{th} classis.

3.5 Setting

All the secondary schools in the Gaza strip the school were selected randomly from the Ministry of Education, and Higher Education annual report then taking stratified random sample from classis

3.6 Selection Criteria

The selection of subjects must meet the purpose of the study, where only the school students at 10^{th}, 11^{th} , and 12^{th} classis. from secondary school), male and female.

3.7 Eligibility criteria

3.7.1 Inclusion criteria

- Student of 10^{th} ,11^{th} ,and 12^{th} classis.
- Student has a family members

3.7.2 Exclusion criteria

- student class less than 10^{th} and more than 12^{th} class

3.8 Period of the study

The study took place in the period from 3/2011to 3/2012 and that included development of proposal, writing chapter one and two, developing the questionnaire, data collection, entry, analysis , then research writing (chapter three , four and five) , and finally dissemination of findings.

3.9 Data collection methods

450 questionnaires were distributed to the research population and **434** questionnaires are received.

In order to collect the needed data for this research, we used the secondary resources in collecting data. Such as, books, journals and statistics. In addition to, preliminary resources that not available in secondary resources through distribute questionnaires on study population in order to know **the effect of family and social support on PTSD on secondary school students in the Gaza strip**. Research methodology

depended on the analysis of data on the use of descriptive analysis, which depends on the use of main program (SPSS).

3.10 Instruments of the study

3.10.1 Gaza Traumatic Event Checklist

The GTEC was used to assess participants exposure to traumatic events over the last six months. It consisted of 20 traumatic events that commonly occur during the ongoing political and military violence in the Gaza Strip. The initial version was developed by the research department of Gaza Community Mental Health Program (GCMHP) and used in previous studies on Palestinian children (Thabet et al. 1999, 2002). Items require dichotomous answers, yielding a range of total trauma scores from 0 to 20. This checklist has shown satisfactory split half reliability (R = 0.776) and internal consistency (Cronbach alpha = 0.749), Thabet et al. 2002; 2009).

In which 19 events a checklist commonly occurs during times of political and military violence in the Gaza Strip. The checklist was based on previous checklist used in the Gaza strip (Thabet et al 2004).

3.10.2 Davidson Traumatic Scale (DTS)

The DTS is a self-rated scale, comprising 17 items were designed to measure posttraumatic stress reactions in youngsters aged 6 to 18 years. Tailored closely to the symptom definitions of the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV), these pertain to intrusive re-experiencing (DSM-IV criteria B), avoidance and numbness (DSM-IV criteria C) and hyper arousal reactions (DSM-IV criteria D) (American Psychiatric Association, 1994).

3.10.3 F- copes:

Family Crisis Oriented Personal Evaluation Scale

F-COPES Operationally the coping dimensions of the Double ABCX model of family stress theory and focuses on two levels of interaction as the following:

(1) The ways in which the family handles difficulties and problems that arise between family members.

(2) The ways in which the family handles problems or demands that come from the social environment, but that affect family members, McCubbin, H. I., Olson, D. H., & Larsen, A. S. (1991).

3.10.4 Vivian Khamis scale for social support.

Social support scale (SSS) contains 29 items and was designed to measure the three factors of social support factor respondent's perceived social supports from immediate family members and significant others factor, provision and reception of social support from social institutions facto, and religious group's supports.

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.

The sections in the questionnaires verifies the objectives of this research related to measure the **effect of family and social support on PTSD on secondary school students in the Gaza strip and the** Instruments of the study consist as the following:

1 Gaza Traumatic Event Checklist (GTEC).

All questions follow scale as the following:

Level	YES	NO
Scale	2	1

2 Davidson Traumatic Scale (DTS).

All questions follow lekart scale as the following:

Level	Never	rarely	sometimes	Often	alwa ys
Scale	1	2	3	4	5

3 **Social support scale**

All questions follow scale as the following:

Level	never	sometimes	always
Scale	1	2	3

4 - F- cope scale for family support

All questions follow scale as the following:

Level	strongly disagree	disagree	I don't know	agree	strongly agree
Scale	1	2	3	4	5

3.12 Pilot Study

A pilot study for the questionnaire was conducted before collecting the results of the sample. Twenty-seven students of the target population were selected randomly from three schools. pilot study provides a trial run for the questionnaire, which involves testing the wordings of question, identifying ambiguous questions, testing the techniques that used to collect data, and measuring the effectiveness of standard invitation to respondents.

3.13 Validity of the Research

Validity defined as an instrument that determines the extent to which the instrument actually reflects the abstract construct being examined. "Validity refers to the degree to which an instrument measures what it is supposed to be measuring". High validity is the absence of systematic errors in the measuring instrument. When an instrument is valid, it truly reflects the concept it is supposed to measure. Achieving good validity required the care in the research design and sample selection . The amended questionnaire was by the supervisor and nine expertises in the tendering and bidding environments to evaluate the procedure of questions and the method of analyzing the results. The expertise agreed that the questionnaire was valid and suitable enough to measure the purpose that the questionnaire designed for them.

3.14 Content Validity of the Questionnaire

Content validity test was conducted by consulting two groups of experts. The first was requested to evaluate and identify whether the questions agreed with the scope of the items and the extent to which these items reflect the concept of the research problem. The other was requested to evaluate that the instrument used is valid statistically and that the questionnaire was designed well enough to provide relations and tests between variables. The two groups of experts did agree that the questionnaire was valid and suitable enough to measure the concept of interest with some amendments.

3.15 Statistical Validity of the Questionnaire

To insure the validity of the questionnaire, two statistical tests were applied. The first test is Criterion-related validity test (Pearson test) which measures the correlation Coefficient between each item in the field and the whole field. The second test is structure validity test (Pearson test) that used to test the validity of the questionnaire structure by testing the validity of each field and the validity of the whole questionnaire. It measures the correlation coefficient between one filed and all the fields of the questionnaire that have the same level of similar scale.

3.16 Internal consistency:

3.16.1 Cronbach's Coefficient Alpha

This method is used to measure the reliability of the questionnaire between each field and the mean of the whole fields of the questionnaire. The normal range of Cronbach's coefficient alpha value between 0.0 and + 1.0, and the higher values reflects a higher degree of internal consistency. As shown in Table No. (17) The Cronbach's coefficient alpha was calculated for the first field of the causes of claims, the second field of common procedures and the third field of the Particular claims. The general reliability for all items equal 0.8997. This range considered high, and the result ensures the reliability of the questionnaire.

Internal consistency of the questionnaire is measured by a scouting sample, which consisted of twenty-seven questionnaires, through measuring the correlation coefficients between each paragraph in one field and the whole filed. Tables No. (3.1) below shows the correlation coefficient and p-value for each field items. As show in the table the p- Values are less than 0.05 or 0.01,so the correlation coefficients of this field are significant at $\alpha = 0.01$ or $\alpha = 0.05$, so it can be said that the paragraphs of this field are consistent and valid to measure what it was set for.

Table (3.1)
Reliability Cronbach's Alpha

section	**Cronbach's Alpha**
Gaza Traumatic events checklist	0.8260
The Davidson Trauma Scale (DTS)	0.8705
Social support scale	0.9039
Family Crisis Oriented Personal Evaluation Scales (FCOPES).	0.9267
All scales	0.8997

3.17 Structure Validity of the Questionnaire

Structure validity is the second statistical test that used to test the validity of the questionnaire structure by testing the validity of each field and the validity of the whole questionnaire. It measures the correlation coefficient between one filed and all the fields of the questionnaire that have the same level of liker scale.

As shown in table No. (3.2), the significance values are less than 0.05 or 0.01, so the correlation coefficients of all the fields are significant at $\alpha = 0.01$ or $\alpha = 0.05$, so it can be said that the fields are valid to be measured what it was set for to achieve the main aim of the study .

Table No. (3.2)
Structure Validity of the Questionnaire

section	Spearman correlation coefficient	p-value
Gaza Traumatic events checklist	0.781	0.000
Davidson Trauma Scale (DTS)	0.787	0.000
Social support scale	0.475	0.008
Family Crisis Oriented Personal Evaluation Scales (FCOPES).	0.678	0.000

3.18 Reliability of the Research

Reliability of an instrument is the degree of consistency with which measures the attribute that supposed to be measuring. The test is repeated to the same sample of people on two occasions and then compared the scores obtained by computing a reliability coefficient. For the most purposes reliability coefficient above 0.7 are considered satisfactory.

Period of two weeks to a month is recommended between two tests Due to complicated conditions that the contractors is facing at the that time. It was too difficult to ask them to responds to our questionnaire twice within short period. The statistician's explained that, overcoming the distribution of the questionnaire twice to measure the reliability can be achieved by using Kronpakh Alpha coefficient and Half Split Method through the SPSS software.

3.19 Split Half Method

This method depends on finding Pearson correlation coefficient between the means of odd rank questions and even rank questions of each field of the questionnaire. Then, correcting the Pearson correlation coefficients can be done by using Spearman Brown correlation coefficient of correction. The corrected correlation coefficient (consistency coefficient) is computed according to the following equation :

Consistency coefficient = 2r/(r+1), where r is the spearman correlation coefficient. The normal range of corrected correlation coefficient 2r/(r+1) is between 0.0 and + 1.0 As shown in Table No.(3.3), and the general reliability for all items equal 0.8897, and the significant (α) is less than 0.05 so all the corrected correlation coefficients are significance at α = 0.05. It can be said that according to the Half Split method, the dispute causes group.

Table (3.3)
Split-Half Coefficient method

section	person-correlation	Spearman-Brown Coefficient	Sig. (2-Tailed(
Gaza Traumatic events checklist	0.7264	0.8415	0.000
Davidson Trauma Scale (DTS)	0.7260	0.8413	0.000
Social support scale	0.8143	0.8976	0.000
Family Crisis Oriented Personal Evaluation Scales (FCOPES).	0.8481	0.9178	0.000
All scales	0.8013	0.8897	0.000

3.20 Statistical Manipulation:

To achieve the research goal, the researcher used the statistical package for the Social Science (SPSS) for Manipulating and analyzing the data.

3.21 Statistical methods are as follows:

1- Frequencies and Percentile
2- Alpha- Cronbach's Test for measuring reliability of the items of the questionnaires
3- Person correlation coefficients for measuring validity of the items of the questionnaires.
4- Spearman –Brown Coefficient
5- One sample t test
6- Independent sample t test
7- One way ANOVA
8-LSD for multiple comparisons

3.22 Study limitation

1 the scale witch used are a loot and some times burden the sample
2 Some schools were refused to take the sample from 12^{th} classes because they are at critical year of study.
3 The huge number of schools and the study population make the collection of the sample difficult to researcher.
4 Lake of local references about the study topic in English.
5 Lake of logistic support (recurrent electricity cutting) .

3.23 Ethical considerations

1- Before starting the study the researcher, take Helsinki committee approval.
2- Taking of ministry of education approval before distributing the questionnaire.
3- Taking governorates directorate approval before distributing the questionnaire.
4- Approval of students before answering the questionnaire.

Chapter IV

Data Analysis

4.1 One Sample K-S Test

One Sample K-S test was used to identify if the data follow normal distribution or not. This test is considered necessary in case testing hypotheses as most parametric Test stipulate data to be normality distributed and this test used when the size of the sample are greater than 50. Results test as shown in table (4.4), clarifies that the calculated p-value is greater than the significant level, which equals 0.05 (p-value. > 0.05). This in turn denotes that data follows normal distribution, and so parametric Tests must be used.

Table (4.4)
One Sample K-S

Section	Statistic	P-value
Gaza Traumatic events checklist	1.306	0.066
Davidson Trauma Scale (DTS)	0.666	0.767
Social support scale	1.340	0.055
Family Crisis Oriented Personal Evaluation Scales (FCOPES).	0.803	0.539

4.2 results of the study

Personal information and Socio demographic data table

Table No. (4.5)

variables	Items	Frequency	Percentages
class	Tenth	242	55.8%
	Eleventh	155	35.7%
	Twelfth	37	8.5%
gender	Male	201	46.3%
	Female	233	53.7%
Type of accommodation	Camp	244	56.2%
	City	153	35.3%
	Village	37	8.5%
Numbers of family members	1-4 members	16	3.7%
	5-7 members	158	36.4%
	More than 8 members	260	59.9%
Education of the father	Illiterate	14	3.2%
	Elementary school	39	9.0%
	Preparatory school	63	14.5%
	Secondary school	126	29.0%
	Diploma	60	13.8%
	University	95	21.9%
	Graduated university	37	8.5%
Education of the mother	Illiterate	25	5.8%
	Elementary school	20	4.6%
	Preparatory school	82	18.9%
	Secondary school	180	41.5%
	Diploma	55	12.7%
	University	57	13.1%
	Graduated university	15	3.5%
Work of the father	Dose not work	120	27.6%
	An ordinary employee	59	13.6%
	Craftsman	41	9.4%
	Employee	159	36.6%
	dealer	34	7.8%
	other	21	4.8%
Work of the mother	Housewife mother	366	84.3%
	Employee	55	12.7%
	other	13	3.0%
House monthly income	Less than 1000 NIS	169	38.9
	1001 - 2000	103	23.7
	2001 - 3000	67	15.4
	3001 – 4000	40	9.2
	More than 4000	55	12.7

4.3 Class frequency

Table 4.5 shows 55.8% from the sample are "tenth class ", 35.7 % from the sample are "eleventh class ", and 8.5 % from the samples are " twelfth class ". This appears in the tenth class more than in eleventh and twelfth in the study population they are more so 10^{th} will be are more than 11^{th} and 12^{th} in the study sample.

4.4 Gender frequency

Table 4.5 shows that 46.3% from the sample are "Male", and 53.7% from the sample are "Female " the study population characterized by female more than meals so it is logically to be the female are more than meal in the study sample .

4.5 Address frequency

Table 4.5 shows that 20.54% from the sample are from " Northern governorate " , 24.2% from the sample are from " Gaza governorate " , 19.4% from the sample are from " Mid-area governorate " , 16.8 % from the sample are from " Khanyounis governorate " , and 19.1 % from the sample are from " Rafah governorate " the percentage of all governorate are likely to be convergent.

4.6 Type of accommodation frequency

Table No. 4.5 shows that 56.2% from the sample type of accommodation are " camp " . 35.3% from the sample type of accommodation are "City". 8.5% from the sample type of accommodation are " Village " most of the sample is living in camps that because the all of the mid area are camps ,the north densities of people are love in jabalia camp. However, in some areas there are differences between the city and the village like bethanon , absan , bnesohila . .

4.7 Number of family member's frequency

Table No.4.5 shows that 3.7% from the sample the number of family members are" 1-4" , and 36.4 that % from the sample the number of family members are"5-7 " , and 59.9 that % from the sample the number of family members are" 8 or more " its appear to be the Palestinian families are in medium family members.

4.8 Education of the father frequency

Table No.4.5 shows that 3.2% from the sample father's "illiterate" and 9.0% from the sample the education of the father are elementary school. While, 14.5% from the samples their father's education are " preparatory school", and 29.0% from the samples father's finished " secondary school ". In addition to 13.8% from the sample the education of the father are " Diploma " , 21.9% from the sample the education of the father are " University " , and 8.5 % from the sample the education of the father are " Graduated study".

4.9 Education of the mother frequency

Table No.4.5 shows that 5.8% from the sample illiterate, 4.6% from the sample the education of the mother "did not learn". 18.9% from the sample the education of the mother finished "elementary school". 41.5% from the sample the education of the mother finished "preparatory school" , and 12.7% from the sample the education of the mother finished" secondary school". 21.8% from the sample the education of the mother finished "Diploma". 13.1% from the sample the education are University" 3.5 % from the sample the education of the mother have been "Graduated study".

4.10 The work of the father frequency

Table No.4.5 shows that 27.6% from the sample fathers' do not work; 13.6% from the sample fathers' work as " an ordinary employee " . 9.4% from the sample fathers' work as " craftsman " , 36.6% from the sample fathers' work as " employee " , 7.8% from the sample fathers works as " Dealer " , and 4.8% from the sample fathers' work as " other ". Its appears that unemployment is very high .

4.11 The work of the mother frequency

Table No.4.5 shows that 84.3 % from the samples mothers' work as " a housewife " ; 12.7% from the samples mother work as " employee " , 3.0% from the samples mother work as " Other works ". Thus, the majority of Palestinian mothers do not work. It doesn't mean that they are not educated because in the last table 3.1shows that most of the mother are educated. However, the chance fore work is less for women or the culture does not support the work of women.

4.12 The amount of monthly home income (in shekels) frequency

Table No. 4.5 shows that 38.9% from the sample have a monthly income " Less than 1000 NIS " , 23.7% from the sample have a monthly income , " from 1001-2000 NIS " .
15.4 %. from the sample have a monthly income , " from2001-3000 NIS " , 9.2%, from the sample have a monthly income , " from3001-4000 NIS ", 12.7%, from the sample have a monthly income , " more than 4000 NIS ". This reflects that the Palestinian families income are low ,and the majority have low income less than 1000 NIS so the people are live in hard situations and that affect the quality of life .

According to 2007 report by the Palestinian Central Bureau of Statistics and the National Coalition for the Global Call to Action against Poverty-Palestine, and based on income data. 79.4% of households in the Gaza Strip have income lower than the national poverty line of US$3 per day. The unemployment rate is estimated by a recent UNDP survey to have increased from 36%, prior to the Israeli operations, to 43%. The survey also estimated that poverty among the unemployed has increased from 56% to 66% in the aftermath of military operations (PCBS, 2007).

4.13 Gaza Traumatic events checklist Scale

The researcher used one sample t test to test if the opinion of the respondent in the content of the sentences is positive (weight mean greater than "75%" and the p-value less than 0.05). The opinion of the respondent in the content of the sentences is neutral (p- value is greater than 0.05) ,or the opinion of the respondent in the content of the sentences is negative (weight mean less than "75%" and the p-value less than 0.05). The results shown in Table No (4. 6) shows that the average mean for all items equals 1.23 (from 2) and the

weight mean equals 61.5 %, which is, less than " 75%". The absolute value of t test equals 32.883, which is greater than the critical value, which equals 1.96, and the p- value equals 0.000, which is less than 0.05. It means that the effect of social and family support on the PTSD symptoms in children in the Gaza strip are strong.

Table (4.6)
Gaza Traumatic events checklist Scale

No.	Event and trauma	**Mean**	**standard deviation**	**Weight mean**	**t-value**	**P-value**
1	Witnessing death of a friend or relative of yours in front of you as a result of bombing	1.26	0.439	63.00	-11.363	0.000
2	Witnessing death of a father or a brother or a sister or a relative of yours in front of you as a result of bombing	1.05	0.224	52.50	-41.520	0.000
3	Witnessing injuring a friend or a relative was shot dead in front of you or shrapnel	1.26	0.442	63.00	-11.082	0.000
5	Witnessing your neighbors house is destroyed by shelling	1.50	0.501	75.00	0.000	1.000
6	Witnessing your home is destroyed by shelling or bulldozers and demolished	1.15	0.360	57.50	-20.162	0.000
7	Witnessing homes, and neighbors are shelling with heavy artillery and machine guns, and airplanes	1.36	0.480	68.00	-6.095	0.000
8	Witnessing your home is bombarded with heavy artillery and machine guns, and airplanes.	1.09	0.293	54.50	-28.852	0.000
9	See injured and the remains of the martyrs in the television	1.92	0.273	96.00	32.048	0.000
10	You have been injured by shrapnel bomb or missile, or bullet	1.07	0.262	53.50	-33.941	0.000
11	You have been detained in the house	1.26	0.438	63.00	-11.505	0.000
12	you have been beaten and humiliated by the Israeli army	1.01	0.117	50.50	-26.365	0.000
13	You have been deprived of water and electricity and eating and going to the toilet	1.24	0.429	62.00	-12.539	0.000

No.	Event and trauma	Mean	standard deviation	Weight mean	t-value	P-value
	as a result of the war					
14	Exposure to fire by the Israeli army with a view to intimidation and intimidation	1.27	0.444	63.50	-10.805	0.000
15	personal property was destroyed, and crushing and looting during the war	1.28	0.449	64.00	-10.265	0.000
16	Expose you personally threatened with death by the military	1.09	0.283	54.50	-30.364	0.000
17	Use as a human shield for the inspection of houses of the neighborhood or a neighbor to catch you	1.04	0.205	52.00	-46.399	0.000
18	Expose you forced to leave your home with your family and relatives as a result of the war	1.38	0.486	69.00	-5.136	0.000
19	You have been injured by burning phosphorous bombs and the regular	1.05	0.210	52.50	-45.050	0.000
	All statement	1.23	0.168	61.50	-32.883	0.000

Critical value of **t** at df "433" and significance level 0.05 equal 1.96.

4.14 Davidson Trauma Scale (DTS)

The researcher used one sample t test to test if the opinion of the respondent in the content of the sentences is positive (weight mean greater than "60%" and the p-value less than 0.05). The opinion of the respondent in the content of the sentences is neutral (p- value is greater than 0.05), or the opinion of the respondent in the content of the sentences is negative (weight mean less than "60%" and the p-value less than 0.05). The results shown in Table No (4. 7) the average mean for all items equals 2.55 and the weight mean equals 51.07% which is less than " 75%", and the value of t test equals 14.249 which is greater than the critical value which equals 1.96, and the p-value equal 0.000 which is less than 0.05. This means that the family and social support influence weakly by the PTSD symptoms.

Table(4.7)
Davidson Trauma Scale (DTS)

No.	Items	**Mean**	**standard deviation**	**Weight mean**	**t-value**	**P-value**
1	Have you had painful images memories or thoughts of the event?	2.91	1.094	58.16	-1.755	0.080
2	Have you had distressing dreams of the event?	2.42	1.281	48.48	-9.372	0.000
3	Have you felt as though the event was re-occurring?	3.28	1.282	65.62	4.568	0.000
4	Have you been upset by something which reminded?	3.36	1.315	67.24	5.733	0.000
5	Have you been avoiding any thoughts or feelings about the event?	3.19	1.389	63.73	2.798	0.005
6	Have you been avoiding doing thing s or going into situations which remind you about the event?	3.11	1.449	62.26	1.623	0.105
7	Have you found yourself unable to recall important parts of the event	1.25	0.689	25.02	22.647	0.000
8	Have you had difficulty enjoying things?	2.63	1.458	52.67	-5.234	0.000
9	Have you felt distant or cut off from other people	2.19	1.333	43.82	-12.642	0.000
10	Have you been unable to have sad or loving feeling	1.61	1.097	32.21	-26.383	0.000
11	Have you found it hard to imagine along life span fulfilling your goals?	2.55	1.369	50.97	-6.873	0.000
12	Have you had trouble	2.30	1.251	46.08	-11.586	0.000

No.	Items	**Mean**	**standard deviation**	**Weight mean**	**t-value**	**P-value**
	falling asleep or staying a sleep?					
13	Have you been irritable or had outbursts of anger?	2.64	1.366	52.76	-5.516	0.000
14	Have you had difficulty concentrating?	2.92	1.161	58.43	-1.406	0.160
15	Have you felt on edge, been easily distracted, or had to stay on guard	2.66	1.353	53.23	-5.213	0.000
16	Have you been jumpy or easily startled?	2.31	1.198	46.22	-11.985	0.000
17	Have you been physically upset by reminders of the event?	2.07	1.345	41.34	-14.456	0.000
	All statement	2.55	0.653	51.07	-14.249	0.000

Critical value of **t** at df "433" and significance level 0.05 equal 1.96

4.15 Social support scale

The researcher used one sample t test to test if the opinion of the respondent in the content of the sentences is positive (weight mean greater than "66.6%" and the p-value less than 0.05). The opinion of the respondent in the content of the sentences is neutral (p- value is greater than 0.05) or the opinion of the respondent in the content of the sentences is negative (weight mean less than "66.6%" and the p-value less than 0.05)

4.15.1 Support perceived from family and relatives

The researcher used one sample t test to test if the opinion of the respondent about the Support perceived from family and relatives. The results shown in Table No. (4.8) which shows that the average mean for all items equals 2.48 (from 3) and the weight mean equals 82.81% which is greater than " 66.6%" . The absolute value of t test equal 36.452 which is greater than the critical value which equals 1.96 and the p- value equal 0.000 which is less than 0.05 . This means that Support perceived from family and relatives is high.

Table(4.8)
Support perceived from family and relatives

No.	statement	Mean	standard deviation	Weight mean	t-value	P-value
1	my family members being with me when I need them	2.71	0.503	90.32	29.411	0.000
2	my relatives give me advice when I need	2.56	0.625	85.25	18.591	0.000
3	My family helps me to overcome the problems that I face	2.60	0.553	86.56	22.480	0.000
4	I have a sufficiency of friends around me	2.37	0.808	78.88	9.445	0.000
5	The friendship in my family is characterized by psychological support	2.53	0.670	84.25	16.415	0.000
6	my family give me advice when I need	2.80	0.438	93.39	38.163	0.000
7	relatives encourage us to overcome the psychological problems that I face	2.32	0.723	77.34	9.226	0.000
8	my family does not help me when I need	1.29	0.663	43.16	-22.159	0.000
9	When I have a problem I can ask for help from my parents and my relatives	2.66	0.587	88.71	23.468	0.000
10	my family made me feel satisfied and strong	2.78	0.488	92.55	33.116	0.000
11	I feel comfortable when I'm asking for support from my family	2.71	0.545	90.48	27.308	0.000
	Total items	2.48	0.277	82.81	36.452	0.000

4.15.2 Psychosocial support provided by friends

The researcher used one sample t test to test if the opinion of the respondent about the Psychosocial support provided by friends. Its results shown in Table No. (4.9) which show that the average mean for all items equals 2.26(from 3) and the weight mean equals 75.27% which is less than " 66.6%" and the absolute value of t test equal 16.509which is greater than the critical value which equals 1.96 and the p- value equal 0.000 which is less than 0.05. This means that psychosocial support provided by friends is high.

Table (4.9)
Psychosocial support provided by friends

No.	statement	Mean	standard deviation	Weight mean	t-value	P-value
1	My friends always ready to listen to my problems	2.50	0.628	83.41	16.676	0.000
2	I have sufficiency of the friends around me who	2.38	0.807	79.26	9.754	0.000
3	My friends help me financially when needed	2.19	0.794	73.04	5.016	0.000
4	my friends come to me alone when they need me	2.22	0.685	74.12	6.795	0.000
5	I feel that I am of interest to my colleagues who live close to me	2.46	0.665	81.95	14.354	0.000
6	When I'm in a problem that I relied on my close colleagues to help me	2.41	0.684	80.26	12.414	0.000
7	all my life I find whom helping me when I need help	2.24	0.690	74.50	7.098	0.000
8	I find it difficult to seek professional help	1.95	0.743	64.98	-1.422	0.156
9	My relation with my friends make me feel important	2.74	0.521	91.32	29.569	0.000
10	I feel that there is no real support from my friends	1.50	0.733	49.85	-14.346	0.000
	Total items	2.26	0.326	75.27	16.509	0.000

4.15.3 Psychosocial support provided by the institutions

The researcher used one sample t test to test if the opinion of the respondent about the psychosocial support provided by the institutions, and the results shown in Table No. (4.10). It shows that the average mean for all items equals 1.60 (from 3), and the weight mean equals 5.47 % which is less than "66.6%". The absolute value of t test equals 17.199 which is greater than the critical value which equals 1.96 and the p- value equals 0.000 which is less than 0.05. It means that psychosocial support provided by the institutions is weak.

Table (4.10)
psychosocial support provided by the institutions

No.	statement	Mean	standard deviation	Weight mean	t-value	P-value
1	There is institutions and programs with psychosocial support in my area that providing assistance to families in need such as family	1.60	0.808	53.23	-10.401	0.000
2	There institutions in my area which give us financial and moral support and	1.74	0.877	58.06	-6.130	0.000
3	I receive psychological help from the institutions that provide psychological counseling	1.24	0.524	41.32	-30.206	0.000
4	There is at least one institution which provide me with financial support	1.54	0.832	51.46	-11.425	0.000
5	I find it very difficult to get help from social institutions, which provide assistance to families in need such as family	1.90	0.862	63.29	-2.451	0.015
	Total items	1.60	0.479	53.47	-17.199	0.000

Critical value of **t** at df "433" and significance level 0.05 equal 1.97

4.15.4 All sub fields of (Social support scale)

The researcher used one sample t test to test if the opinion of the respondent about the Social support scale and the results shown in Table No. (4.11). It shows that the average mean for all items equals 2.23 (from 3) and the weight mean equals 74.27 % which is less than " 66.6%" . The absolute value of t test equals 21.154 which is greater than the critical value which equals 1.96 and the p- value equals 0.000 which is less than 0.05. It means that social support is good .

Table(4.11)
Social support scale all sub fields

No.	Subfields	Mean	standard deviation	Weight mean	t-value	P-value
1	Support perceived from family and relatives	2.48	0.277	82.81	36.452	0.000
2	Psychosocial support provided by friends	2.26	0.326	75.27	16.509	0.000
3	psychosocial support provided by the institutions	1.60	0.479	53.47	-17.199	0.000
	Total items	2.23	0.225	74.27	21.154	0.000

4.16 Family Crisis Oriented Personal Evaluation Scales (FCOPES)

The researcher used one sample t test to test if the opinion of the respondent in the content of the sentences are positive (weight mean greater than "60%" and the p-value less than 0.05). The opinion of the respondent in the content of the sentences is neutral (p- value is greater than 0.05), or the opinion of the respondent in the content of the sentences is negative (weight mean less than "60%" and the p-value less than 0.05) .

4.16.1 Requesting for social support

The researcher used one sample t test to test if the opinion of the respondent about the requesting for social support and the results shown in Table No. (4.12) . It shows that the average mean for all items equals 3.66 (from 5) and the weight mean equals 73.25 % which is greater than " 60%". The absolute value of t test equal 25.231 which is greater than the critical value which is equals 1.96 and the p- value equal 0.000 which is less than 0.05. This means that requesting for social support is high.

Table(4.12)
requesting for social support

No.	**statement**	**Mean**	**standard deviation**	**Weight mean**	**t-value**	**P-value**
1	We share our relatives difficulties	4.31	0.921	86.22	29.667	0.000
2	ask for encouragement and support from friends	3.98	0.875	79.54	23.251	0.000
5	ask the advice of relatives (eg grandparents)	4.00	1.019	80.09	20.530	0.000
8	receive gifts and assistance from neighbors such as food and clothing.	2.88	1.191	57.56	-2.136	0.033
10	ask for help from neighbors	3.26	1.136	65.30	4.860	0.000
16	share with close friends we are concerned	3.76	1.207	75.25	13.166	0.000
20	Participate our relatives in activities that are beneficial (family meetings, and invite them to dinner in)	4.21	0.884	84.10	28.383	0.000
25	We ask relatives about what they feel toward our problem	3.71	1.073	74.29	13.867	0.000
29	share our problem with our neighbors	2.84	1.386	56.87	-2.356	0.019
	Total items	3.66	0.547	73.25	25.231	0.000

4.16.2 Restructuring

The researcher used one sample t test to test the opinion of the respondent about the Restructuring and the results shown in Table No. (4.13) . The table shows that the average mean for all items equals 3.94, and the weight mean equals 78.80% which is greater than " 60%". The absolute value of t test equals 33.920 which is greater than the critical value which equals 1.96 and the p- value equal 0.000 which is less than 0.05. It means that Restructuring is good.

Table(4.13)
Restructuring of family

No.	statement	Mean	standard deviation	Weight mean	t-value	P-value
3	we know that we have the power to solve the general problems	3.95	0.974	78.99	20.302	0.000
7	know that we have the ability to solve our problems	4.00	0.887	79.95	23.421	0.000
11	face the problems and trying to find solutions to them immediately	4.08	1.078	81.57	20.836	0.000
13	we show we are strong	3.67	1.192	73.46	11.756	0.000
15	accept the fact stressful events in life	3.88	1.004	77.56	18.215	0.000
19	accept that these problems can occur without expecting	3.85	1.186	76.91	14.859	0.000
22	believe that we can solve our problems ourselves	3.96	0.907	79.12	21.964	0.000
24	put the problem in the a positive context of family so as not frustrated	4.14	0.967	82.86	24.614	0.000
	Total items	3.94	0.577	78.80	33.920	0.000

4.16.3 Request for spiritual (religious) support

The researcher used one sample t test to test the opinion of the respondent about the Request for spiritual (religious) support and the results shown in Table No. (4.14). It shows that the average mean for all items equals 4.29 and the weight mean equals 85.77 % which is greater than " 60%". The absolute value of t test equal 25.911 which is greater than the critical value which equals 1.96 and the p- value equals 0.000 which is less than 0.05. This means that Request for spiritual (religious) support is high.

Table(4.14)
Request for spiritual (religious) support

No.	statement	Mean	standard deviation	Weight mean	t-value	P-value
14	attend religious seminars	4.15	0.973	82.90	24.521	0.000
23	participate in religious seminars	4.25	0.938	84.93	27.698	0.000
27	ask the advice of religious leaders (Sheikh, a man of repair)	3.97	1.070	79.35	18.845	0.000
30	We believe that this is the will of God	4.79	0.688	95.90	54.378	0.000
	Total items	4.29	0.585	85.77	25.911	0.000

4.16.4 Positive evaluation

The researcher used one sample t test to test the opinion of the respondent about the positive evaluation and the results shown in Table No. (4.15). The table shows that the average mean for all items equals 3.63 and the weight mean equals 72.62 % which is greater than " 60%". The absolute value of t test equals 21.416 which is greater than the critical value which equals 1.96. The p- value equals 0.000 which is less than 0.05, that means the evaluation is positive.

Table(4.15)
Positive evaluation

No.	statement	Mean	Standard deviation	Weight mean	t-value	P-value
12	watch television	4.20	0.914	84.01	27.368	0.000
17	We know that luck can play a role as we do to solve our problems, family	3.42	1.311	68.48	6.738	0.000
26	feel that it is important to the work of precautions to avoid problems, otherwise we will face difficulties in solving problems	4.27	0.860	85.44	30.826	0.000
28	believe that if we wait enough time, the problem will end on its own	2.63	1.266	52.53	-6.144	0.000
	Total items	3.63	0.614	72.62	21.416	0.000

4.16.5 Action of the family

The researcher used one sample t test to test the opinion of the respondent about the action of the family and the results shown in Table No. (4.16). The table shows that the average mean for all items equals 3.69 and the weight mean equals 73.83 % which is greater than " 60%" . The absolute value of t test equals 22.345 which is greater than the critical value which equals 1.96 and the p- value equal 0.000 which is less than 0.05. This means the action of the family is good.

Table(4.16)
Action of the family

No.	statement	Mean	standard deviation	Weight mean	t-value	P-value
4	ask the advice of members of the families have faced similar problems	3.85	1.102	77.10	16.160	0.000
6	ask for help from institutions specializing in helping families	3.21	1.256	64.15	3.439	0.001
9	ask for advice and information from the clinic doctor	3.71	1.118	74.24	13.270	0.000
18	practice exercises with friends to reduce tension	3.91	0.976	78.16	19.381	0.000
21	ask for help from specialists in counseling to help families located in the problem	3.78	1.124	75.53	14.388	0.000
	Total items	3.69	0.645	73.83	22.345	0.000

Critical value of **t** at df "433" and significance level 0.05 equal 1.97

4.16.6 All sub fields

The researcher used one sample t test to test the opinion of the respondent about family supports, the results shown in Table No. (4.17). It shows that the average mean for all items equals 3.82 and the weight mean equals 76.41 % which is less than " 60%" . The absolute value of t test equals 31.708, which is greater than the critical value, which equals 1.96, and the p- value equals 0.000, which is less than 0.05. That means the family support is good.

Table (4.17)

Family Crisis Oriented Personal Evaluation Scales (FCOPES)

No.	**Subfields**	**Mean**	**standard deviation**	**Weight mean**	**t-value**	**P-value**
1	requesting for social support	3.66	0.547	73.25	25.231	0.000
2	Restructuring	3.94	0.577	78.80	33.920	0.000
3	Request for spiritual (religious) support	4.29	0.585	85.77	25.911	0.000
4	positive evaluation	3.63	0.614	72.62	21.416	0.000
5	action of the family	3.69	0.645	73.83	22.345	0.000
	Total items	3.82	0.410	76.41	31.708	0.000

4.17Analysis of socio demographic data

Is There significant difference at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist, Davidson Trauma Scale (DTS), Social support scale, and FCOPES due to demographic data (gender, Place of residence governorate, Type of accommodation, no. of family, education of the father , education of mother, the work of father, the work of mother, and the amount of monthly household income)?

These questions divided into sub questions as follows:

4.17.1Gender

Is there a significant difference at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist, (DTS), Social support scale, and (FCOPES) due to (gender)?

To answer the question the researcher used the independent Samples t test and the result illustrated in table no.(4.18). It shows that the p-value for each scale greater than 0.05 (except at Gaza Traumatic events checklist p-value = 0.041 which is less than 0.05). The absolute value of T test for each scale less than the value of critical value which equals 1.97(except at Gaza Traumatic events checklist t = 2.047 which is greater than 1.97). This means that there is no significant difference at $\alpha \leq 0.05$ among (DTS), Social support scale, and (FCOPES) due to sex. In addition, there is a significant in Gaza Traumatic events checklist difference at $\alpha \leq 0.05$ and the differences in female's favor.

Table No.(4.18)
Independent Samples Test for difference among (Gaza Traumatic events checklist, Davidson Trauma Scale (DTS), Social support scale Family Crisis Oriented Personal Evaluation Scales (FCOPES) due to gender

Field	Gender	N	Mean	Std. Deviation	T	P-value
Gaza Traumatic events checklist	male	201	1.217	0.148	-2.047	0.041
	female	233	1.250	0.183		
The Davidson Trauma Scale (DTS)	male	201	2.523	0.705	-0.901	0.368
	female	233	2.580	0.604		
Social support scale	male	201	2.222	0.227	-0.488	0.626
	female	233	2.233	0.223		
Family Crisis Oriented Personal Evaluation Scales (FCOPES	male	201	3.825	0.398	0.195	0.846
	female	233	3.817	0.421		
All scales	male	201	2.593	0.202	-0.914	0.361
	female	233	2.611	0.202		

Critical value of **t** at df "432" and significance level 0.05 equals 1.97

4.17.2 Place of residence governorate

Is there a significant difference at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist, (DTS), Social support scale ,and (FCOPES) due to place of residence governorate?

To answer the question the researcher used one way ANOVA and the result illustrated in table no. (4.19). It shows that the p-value for Social support scale (FCOPES) equals 0.000, and 0.002 respectively which is less than 0.05. The value of F test equals (6.001, and 4.258 respectively) which is greater than the value of critical value that equals 2.39. This means that there is a significant difference at $\alpha \leq 0.05$ in Social support scale (FCOPES). In general, the value of F statistic for all scale equals 4.364 which is greater than the value of critical value which equals 2.39 and the p- value equals 0.002 which is less than 0.05. This means that There is a significant difference at $\alpha \leq 0.05$ in all scales to gophers due to Place of residence governorate , and from LSD TEST table No.(4.20). It shows that the difference between "North", and "Middle", and the difference in favor of "North"

Table No.(4.19)
One way ANOVA test for difference among in (Gaza Traumatic events checklist, Davidson Trauma Scale (DTS), Social support scale Family Crisis Oriented Personal Evaluation Scales (FCOPES) due to Place of residence governorate

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Gaza Traumatic events checklist	Between Groups	0.076	4	0.019	0.666	0.616
	Within Groups	12.194	429	0.028		
	Total	12.270	433			
The Davidson Trauma Scale (DTS)	Between Groups	1.410	4	0.352	0.826	0.509
	Within Groups	182.982	429	0.427		
	Total	184.392	433			
Social support scale	Between Groups	1.157	4	0.289	6.001	0.000
	Within Groups	20.678	429	0.048		
	Total	21.835	433			
Family Crisis Oriented Personal Evaluation Scales (FCOPES)	Between Groups	2.777	4	0.694	4.258	0.002
	Within Groups	69.963	429	0.163		
	Total	72.741	433			
All scales	Between Groups	0.691	4	0.173	4.364	0.002
	Within Groups	16.976	429	0.040		
	Total	17.667	433			

Critical value of F at df "4,429" and significance level 0.05 equal **2.39**

Table No.(4.20)
Tukey LSD

Mean Difference	North	Gaza	Middle	Khan Yunis	Rafah
North		-0.013	-0.085	-0.097*	-0.077
Gaza	0.013		-0.072	-0.084	-0.064
Middle	0.085	0.072		-0.012	0.008
Khan Yunis	0.097*	0.084	0.012		0.020
Rafah	0.077	0.064	-0.008	-0.020	

The mean difference is significant at the .05 level. Is there a significant difference at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist, (DTS), Social support scale .and (FCOPES) due to Type of accommodation?.

4.17.3 Type of accommodation

Is there a significant difference at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist, (DTS), Social support scale and (FCOPES) due to type of accommodation?

To answer the question The researcher used one way ANOVA and the result illustrated in table no. (4.21). It shows that Social support scale (FCOPES) p-value equals 0.020 which is less than 0.05 and the value of F test equals 3.924 which is greater than the value of critical value which equals 3.02 . It mean that there is a significant difference at $\alpha \leq 0.05$ in Social support scale (FCOPES) due to type of accommodation . In general, the value of F statistic for all scale equals 0.148 which is less than the value of critical value which equals 3.02 and the p- value equals 0.863 which is greater than 0.05 . It means that there are no significant differences at $\alpha \leq 0.05$ in all scales to gathers due to Type of accommodation.

Table No.(4.21)
One way ANOVA test for difference among (Gaza Traumatic events checklist, Davidson Trauma Scale (DTS), Social support scale Family Crisis Oriented Personal Evaluation Scales (FCOPES) due to type of accommodation

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Gaza Traumatic events checklist	Between Groups	0.128	2	0.064	2.279	0.104
	Within Groups	12.142	431	0.028		
	Total	12.270	433			
The Davidson Trauma Scale (DTS)	Between Groups	2.205	2	1.103	2.609	0.075
	Within Groups	182.186	431	0.423		
	Total	184.392	433			
Social support scale	Between Groups	0.050	2	0.025	0.490	0.613
	Within Groups	21.786	431	0.051		
	Total	21.835	433			
Family Crisis Oriented Personal Evaluation Scales (FCOPES	Between Groups	1.301	2	0.650	3.924	0.020
	Within Groups	71.440	431	0.166		
	Total	72.741	433			
All scales	Between Groups	0.012	2	0.006	0.148	0.863
	Within Groups	17.655	431	0.041		
	Total	17.667	433			

Critical value of F at df "2,431" and significance level 0.05 equal 3.02

4.17.4 Family members

Is there a significant difference at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist (DTS), Social support scale, and (FCOPES) due to no. of family members ?.

To answer the question The researcher used one way ANOVA and the result illustrated in table no.(4.22) which shows that (DTS) p-value equals 0.035 which is less than 0.05 and the value of F test equals 3.374 which is greater than the value of critical value which equals 3.02 . It means that There is a significant difference at $\alpha \leq 0.05$ in (FCOPES) family members. In general, the value of F statistic for all scale equals 0.045 which is less than the value of critical value which equals 3.02 and the p- value equals 0.956 which is greater than 0.05 that means that there are no significant differences at $\alpha \leq 0.05$ in all scales to gathers family members.

Table No.(4.22)
One way ANOVA test for difference among (Gaza Traumatic events checklist, Davidson Trauma Scale (DTS), Social support scale Family Crisis Oriented Personal Evaluation Scales (FCOPES) due to no. of family members

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Gaza Traumatic events checklist	Between Groups	0.019	2	0.010	0.342	0.711
	Within Groups	12.251	431	0.028		
	Total	12.270	433			
The Davidson Trauma Scale (DTS)	Between Groups	2.843	2	1.421	3.374	0.035
	Within Groups	181.549	431	0.421		
	Total	184.392	433			
Social support scale	Between Groups	0.030	2	0.015	0.295	0.745
	Within Groups	21.806	431	0.051		
	Total	21.835	433			
Family Crisis Oriented Personal Evaluation Scales (FCOPES	Between Groups	0.570	2	0.285	1.703	0.183
	Within Groups	72.170	431	0.167		
	Total	72.741	433			
All scales	Between Groups	0.004	2	0.002	0.045	0.956
	Within Groups	17.663	431	0.041		
	Total	17.667	433			

Critical value of F at df "2,431" and significance level 0.05 equal 3.02

4.17.5 Education of the father

Is there a significant difference at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist (DTS), Social support scale, and (FCOPES)) due to education of the father?.

To answer the question The researcher used one way ANOVA and the result illustrated in table no.(4.23) which shows that the p-value equals 0.504 which is greater than 0.05, and the value of F test equals 0.888 which is less than the value of critical value which equals 2.12. It means that there are no significant differences at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist, (DTS), Social support scale, and (FCOPES) due to education of the father.

Table No.(4.23)
One way ANOVA test for difference among in (Gaza Traumatic events checklist, Davidson Trauma Scale (DTS), Social support scale Family Crisis Oriented Personal Evaluation Scales (FCOPES) due to education of the father

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Gaza Traumatic events checklist	Between Groups	0.099	6	0.017	0.580	0.746
	Within Groups	12.171	427	0.029		
	Total	12.270	433			
The Davidson Trauma Scale (DTS)	Between Groups	4.207	6	0.701	1.662	0.129
	Within Groups	180.184	427	0.422		
	Total	184.392	433			
Social support scale	Between Groups	0.082	6	0.014	0.270	0.951
	Within Groups	21.753	427	0.051		
	Total	21.835	433			
Family Crisis Oriented Personal Evaluation Scales (FCOPES	Between Groups	0.917	6	0.153	0.908	0.489
	Within Groups	71.824	427	0.168		
	Total	72.741	433			
All scales	Between Groups	0.218	6	0.036	0.888	0.504
	Within Groups	17.449	427	0.041		
	Total	17.667	433			

Critical value of F at df "6,427" and significance level 0.05 equal **2.12**

4.17.6 Education of the mother

Is there a significant difference at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist, (DTS), Social support scale ,and (FCOPES)) due to education of mother ?.

To answer the question The researcher used one way ANOVA and the result illustrated in table no.(4.24) which shows that the p-value equals 0.714 which is greater than 0.05 and the value of F test equals 0.321 which is less than the value of critical value which equals 2.12 . It means that there are no significant differences at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist, (DTS), Social support scale, and (FCOPES) due to education of mother.

Table No.(4.24)
One way ANOVA test for difference among (Gaza Traumatic events checklist, Davidson Trauma Scale (DTS), Social support scale Family Crisis Oriented Personal Evaluation Scales (FCOPES) due to education of mother

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Gaza Traumatic events checklist	Between Groups	0.169	6	0.028	0.996	0.428
	Within Groups	12.101	427	0.028		
	Total	12.270	433			
The Davidson Trauma Scale (DTS)	Between Groups	0.730	6	0.122	0.283	0.945
	Within Groups	183.662	427	0.430		
	Total	184.392	433			
Social support scale	Between Groups	0.380	6	0.063	1.260	0.275
	Within Groups	21.456	427	0.050		
	Total	21.835	433			
Family Crisis Oriented Personal Evaluation Scales (FCOPES	Between Groups	0.339	6	0.057	0.334	0.919
	Within Groups	72.401	427	0.170		
	Total	72.741	433			
All scales	Between Groups	0.153	6	0.025	0.621	0.714
	Within Groups	17.514	427	0.041		
	Total	17.667	433			

Critical value of F at df "6,427" and significance level 0.05 equal **2.12**

4.17.7 Work of the father

Is there a significant difference at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist, (DTS), Social support scale , and (FCOPES)) due to the work of father?

To answer the question The researcher used one way ANOVA and the result illustrated in table no.(4.25) which shows that the p-value equal 0.363 which is greater than 0.05 and the value of F test equals 1.095 which is less than the value of critical value which equals 2.24 . It means that there are no significant differences at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist, (DTS), Social support scale, and(FCOPES)) due to the work of father.

Table No.(4.25)
One way ANOVA test for difference among in (Gaza Traumatic events checklist, Davidson Trauma Scale (DTS), Social support scale Family Crisis Oriented Personal Evaluation Scales (FCOPES) due to the work of father

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Gaza Traumatic events checklist	Between Groups	0.146	5	0.029	1.029	0.400
	Within Groups	12.124	428	0.028		
	Total	12.270	433			
The Davidson Trauma Scale (DTS)	Between Groups	1.412	5	0.282	0.660	0.654
	Within Groups	182.980	428	0.428		
	Total	184.392	433			
Social support scale	Between Groups	0.195	5	0.039	0.772	0.570
	Within Groups	21.640	428	0.051		
	Total	21.835	433			
Family Crisis Oriented Personal Evaluation Scales (FCOPES	Between Groups	0.955	5	0.191	1.139	0.339
	Within Groups	71.786	428	0.168		
	Total	72.741	433			
All scales	Between Groups	0.223	5	0.045	1.095	0.363
	Within Groups	17.444	428	0.041		
	Total	17.667	433			

Critical value of F at df "5,428" and significance level 0.05 equal **2.24**

4.17.8 Work of the mother

Is there a significant difference at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist, (DTS), Social support scale , and (FCOPES)) due to the work of mother?.

To answer the question The researcher used one way ANOVA and the result illustrated in table no.(4.26) which shows that (for Gaza Traumatic events checklist)the p-value equals 0.012 which is less than 0.05 and the value of F test equals 4.497 which is greater than the value of critical value which equals 3.02. It means that there are a significant differences at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist) due to the work of mother. In general, the value of F statistic for all scale equal 2.137 which is less than the value of critical value which equals 3.02 and the p- value equals 0.119 which is greater than 0.05. It means that there are no significant differences at $\alpha \leq 0.05$ in all scales to gathers family members due to the work of mother.

Table No.(4.26)
One way ANOVA test for difference among in (Gaza Traumatic events checklist, Davidson Trauma Scale (DTS), Social support scale Family Crisis Oriented Personal Evaluation Scales (FCOPES) due to the work of mother

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Gaza Traumatic events checklist	Between Groups	0.251	2	0.125	4.497	0.012
	Within Groups	12.019	431	0.028		
	Total	12.270	433			
The Davidson Trauma Scale (DTS)	Between Groups	0.490	2	0.245	0.574	0.564
	Within Groups	183.902	431	0.427		
	Total	184.392	433			
Social support scale	Between Groups	0.088	2	0.044	0.867	0.421
	Within Groups	21.748	431	0.050		
	Total	21.835	433			
Family Crisis Oriented Personal Evaluation Scales (FCOPES	Between Groups	0.486	2	0.243	1.449	0.236
	Within Groups	72.255	431	0.168		
	Total	72.741	433			
All scales	Between Groups	0.173	2	0.087	2.137	0.119
	Within Groups	17.493	431	0.041		
	Total	17.667	433			

Critical value of F at df "2,431" and significance level 0.05 equal 3.02

4.17.9 Amount of monthly household income

Is there a significant difference at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist, (DTS) Social support scale, and (FCOPES)) due to the amount of monthly household income?

To answer the question The researcher used one way ANOVA and the result illustrated in table no.(4.27) which shows that the p-value equals 0.889 which is greater than 0.05 and the value of F test equals 0.283 which is less than the value of critical value which equals 2.39. It means that there are no significant differences at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist, (DTS), Social support scale, and(FCOPES)) due to the amount of monthly household income.

Table No.(4.27)
One way ANOVA test for difference among in (Gaza Traumatic events checklist, Davidson Trauma Scale (DTS), Social support scale Family Crisis Oriented Personal Evaluation Scales (FCOPES)) due to the amount of monthly household income

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Gaza Traumatic events checklist	Between Groups	0.091	4	0.023	0.798	0.527
	Within Groups	12.179	429	0.028		
	Total	12.270	433			
The Davidson Trauma Scale (DTS)	Between Groups	1.030	4	0.258	0.603	0.661
	Within Groups	183.362	429	0.427		
	Total	184.392	433			
Social support scale	Between Groups	0.090	4	0.023	0.446	0.775
	Within Groups	21.745	429	0.051		
	Total	21.835	433			
Family Crisis Oriented Personal Evaluation Scales (FCOPES	Between Groups	0.674	4	0.169	1.003	0.406
	Within Groups	72.066	429	0.168		
	Total	72.741	433			
All scales	Between Groups	0.047	4	0.012	0.283	0.889
	Within Groups	17.620	429	0.041		
	Total	17.667	433			

Critical value of F at df "4,429" and significance level 0.05 equal 2.39

There is significant relationship at significance level among the four scale (Gaza Traumatic events checklist, (DTS), Social support scale, and (FCOPES) at significance level $\alpha = 0.05$.

What is the correlation between each scale?

To answer the question the researcher used the Pearson correlation between each two scales (Gaza Traumatic events checklist,(DTS), Social support scale, and (FCOPES)), and the results shown in table No.(4.28). It Illustrates that there is a positive significant correlation at significance level $\alpha = 0.05$ between (Gaza Traumatic events checklist, and (DTS)) and positive correlation between (DTS) ,and Gaza Traumatic events checklist) . Negative correlation between (DTS), and social support scale) ,and negative correlation between social support scale , and (DTS)) , and positive correlation between (FCOPES), and social support scale .

Table No.(4.28)

Correlation between each two scales (Gaza Traumatic events checklist, The Davidson Trauma Scale (DTS), Social support scale Family Crisis Oriented Personal Evaluation Scales (FCOPES)

Section	**statistic**	Gaza Traumatic events checklist	The Davidson Trauma Scale (DTS)	Social support scale	Family Crisis Oriented Personal Evaluation Scales (FCOPES)
Gaza Traumatic events checklist	Pearson coloration	1	0.215*	0.020	-0.047
	p-value	.	0.000	0.679	0.326
	N	434	434	434	434
The Davidson Trauma Scale (DTS)	Pearson coloration	0.215*	1	-0.097*	-0.045
	p-value	0.000	.	0.044	0.351
	N	434	434	434	434
Social support scale	Pearson coloration	0.020	-0.097*	1	0.273
	p-value	0.679	0.044	.	0.000
	N	434	434	434	434

Family Crisis Oriented Personal Evaluation Scales (FCOPES)	Pearson coloration	-0.047	-0.045	0.273*	1
	p-value	0.326	0.351	0.000	.
	N	434	434	434	434

Critical value of r at significance level 0.05 and df equal 53 equal 0.269

The stares mean that there is a correlation negative mean negative correlation and the positive mean positive correlation.

Chapter V

5.1 Introduction

This chapter presents a discussion of the results as presented in chapter four and they are discussed in the light of the research questions and objectives of the study. These findings are in line with reviewed literature. It is important to clarify the results and its relation with other studies that may be helpful in supporting our finding and recommendations regarding to trauma, resilience and self-esteem among university students. In addition to, provide recommendations for future research based on the result of the current study.

5.2 Main results

The study revealed that the weight mean of traumatic experience is 61.5% (SD=0.168). (p value 0.000)and t value (-32.883) .

While the most traumatic events the study sample was exposed "See injured and the remains of the martyrs in the television 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 %".

While the trauma symptoms occur with the study sample according to Davidson trauma scale (DTS) was weight mean was (51.07%) and (SD=0.653).the weight mean is less than the expected mean (60%). It means the study population affected by the family and social support is strong.

Most symptoms of PTSD ware appeared in the study sample ware "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 event25.02%".

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 and (SD=0.277),(t=36.452),(p=0.000). 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) (t= 16.509),(p= 0.000) and(SD=0.326) 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(SD=0.479), (p=0.000) and (t=17.199)) 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%" (SD= 0.225),(t= 21.154)and (p= 0.000) . It means that Social support provided to study sample are high and that can decrease the PTSD symptoms.

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 (SD= 0.547),(p= 0.000)and (t= 25.231)) 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 (SD= 0.577),(t= 33.920)and (p= 0.000) 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 (SD=0.585),(t=25.911,p=0.000) 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 (SD=0.614),(t=21.416,p=0.000) 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 (SD=0.645),(t=22.345)and (p=0.000) 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 (SD=0.410),(t=31.708)and(p=0.000) 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.

The result shows that no gender differences in all scales. However, in Gaza traumatic event checklist there is a significant differences p-value for each scale greater than 0.05 (except at Gaza Traumatic events checklist(p-value = 0.041) , except at Gaza Traumatic events checklist(t = 2.047 which is greater than 1.97). It means that there are no significant differences among (DTS), Social support scale, and (FCOPES) due to sex. In addition, there is a significant in Gaza Traumatic events checklist difference and the differences in favor of female that mean the females was effected by trauma more than males .

There is a significant difference at $\alpha \leq 0.05$ in (Social support scale and (FCOPES) due to place of residences p-value. (For Social support scale, and (FCOPES) equals 0.000, and 0.002 respectively, which is less than 0.05. In addition, the value of F test equals (6.001 and 4.258 respectively) which is greater than the value of critical value, which equals (2.39).

In general, the value of F statistic for all scale equals 4.364, which is greater than the value of critical value, which equals 2.39 and the p-, value equal 0.002, which is less than 0.05. It means that there are significant differences at $\alpha \leq 0.05$ in all scales to gophers due to Place of residence governorate , and from LSD TEST that the difference between " North " , and " Middle " , and the difference in favor of " North " .

The results show that there are significant differences in Social support scale, and (FCOPES), due to place of accommodation village, camp, or city. For Social, support

scale, and (FCOPES) the p-value equals 0.020, which is less than 0.05, and the value of F test equals 3.924. Therefore, it is greater than the value of critical value, which equals 3.02. In general, the value of F statistic for all scale equals 0.148 which is less than the value of critical value which equals 3.02 and the p- value equals 0.863 which is greater than 0.05. This means that there are no significant differences at $\alpha \leq 0.05$ in all scales together due to Type of accommodation.

The results show that there are no significant differences in all scales due to number of family members. The general value of F statistic for all scale equals (0.045) which is less than the value of critical value, which equals 3.02, and the p- value, which equals (0.956).

There are no differences in (Gaza Traumatic events checklist, (DTS), Social support scale, and (FCOPES)due to education of the father F test equals (0.888) which is less than the value of critical value which equals (2.12) and p-value which equals (0.504).

There are no significant differences in (Gaza Traumatic events checklist, (DTS), Social support scale, and (FCOPES)) due to education of mother, F test equals (0.321) which is less than the value of critical value which equals (2.12) and p-value which equals (0.714).

There are no significant differences in (Gaza Traumatic events checklist, (DTS), Social support scale, and (FCOPES) due to the amount of monthly household income the p-value equals (0.889) and the value of F test equals (0.283) which is less than the value of critical value which equals 2.39 .

There are positive significant correlation at significance level $\alpha = 0.05$ between (Gaza Traumatic events checklist , and (DTS)) and positive correlation (DTS) ,and Gaza Traumatic events checklist). Besides, negative correlation between (DTS), and Social support scale) ,and positive correlation between (FCOPES), and social support scale)

5.3 Discussion of the results

5.3.1 Post traumatic stress disorder

What is the rate of the traumatic experiences among secondary school students?

Our findings found that 61.5% of the participants experienced to trauma . The researcher attributed these finding to continue trauma witch exposed during Al Aqsa intefada and the comprehensiveness of the war on all parts of the Gaza-Strip. This was constant with most of studies performed in the Gaza strip. In reviewing of the recent study, the researcher found that their is many differences in many studies in the rate of trauma according to the use of different type of scales , the time, and the type of trauma. Before Gaza war, the trauma was less than after the war and that because severity of the war, which affected all parts of Gaza, strip. Studies examined trauma found high rate traumatic event. In Gaza strip 99% of children experienced at least one traumatic event (Altawil, et al., 2008), Thabet et al (2008) study showed more events involving children saw the pictures of the wounded and the martyrs in the TV percent 95.6%. In addition to hearing the artillery shelling in different parts of the Gaza Strip at a rate of 95.6%. In this study, The researcher found that 60% of children exposed to medium trauma, and 6.7% are subjected to a simple trauma While 33.3% of children are exposed to severe psychological trauma. For post-traumatic stress disorder, It showed that 15.6% suffer mild (PTSD) symptoms , and 62.2% with Medium a degree , while 20% suffer drastically. That study constant with the researcher's study and the percent is near to his one.

Amir and Sol (1999) found that 67 % of undergraduates reported one event while 37 % of them reported more than one trauma. In Japan, the traumatic events in life were revealed as 80 % of college students (Mizuta, et al., 2005). Civilian war survivor in Kosovo showed high prevalence of traumatic experiences (83%) with high psychological distress Nexhmedin M, Gernot C. (2006). 66% of college students reported exposure to a criterion A trauma. (Jennifer, P., et al., 2011). T he study of New-Zealand adults revealed that 61% of the sample experienced trauma events in their lifetime (Nikolaos K., et al., 2010). In Sweden, 80.8 % of the participants represents general population experienced at least one traumatic event (Frans, et al., 2005). Almost 94% of children met Diagnostic and Statistical Manual of Mental Disorders, 4th ed., criteria for posttraumatic stress disorder. 90, 6%and 95.5% of the children reported significant life activity affecting sadness and anxiety, respectively (Richard et al, 1997).

What types of traumatic events are most likely associated with the development of PTSD? In the development of (PTSD) of the study sample 51.07%of the study population has (PTSD) and that was constant with other Palestinian and national studies. Such as, Al Saraj and Quta (2004) study of the prevalence of PTSD and other psychological suffering among Palestinian children living under sever condition during last tow and half years; during Al Aqua Intifada. The results indicated that 32.7% of children started to develop acute PTSD symptoms that need psychological intervention. In another study to Thabet et al (2002)The results indicated that symptom of PTS was more with children who were exposed to bombardment in comparison to children in the control group. Thabet et al (2008) Exposure to war trauma has been independently associated with (PTSD) Results Both in children and parents reported a high number of experienced traumatic events, and high rates of PTSD and anxiety scores above previously established cut-off. Among children, trauma exposure was significantly associated with total and subscales PTSD scores, and with anxiety scores. In contrast, trauma exposure was significantly associated with PTSD intrusion symptoms in parents. (Vivian Khamis1993).

In a study was performed to assess the prevalence of PTSD among Palestinian school-age children the Results shows a substantial number of children experienced at least one lifetime trauma (54.7%). (PTSD) was diagnosed in 34.1% of the children. There has been little formal consideration of the variability in PTSD seen in Palestinian children in general. A few studies have investigated school age children in non-traumatic situations (Berna & Hyman, 1993; Motta, 1994), and as a result the prevalence of PTSD in these children is unknown. Estimates of the prevalence rates of PTSD have varied from 2% in school—age children) to 50% in children who have experienced war atrocities (Anthony, 1986). The discrepancy in these results may be attributed to the magnitude and severity of the stressors (Khamis, 1993; March, 1993; Pynoos, 1990). Most of whom were refugees, males, and working on a study to Maksoud, (1992) Lebanese children found that on average, a Lebanese child has experienced witnessing violent actions were the most common traumatic experience faced by Lebanese children. War related traumatic events during his or her life witnessing violent actions were the most common traumatic experience faced by Lebanese children. In contrast, involving in military activities, being a victim of violent actions , and suffering from serious physical injuries were less common experience on a study to Thabet et al (1999). The measures of post traumatic stress,

anxiety and fears, he found that , significantly more children exposed to bombardment and home demolition reported symptoms of PTSD and fear than controls group. In study conducted in Russia, Vladislav, (1998), (42%) fulfilled partial criteria and (25%) fulfilled full DSM-IV criteria for Posttraumatic stress disorder. (42%) fulfilled partial criteria and 87 (25%) fulfilled full DSM-IV criteria for Post traumatic stress disorder (Vladislav, 1998). More than 40% of the students reported knowing someone injured and more than one-third reported knowing someone killed in the blast Betty et al, (1999). (22.9%) fulfilled the DSM-IV criteria for PTSD. 67% of young adult college students have been estimated to experience comparable traumatic events (Bernat, Ronfeldt, Calhoun, & Arias, 1998).There were significant differences between children with and without PTSD on each individual component of screening battery an 90% of children diagnosed with PTSD after 6weks evaluation Paul, et al, (1999). Bosnian studies Almost 94% of children met Diagnostic and Statistical Manual of Mental Disorders, 4th ed., criteria for posttraumatic stress disorder (Richard et al, 1997). al Saraj and Quta (2004)study 49.2%of Palestinian children living under sever condition suffered from moderate level of PTSD symptoms, According to (Maksoud, 1992). Study to Betty et al, (1999) he found that The number of war trauma were experienced by a child was positively related to PTSD symptom's and various type of war traumas were differentially related to PTSD. Betty et al, (1999), Found that, PTSD has been described in children exposed to variety of traumatic experience is. Partial symptomatology and co-morbidity is common. Vladislav, (1998), study showed that(42%) fulfilled partial criteria and 87 (25%) fulfilled full DSM-IV criteria for post traumatic stress disorder. They found that, Russian juvenile delinquents represent a severely traumatized population, mainly due to high levels of violence exposure. those with full posttraumatic stress disorder are the most severely traumatized and have highest rates of psychopathology, in But, Paul, et al, (1999) study found (22.9%) fulfilled the DSM-IV criteria for PTSD and after 6 weeks post trauma the screen identified up to 90% of children diagnosed with PTSD and 37% with borderline conditions. Moreover, in various studies of the effects of Road Traffic Accidents rates have varied from 29% at four weeks, 36% at 6 weeks, 6%–25% at 12–15 weeks through to 14% at 9 months post-accident (Stallard, Salter, & Velleman, 2004). Other studies of 200 adolescent survivors of the sinking of the cruise ship Jupiter (Yule et al., 2000) reported an incidence of PTSD of 51%. Most cases manifested within the first few weeks, with delayed onset being rare. Other disorders such as anxiety and depression were also common. Following a discothèque fire that killed 63 adolescents, 25% of the 275 survivors met DSM-IV criteria

for PTSD (Broberg, Dyregrov, & Lilled, 2005) 18 months after the fire. Following another fatal fire in a youth cafe´ in Volendam, Netherlands, Reijneveld, Verhulst and Verloove-Vanhorick (2003) were able to examine pre-disaster mental health ratings with post-fire ones as many of the adolescents had participated previously in an epidemiological study. The findings indicated the need to look at disorders such as anxiety, depression, aggression and alcohol abuse as well as PTSD. Studies of rates of childhood PTSD in warfare and among child refugees from war torn countries find that the incidence varies from 25% to 70%, depending on exposure and type of warfare. Following sexual abuse, the rates reported have also varied between 0% to 90% (Salmon & Bryant, 2002), but usually with high rates. Similar rates have been found in children who witness family violence or they themselves suffer physical violence (the two often go together). Peer victimization is also associated with posttraumatic stress, as is the exposure to community violence (Mynard, Joseph, & Alexander, 2000; Luthar & Goldstein, 2004). Margolin and Gordis (2000) presented an overview of the effect on violence on children.

However, in (Ahmed et al, 2000) study the percentage of trauma was very high Eighty seven percent 87% of children reported PTSD Children's, trauma scores were positively correlated with posttraumatic stress disorder. Another study reported the high level of PTSD Nader et al (1993) assessed Kuwaiti children following the Gulf crisis, and found that 70% reported moderate to sever PTSD reactions. For instance, across studies, events cited by two-thirds to more than 90% of Palestinian children include seeing victims of violence on television, witnessing funerals, shootings, bombardments and shelling and injured or dead persons. (Qouta et al., 2003; Thabet, Abed, and Vostanis, 2001). %60.7 of American adults reported experiencing at least one traumatic event during their lives, but only 8.2% of the men and 20.4% of the women ever developed PTSD (Kessler et al 1995).

What are most common traumatic events that affect secondary school students **?**

The most type of trauma that Gaza children exposed to was See injured and the remains of the martyrs in the television Weight mean was 96.00% . The second one Witnessing neighbors house destroyed by shelling or bulldozers and demolished .Weight mean was 75.00 % but the lowest trauma was Used as a human shield for the inspection of houses of the neighborhood or a neighbor to catch you 52.00%. Then, beaten and humiliated by the Israeli army weight mean was 50.50%. Thabet et al (2008) is constant with the researcher's study. More events involving children who saw the pictures of the wounded and the martyrs in the TV percent 95.6%, and other study was consistent with the

researcher's study. El-Buhaisi (2010) took in his study about the psychological effects among adolescents exposed to war on Gaza. He found that the most traumatic events due to war on Gaza was 90.8 % of adolescents " Watching mutilated bodies in TV" . Another study conducted in the Gaza strip found that 99% of children had suffered humiliation (to either themselves or a family member); 97% had been exposed to the sound of explosions/bombs; 85% had witnessed a martyr's funeral and 84% had witnessed shelling by tanks, artillery, or military planes (Altawil, et al., 2008).

The results are near to each other because the researcher used the same scale. The researcher attributed these finding to the widespread interest by the population in the Gaza Strip to follow up the news of the war through the media. Especially, most citizens were banned from going out of their homes as well as on the availability of television in every home. However, in Al Saraj and Quta (2004)the results showed that the most prevalent types of trauma exposure for children are for those who had witnessed funerals 94.6% , witnessed shooting 83.2%, saw injured or did who are not relatives 66.9% ,and saw family members who injured or killed 61.6%. Thus, far the most symptom of PTSD is not constant with the researcher's study because of tow reason. The first is the time of the study before Gaza war so many people injured, have been shouted and the people not under restriction of the Israeli army. However, in Gaza war the people were restricted to exit from home . Therefore, the only method was watching TV in order to know the news.

Thus, the other type of trauma the destruction of homes because all Palestinian people are targeted to war and, live in a small region, and Gaza strip ware home is overcrowded.

The second reason was using different scale that my change the results.

5.3.2 Social and family support roll

What is the level of social support among secondary school students in Gaza strip**?**

Social support level according to social support scale was divided into 3 sub scales the following:

First, support provided by family and relative was (82.81%). Second, support provided by friends was (75.27%). Third, social support provided by the institution was (53.47%), and all sub field was 974.27%).Thus, the social support was high; the study sample was perceived by social support is good. the study sample was received the most social support from the family, relatives and from the friends. In contrast, the support received from the

institution was not high but in the sum of all psychosocial support, was high. This can decrease the symptoms of PTSD.

What is the level of family support among secondary school students?

according to (F-COPES) the family support was as follows the scale was divided into 5 sub scale as the following: First, requesting for social support 73.25%. Second, Restructuring (78.80%). Third, Request for spiritual (religious) support (85.77%). Fourth, positive evaluation (72.62%). Fifth, action of the family 73.83, and all sub fields 76.41. Thus, the most support received by the Request for spiritual (religious) support. This means that the study sample firstly and mostly approached to Allah and religion and to decrees their anxiety and stress.

Does the family and social support influence the PTSD symptoms?

Social and family support in the researcher study was high .and that was constant with many recent studies.

The recent study is constant with the researcher's study as the fowling social support can reduce or exclude the consequences of these significant life events on health (Coune & Dawney, 1991). Individual who enjoys the social support that have affection from others since the first years of his life then becomes a person with high self confident and able to provide social support to others (Bowlpy, J, 1980). Barbarin et al. (2001), the children's experiences of violence depended on their families' ability to act as barriers to the violence and the quality of family relationships and other social support resources available. However, Ahern et al. (2004) showed low levels of social support and high levels of traumatic exposure exhibited the highest rate of PTSD symptoms, (Brewin et al., 2000). Positive elements such as the perception of emotional and practical support. (Armando A. Pina and Ian K. Villalta 2008) that greater helpfulness from extra familial sources of social support predicted lower levels of child-rated symptoms of PTSD anxiety. In (Imad Mukhaimar, 1997; Nabil Dokhan and Basher Hajjar, 2006; Emad Abd elRazek, 1998 stud .(In addition to Vitaliano's study and his colleagues (Vitaliano et al. 2001) "the social support received by the individual through the groups to which he belongs, such as family, friends and colleagues in work and study, or club play a major role in reducing the negative effects of the events and bad attitudes that he did not exposed. In addition, it agrees with the results of a study of (Pattrrson et al. 1989) to emphasize the importance of the availability of social support through parental pattern of sons, and to take the size of predictable a standard of social support

for social relations development of a network of individuals who suffer from severe stressful life events.

(Hisham Abdullah, 1995), the lower of the social support level more level of PTSD. Ali Abdel Salam (1997) there is significant differences between the high social support the lower of PTSD. Two recent 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, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003). Low perception of social support would result in development of posttraumatic symptoms, especially, if there were a lack of family support and Social support. Family is one of the most important protective factors for coping with trauma. On the other hand, (Quta & al Saraj 2004) found that differences in perceiving social support did not account for variation in stress response among the injured of the intifada; supported individuals did not report less stress than unsupported individuals did. The strength of the relationship between social support and the severity of PTSD symptoms may vary from one type of trauma to another (Valentiner, Foa, Riggs, & Gershuny, 1996). Lack of social support emerged as a risk factor for PTSD across all population sample (Brewin, Andrews, and Valentine 2000). the lower of the social support level reported more depression and hopelessness and anxiety and vice versa, social support improve and modify the methods in facing the pressures of life and deal with the higher level of depression and anxiety and vice versa, (Hisham Abdullah, 1995). Therefore, most of last studies are congruent with the study the more social and family supports the lower PTSD symptoms.

5.3.3 Gender differences role

Is there significant difference at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist,(DTS), Social support scale, and (FCOPES)) due to gender?

The result illustrated that the p-value for each scale greater than 0.05 except at Gaza Traumatic events checklist p-value = 0.041 which is less than 0.05). It means that there is no significant difference at $\alpha \leq 0.05$ among(DTS), Social support scale, and(F.COPES) due to sex . In contrast, there are significant differences in Gaza Traumatic events checklist and the differences in the female's favor. It means that the females are exposed to trauma more than males. On the other hand, the symptoms due to trauma, social support and family

support are equal no gender differences. This result is Consistent with many studies Regarding gender, girls generally appear to be more vulnerable toward PTSS than boys (Dyregrov et al., 2002; Braun-Lewensohn et al., 2009; Orla, 2003; Orlee, Boyle, and Yule,2000). Although this tendency also comes forward in the Palestinian context (e.g. Punamaki, and Puhakka, 1997; Qouta et al., 2003, Qouta, Punamaki, and El Saraaj. 2004; Thabet et al., 2001), it extent remains equivocal, with some studies suggesting no gender differences or even higher levels of posttraumatic stress in males, as in Punamaki et al.□ (2005). female more vulnerable to trauma than male, female to male (2to1) (APA 1994). PTSD following the disaster was significantly associated with being female (Orlee, et al, 2000). This differs from Garbarino et al (1996), in his study of 150 Palestinian children and their mothers living in cities and villages in the West Bank, he founds that; boys were more vulnerable to risks than girls.

Unlike other studies, the researcher's study showed that there are no gender differences in social and family support. Thus, both sexes received support equally. In contrast, (Belle, 1987; Vaux, 1988) Assumed that Women seem to be more likely to both receive support and benefit from support than men. Moreover, women appear to be more overwhelmed by the emotional burden of the support process than men (Kessler, McCleod, & Wethington, 1985). On the other hand, men seem to perceive support as useful for accomplishing a task but are less inclined to disclose their emotions (Veroff, Douvan, & Kulka, 1981). Although evidences indicate that social support has more effect on women than on men, very little is known about the variables explaining these relationships for victims who experience PTSD. However, on the social support the results showed that there are no significant differences and that differs from Dunmore et al.,(2001). Negative social support, at least in the case of violent crime, appears to be more prevalent for women than for men victims. Boys were more vulnerable to risks than girls were. Moreover, boys were especially susceptible to multiple risks.(Garbarino et al 1996), Negative social support, at least in the case of violent crime, appears to be more prevalent for women than for men victims(Tarrier, Sommerfield, & Pilgrim, 1999).

5.3.4 Place of residence governorate

Is there significant difference at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist, (DTS), Social support scale, and (FCOPES)) due to Place of residence governorate?

Results illustrated that the p-value (for Social support scale Family Crisis Oriented Personal Evaluation Scales (FCOPES)) equal 0.000, and 0.002 respectively which is less than 0.05 and the value of F test equal (6.001 , and 4.258 respectively) which is greater than the value of critical value which is equal 2.39 . It means that There are significant differences in (Social support scale and (FCOPES)), due to Place of residence governorate . Also, HSD TEST showed that the difference between " North " , and " Khanyones " and the difference in favor of " North " There is not a lot studies compare between the governorates of Gaza in trauma. In contrast, Thabet et al (2008) showed that The city of Rafah and Beit Lahia from the cities and regions more vulnerable to Israeli violence and terrorism. This due to its proximity to the points of the Israeli army on the Egyptian border and the border With Israel, where Israeli troops on the border shelling of Palestinian civilians daily incursions with various weapons in order to intimidate and terrorize the Palestinian population. Also, they want to demolish Palestinian homes in order to discharge the cities of the Palestinian population. Therefore, the researcher sees that all Gaza governorate was exposed to the Israeli war but their was area affected more than other areas especially the north governorate that multiple trauma to the north and other area let the people to support others more than other area. In other study of Palestinian children living close to Israeli settlements found acute levels of posttraumatic stress to an important extent (55%)(Quota et al., 2005). While other research found children meeting the criteria of PTSD to come mainly from urban areas (Thabet et al., 2001).

5.3.5 Home monthly income role

Is there significant difference at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist, (DTS), Social support scale, and (FCOPES)) due to the amount of monthly home income?

There are no significant differences at $\alpha \leq 0.05$ in (Gaza Traumatic events checklist, (DTS), Social support scale, and (FCOPES)) due to the amount of monthly household income. This means that the house holed income don not affect the trauma, social support or family support. The researcher deduced that because all the Gaza strip affected by Israeli war and the war did not compare between rich or poor and the support socially or familial was given to the study sample.

5.4 Correlations

The correlations between each scale was there is positive significant correlation at significance level $\alpha = 0.05$ between (Gaza Traumatic events checklist and (DTS)). It means that when the trauma is increased the symptoms of PTSD will increased and vice versa. Also, negative correlation between (DTS), and Social support scale). It means when the social support is increased the symptoms of PTSD decreased and vice versa.

In addition to positive correlation between (FCOPES), and social support scale). It means when the social support increased the family support increased and vice versa.

Recommendation

- Immediate intervention to children and their families in case of trauma that will decrease the consequence of PTSD.
- Training of school social and psychological workers about PTSD, how to discover it early, and how to manage such disorders.
- Put weekly lessons for students abut dealing with hard situations by social and psychological workers.
- Teach families abut the importance of their roles in case of PTSD and how to deal with their children.
- It is necessary to provide therapeutic intervention program such as crisis intervention for students who ware affected directly from Israeli violence, or those who are at risk.
- 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.
- Encourage Exercises and increase the sports lessons at every school that will decrease anxiety and lower the tension.
- Modification of institutions Programs and plans which meet all generations and families and cover all levels of community.
- Increases the community institutions witch provide social support.

5.6 Conclusion and suggestion for further researches

The integration of social and family support concepts in the study of PTSD are challenging, so it is still in its infancy. However, it considers the evidence for a global link between social support, family support and PTSD, it is not soon to orient researchers and clinicians toward the development of psychotherapies that integrate social support, and family support interventions. Researchers should now invest in studies that target the unique cognitive, emotional, and behavioral processes underlying this link. Numerous issues must also be addressed, including the elaboration, adaptation, and use of instruments. That measures social and family support perceptions and behaviors related to PTSD; the identification of the characteristics of social and family support (i.e., received and perceived, most influential sources) that are more closely related to the development and maintenance of the disorder. As well as resilience to trauma; and the specification of the impact of factors; such as, gender and co morbid disorders (especially major depression). Advances in these areas will motivate researchers to elaborate a definition of a social and family support construct adapted to the specific conditions of this mental health disorder to enhance future etiological models of PTSD.

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Annexes
Annex No.(1)
Covering letter and socio-demographic scale

بسم الله الرحمن الرحيم

عزيزي الطالب عزيزتي الطالبة يقوم الباحث بإجراء دراسة بعنوان تأثير الدعم الأسري و الاجتماعي على أعراض ما بعد الصدمة عند طلاب و طالبات المرحلة الثانوية في قطاع غزة حيث أن هذه الدراسة هي لاستكمال متطلبات بحث التخرج لدراسة ماجستير الصحة النفسية المجتمعية بجامعة القدس – أبو ديس . ويهدف الباحث من خلال هذه الدراسة للتعرف على مدى تأثر طلاب الثانوية بالخبرات الصادمة التي تعرضوا لها و تأثير الدعم الأسري و الاجتماعي عليهم

لذا أمامكم عدة أسئلة لقياس الصدمات و المساندة الاجتماعية و الأسرية أرجو منكم الإجابة بصدق عن كل الأسئلة التالية و سوف تراعى السرية التامة في هذه الإجابات مع العلم أنها سوف تستخدم لغرض البحث العلمي

ملاحظة: المشاركة في البحث اختيارية وليست إجبارية.و لا داعي لكتابة الاسم

ولكم جزيل الشكر

الباحث

علاء الدين سعيد الكرد

أولا / البيانات الديموغرافية .

1- المدرسة---------- 2- الصف---------- 3-العمر ---------

4- الجنس □ ذكر □ أنثى

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

6- نوع السكن □ مدينة □ مخيم □قرية

7- عدد أفراد الأسرة □ 1 – 4 □ 5-7 □ 8 فما فوق

8- تعليم الأب□ لم يتعلم □ ابتدائي □ إعدادي □ ثانوي □دبلوم □جامعي □دراسات عليا.

9- تعليم الأم □ لم تتعلم □ ابتدائي □ إعدادي □ ثانوي □دبلوم □جامعي □دراسات عليا.

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

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

12- مقدار الدخل الشهري للأسرة (بالشيقل) .

□اقل من 1000 □ 1001 – 2000 □ 2001-3000 □ 3001-4000 □ أكثر من 4000

Annex No.(2)
Gaza traumatic event check list
مقياس الخبرات الصادمة في غزة الناتجة عن الحرب على غزة في سنة 2009
إعداد: د. عبد العزيز ثابت (ثابت، 2010)

	الحدث أو الخبرة الصادمة	نعم	لا
1	مشاهدة استشهاد صديق أو قريب لك أمامك نتيجة للقصف		
2	مشاهدة استشهاد أب أو أخ أو أخت أو قريب لك أمامك نتيجة للقصف		
3	مشاهدة إصابة صديق أو قريب لك أمامك بالرصاص أو شظايا القنابل		
4	مشاهدة إصابة أب أو أخ أو أخت أو قريب لك أمامك بالرصاص أو شظايا القنابل		
5	مشاهدة بيت جيرانكم و هو يدمر من القصف أو الجرافات و يهدم		
6	مشاهدة بيتكم و هو يدمر من القصف أو الجرافات و يهدم		
7	مشاهدة بيوت الجيران و هي تقصف بالمدفعية الثقيلة والرشاشات، و الطائرات.		
8	مشاهدة بيتكم وهو يقصف بالمدفعية الثقيلة، والرشاشات، و الطائرات		
9	مشاهدة صور الجرحى و أشلاء الشهداء في التلفزيون		
10	تعرضك للإصابة بشظية قنبلة أو صاروخ أو الرصاص		
11	تعرضك للاحتجاز في البيت		
12	تعرضك للضرب والإهانة من قبل الجيش الإسرائيلي		
13	تعرضك للحرمان من الماء و الأكل و الكهرباء و الذهاب لدورة المياه نتيجة للحرب		
14	تعرضك لإطلاق النار من قبل الجيش الإسرائيلي بقصد التخويف و الترويع		
15	تعرض ممتلكاتك الشخصية للتدمير والتكسير والنهب أثناء الحرب		
16	تعرضك شخصياً للتهديد بالقتل من قبل الجيش		
17	استخدامك كدرع بشري لتفتيش بيوت الجيران أو للقبض على جار لكم		
18	تعرضك قسريا لترك بيتكم مع عائلتك وأقاربك نتيجة للحرب		
19	تعرضك للإصابة بالحرق بالقنابل العادية و الفسفورية		

هل تعرضت لخبرات صادمة أخري ----------

Annex No.(3)
مقياس الاضطرابات النفسية الناتجة عن خبرة صادمة
CPTSD- RI Scale according to DSM - IV
مقياس الاضطرابات النفسية الناتجة عن مواقف صادمة
إعداد وترجمة د. عبد العزيز ثابت

الرقم	الخبرة الصادمة	أبدا	نادرا	أحيانا	غالبا	دائما
1-	هل تنتابك صور، ذكريات، وأفكار عن الخبرة الصادمة؟					
2-	هل تنتابك أحلام مزعجة عن الخبرة الصادمة ؟					
3-	هل تنتابك مشاعر فجائية أو خبرات بأن ما حدث سيحدث مرة أخرى؟					
4-	هل تتضايق من الأشياء التي تذكرك بما تعرضت له من خبرة صادمة؟					
5-	هل تتجنب الأفكار أو المشاعر التي تذكرك بالحدث الصادم؟					
6-	هل تتجنب المواقف و الأشياء التي تذكرك بالحدث الصادم؟					
7-	هل لديك فقدان للذاكرة للأحداث الصادمة التي تعرضت لها (فقدان ذاكرة نفسي محدد)					
8-	هل لديك صعوبة في الاستمتاع بالحياة والنشاطات اليومية؟					
9-	هل تشعر بالعزلة وبأنك بعيد عن الآخرين لا يستطيع الشعور بالحب أو الانبساط؟					
10-	هل أنت غير قادر على الشعور بمشاعر الحزن و الحب (متلبد الإحساس)					
11-	هل تجد من الصعوبة تخيل بأنك ستعيش لفترة طويلة لتحقق أهدافك في العمل، الزواج إنجاب أطفال ؟					
12-	هل لديك صعوبة في النوم أو البقاء نائما؟					
13-	هل تنتابك نوبات ن التوتر و نوبات من الغضب؟					
14-	هل تعاني من صعوبات في التركيز؟					
15-	هل تشعر بأنك على حافة الانهيار(واصلة معاك على الأخر) ، من السهل تشتيت انتباهك؟					
16-	هل تستثار أتفه الأسباب ودائما متحفز؟					
17-	هل الأشياء أو الأشخاص الذين يذكرونك بالخبرة الصادمة تجعلك في نوبة من ضيق التنفس، الرعشة، العرق الغزير وسرعة في ضربات القلب؟					

Annex No.(4)

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

Annex No.(5)

مقياس التقييم الشخصي للأسرة أثناء الأزمات(F-COPES)

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 5 وهذا يعني أنك توافق بشده ، وإذا كانت عبارة لم تنطبق عليك فاختار رقم 1 وهذا يعني انك غير موافق بشده ، وإذا كانت العبارة تصف استجابتك ببعض الموافقة فاختار 2 أو 3 أو 4 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 (1)	لا أوافق (2)	لا اعرف (3)	موافق (4)	موافق بشدة (5)
1	يشاركنا أقاربنا بالصعوبات					
2	يقوم أصدقائنا بتقديم الدعم و النصيحة					
3	نعرف أن لدينا القوة لحل المشكلات العامة					
4	يقدم لنا أفراد من اسر واجهوا مشكلات متشابهه الدعم و النصيحة					
5	يقدم لنا الأقارب مثل (الأجداد) النصيحة					
6	تقدم لنا المؤسسات المتخصصة في مساعدة الأسر المساعدة المادية والمعنوية					
7	نعرف أن لدينا المقدرة لحل مشكلاتنا					
8	نتلقى الهدايا والمساعدة من الجيران مثل الطعام والملابس..					
9	نطلب النصيحة والمعلومات من طبيب العيادة					
10	يقدم لنا الجيران المساعدة					
11	نواجه المشكلات ونحاول إيجاد حلول لها فوراً					
12	نشاهد التليفزيون					
13	نظهر أننا أقوياء					
14	نحضر الندوات الدينية					
15	نتقبل الأحداث الضاغطة كحقيقة في الحياة					
16	يشاركنا أصدقائنا المقربين فيما يقلقنا					
17	يلعب الحظ دور بما سنفعله لحل مشاكلنا العائلية					
28	نمارس تمارين رياضية مع الأصدقاء لتقليل التوتر					
19	نقبل بأن هذه المشاكل يمكن أن تحدث بدون توقع					
20	يشاركنا أقاربنا في نشاطات مفيدة(جلسات عائلية، و دعوتهم للعشاء)					
21	يقدم لنا متخصصين في الإرشاد النفسي للعائلات المساعدة و الإرشاد					
22	نؤمن بأننا يمكن أن نحل مشاكلنا بأنفسنا					
23	نشارك في ندوات دينية					
24	نضع المشكلة العائلية في إطار ايجابي حتى لا نصاب بالإحباط					
25	نسأل الأقارب عما يشعروا به تجاه المشكلة					
26	نشعر بأنه من المهم عمل احتياطات لتجنب المشاكل و إلا فأننا سوف نواجه صعوبات في حل المشاكل					
27	نطلب النصيحة من رجال دين (شيخ، رجل إصلاح)					
28	نؤمن بأننا إذا انتظرنا وقتا كافياً فإن المشكلة ستنتهي لوحدها					
29	نشارك مشكلتنا مع جيراننا					
30	نؤمن بأن هذه إرادة الله					

Annex No.(6) Helsinki committee approval

Palestinian National Authority
Ministry of Health
Helsinki Committee

السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

التاريخ:07/03/2011

Name: **Alaa Eldin El Kord**

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

" The effect of family and social support on post traumatic stress disorder among secondary school students in Gaza Strip".

الاسم: علاء الدين الكرد

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

In its meeting on March 2011

and decided the Following:-

To approve the above mention research study.

و ذلك في جلستها المنعقدة لشهر 3 2011

و قد قررت ما يلي:-

الموافقة على البحث المذكور عاليه.

Signature
توقيع

Member
عضو

Member
عضو

Chairperson

Conditions:-

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

8

Annex No. (7) Facilitating of the task

Al-Quds University
Jerusalem
School of Public Health

جامعة القدس
القدس
كلية الصحة العامة

التاريخ:2011/9/5

حضرة الأستاذ الدكتور/ د. زياد ثابت المحترم

وكيل مساعد وزارة التربية والتعليم العالي

تحية طيبة وبعد ،،،

الموضوع مساعدة الطالب علاء الدين الكرد

يقوم الطالب المذكور بأعلاه باجراء بحث بعنوان :

The effect of family and social support on Post-Traumatic Stress Disorder among secondary school students in Gaza Strip. ".

كمتطلب للحصول على درجة الماجستير في الصحة النفسية المجتمعية وعليه نرجو التكرم والإيعاز لمن ترونه مناسب لتسهيل مهمة الطالب في جمع البيانات اللازمة من مدارس المرحلة الثانوية بمؤسستكم الموقرة في محافظات غزة .

علما بأن المعلومات ستكون متوفرة لدى الباحث والجامعة فقط وسنطلعكم على النتائج في حينه .

شاكرين لكم حسن تعاونكم ودعمكم للمسيرة التعليمية .

وتفضلوا بقبول وافر الاحترام والتقدير،،،

د.بسام أبو حمد
منسق برامج الصحة العامة
جامعة القدس – غزة

نسخة:
- الملف

Jerusalem Branch/Telefax 02-24799234
Gaza Branch/telefax 08-2884422-2884411
Sphealth@admin.alquds.edu
فرع القدس/تلفاكس 02-2799234
فرع غزة/تلفاكس 08-2884422-2884411
ص.ب/51000-القدس

Annex No. (8) ministry of education approval

السلطة الوطنية الفلسطينية
وزارة التربية والتعليم العالي
مكتب وكيل الوزارة

Palestinian National Authority
Ministry of Education & Higher Education
Deputy Office

العامة للتخطيط التربوي
الرقم: و ت غ/ مذكرة داخلية (٢٢٢٧)
التاريخ: 2011/09/05م
التاريخ: 7/ شوال/ 1432

السادة/ مدراء التربية والتعليم حفظهم الله،

تحية طيبة وبعد

الموضوع/ تسهيل مهمة بحث

نهديكم أطيب التحيات، وبالإشارة إلى الموضوع أعلاه يرجى تسهيل مهمة الباحث/ **علاء الدين سعيد الكرد**، والذي يجري بحثاً بعنوان: **تأثير الدعم الأسري والاجتماعي على أعراض ما بعد الصدمة لدى طلبة المرحلة الثانوية في مدارس قطاع غزة**. في تطبيق أدوات البحث على عينة من طلبة الصفوف (العاشر، الحادي عشر، الثاني عشر)، وذلك حسب الأصول.

وتفضلوا بقبول فائق الاحترام والتقدير

د. محمد أبو شنيّر
وكيل وزارة التربية والتعليم العالي

أ. محمود مطر
ن.م.م. التخطيط التربوي

نسخة لـ:
- السيد/ وزير التربية والتعليم العالي
- السيد/ مستشار الوزير
- السيد/ وكيل الوزارة المساعد لشؤون التعليم
- السيد/ وكيل الوزارة المساعد لشؤون التعليم العالي
- السيد/ وكيل الوزارة المساعد للشؤون الادارية والمالية

غزة (08 - 2849711) 2861409 - 08 فاكس (08-2865909) Fax : (08-2865909) 2861409 - 2849711 (08) Gaza

Annex No. (9) Gaza governorate approval

Palestinian National Authority
Ministry of Education & Higher Education
Directorate of Education\East Gaza

السلطة الوطنية الفلسطينية
وزارة التربية والتعليم العالي
مديرية التربية والتعليم / شرق غزة

قسم التخطيط التربوي
الرقم: م.ت.ش.غ/17/أ
التاريخ: 23 / 11 /2011م

السادة/ مدراء المدارس المعنية ومديراتها المحترمون

السلام عليكم ورحمة الله وبركاته،،،

الموضوع : تسهيل مهمة

تحية طيبة وبعد، لا مانع من تسهيل مهمة الباحث: علاء الدين سعيد الكرد، والذي يجري بحثاً بعنوان: **تأثير الدعم الأسري والاجتماعي على أعراض ما بعد الصدمة لدى طلبة المرحلة الثانوية(العاشر، الحادي عشر، الثاني عشر) في المدارس** لديكم وذلك حسب الأصول.

واقبلوا فائق الاحترام،،،

أ. محمود أبو حصيرة
/ مدير التربية والتعليم

نسخة/ السيدين: نائبي مدير التربية والتعليم المحترمين
الملف

Annex No.(10) Khanyones governorate approval

السلطة الوطنية الفلسطينية
وزارة التربية والتعليم العالي
مكتب وكيل الوزارة

Palestinian National Authority
Ministry of Education & Higher Education
Deputy Office

العامة للتخطيط التربوي
الرقم: و ت ع/ مذكرة داخلية (٢٢٦٧
التاريخ: 2011/09/05م
التاريخ: 7/ شوال/ 1432

السادة/ مدراء التربية والتعليم حفظهم الله،

تحية طيبة وبعد

الموضوع/ تسهيل مهمة بحث

نهديكم أطيب التحيات، وبالإشارة إلى الموضوع أعلاه يرجى تسهيل مهمة الباحث/ **علاء الدين سعيد الكرد**، والذي يجري بحثاً بعنوان: **تأثير الدعم الأسري والاجتماعي على أعراض ما بعد الصدمة لدى طلبة المرحلة الثانوية في مدارس قطاع غزة.**

في تطبيق أدوات البحث على عينة من طلبة الصفوف (العاشر، الحادي عشر، الثاني عشر)، وذلك حسب الأصول.

وتفضلوا بقبول فائق الاحترام والتقدير

د. محمد أبو شقير
وكيل وزارة التربية والتعليم العالي

أ. محمود مطر
ن.م.ع. التخطيط التربوي

نسخة لـ:
- السيد/ وزير التربية والتعليم العالي.
- السيد/ مستشار الوزير
- السيد/ وكيل الوزارة المساعد لشؤون التعليم
- السيد/ وكيل الوزارة المساعد لشئون التعليم العالي.
- السيد/ وكيل الوزارة المساعد للشؤون الادارية والمالية

غزة هاتف (2849711 – 2861409 – 08 فاكس (2865909 – 08) (08-2865909) Fax : Gaza (08 – 2849711 – 2861409

Annex No.(11) North governorate approval

السلطة الوطنية الفلسطينية
وزارة التربية والتعليم العالي
مكتب وكيل الوزارة

Palestinian National Authority
Ministry of Education & Higher Education
Deputy Office

العامة للتخطيط التربوي
الرقم: و ت ع/ مذكرة داخلية (٢٢٤٧
التاريخ: 2011/09/05م
التاريخ: 7/ شوال/ 1432

السادة/ مدراء التربية والتعليم حفظهم الله،

تحية طيبة وبعد

الموضوع/ تسهيل مهمة بحث

تهديكم أطيب التحيات، وبالإشارة إلى الموضوع أعلاه يرجى تسهيل مهمة الباحث/ **علاء الدين سعيد الكرد**، والذي يجري بحثاً بعنوان: **تأثير الدعم الأسري والاجتماعي على أعراض ما بعد الصدمة لدى طلبة المرحلة الثانوية في مدارس قطاع غزة**.

في تطبيق أدوات البحث على عينة من طلبة الصفوف (العاشر، الحادي عشر، الثاني عشر)، وذلك حسب الأصول.

وتفضلوا بقبول فائق الاحترام والتقدير

د. محمد أبو شقير
وكيل وزارة التربية والتعليم العالي

السادة/ مديرو ومديرات المدارس الثانوية المحترمون
لمتابعة تسهيل مهمة الباحث
مع جزيل الشكر
11/12/cc

السلطة الوطنية الفلسطينية
وزارة التربية والتعليم العالي
مديرية التربية والتعليم / شمال غزة

أ. محمود مطر
ن.م.ع. التخطيط التربوي

نسخة لـ:
- السيد/ وزير التربية والتعليم العالي
- السيد/ مستشار الوزير
- السيد/ وكيل الوزارة المساعد لشؤون التعليم
- السيد/ وكيل الوزارة المساعد لشؤون التعليم العالي
- السيد/ وكيل الوزارة المساعد للشؤون الادارية والمالية

غزة - هاتف (2849711 - 2861409 فاكس (08 - 2865909) (08-2865909 Fax : (2861409 Gaza

Annex No. (11)
Lest of arbitrators

1- Dr Abed elaziz Thabet Al qudes university associated professor community mental health Al qudes, Gaza.

2- Dr. Ebrahem Abu nada assistant supervisor UNRWA.

3- Dr. Anwar El Bana chef psychology department Al Aqsa university Gaza.

4- Dr. Afefa Abu Skhela psychology department lecturer Al Aqsa university Gaza.

5- Dr. Habeb El hwajry chef psychologist the ministry of health Gaza .

6- Dr. Hekmy El romy chef of abnormal child psychiatry in the ministry of health Gaza.

7-Dr. Mohammed Asaliea psychology department lecturer Alaqsa university Gaza.

8- Dr. Ahmad El hwajry general director of school mental health the ministry of education.

9- Dr. Samir safy associated professor Islamic university Gaza faculty of commerce.

Annex No. (13) Gaza strip map

ملخص الدراسة

عنوان الدراسة اثر المساندة الأسرية و الاجتماعية على أعراض ما بعد الصدمة لدى طلاب المرحلة الثانوية في قطاع غزة.

هدفت الدراسة معرفة مدى تأثير المساندة الأسرية و الاجتماعية على أعراض ما بعد الصدمة لدى طلاب و طالبات المرحلة الثانوية أي المرحلة العمرية ما بين 18,17,16 في قطاع غزة و كذلك تحديد الفروق بينهم بحسب (الجنس و مكان السكن و الدخل الشهري)) وهل تؤثر هذه الخصائص الديموغرافية والاجتماعية- الاقتصادية على مستوى وشدة التعرض للصدمة و المساندة الأسرية و الاجتماعية لديهم ، . تم تطبيق طريقة الدراسة التحليلية الوصفية على عينة مكونة من 434 طالبا وطالبة (201 طالبا و233 طالبة) حيث تم اختيارهم ضمن عينة قصديه عشوائية من بعض مدارس الثانوية في جميع محافظات غزة.و قد تم استخدام المقاييس التالية في الدراسة مقياس غزة للخبرات الصادمة إعداد د. عبد العزيز ثابت ،مقياس دافيدسون للصدمات ترجمة د. عبد العزيز ثابت مقياس الدعم الاجتماعي لفيفيان خميس و مقياس الدعم الأسري (F- COPES) التقيم الأسري و الشخصي وقت الأزمات و البيانات الديموغرافية . حيث استخدمت على شكل استبيانات تم تعبئتها من قبل الطلبة وكان ذلك نوفمبر من العام 2011.و قد أظهرت نتائج الدراسة أن وزن المتوسط الكلي هو 61.5% و أكثر نوع صدمة تعرض لها أفراد العينة هي مشاهدة الأشلاء و الضحايا و الشهداء في التلفزيون بوزن وسطي 96.00% و يليها مشاهدة بيوت الجيران و هي تقصف و تدمر بوزن وسطي 75.00% و كانت هناك فروق فردية تعزى لمتغير الجنس لصالح الإناث أي أن الإناث تعرضن للصدمات أكثر من الذكور بينما لا توجد فروق ذات دلالة إحصائية تعزى لمتغير الجنس في الدعم الأسري و الاجتماعي أي انه كلا الجنسين تلقى دعم اسري و اجتماعي بشكل متساوي و كانت هناك فروق ذات دلالة إحصائية تعزى لمكان السكن حيث كانت الفروق بين محافظتي خان يونس و محافظة الشمال و كان الفرق لصالح محافظة الشمال حيث أن الشمال قد تعرضوا لصدمات أكثر من غيرها من المحافظات بينما لا توجد فروق دالة إحصائيا تعزى لكمية الدخل الشهري و أظهرت الدراسة أن أعراض ما بعد الصدمة التي تعرضوا لها بوزن وسطي كان 51.07% و على وجه آخر كان مستوى الدعم الاجتماعي 74.27% و تبين أن الدعم الاجتماعي كان معظمه مقدم من الأسرة الأقارب 82.81%و يليه الدعم المقدم من الأصدقاء 75.27% بينما كان الدعم المقدم من المؤسسات متدني حيث كان 53.47%. و كان مقدار الدعم الأسري نسبته 76.41و كان مستواه عالي و كان مقياس الدعم الأسري مقسم كالتالي ،طلب الدعم الأسري و الاجتماعي 73.25% و إعادة هيكلة أو بناء

78.80% ،طلب الدعم الديني و هو أعلى مستوى 85.77% ، التقييم الايجابي 72.62%و ثم عمل أو فعل الأسرة و كان 73.83% . و كانت العلاقات على النحو التالي توجد علاقة ايجابية أي طردية بين مقياس غزة للخبرات الصادمة و مقياس دافيدسون أي انه كلما زادت الصدمات زادت أعراض ما بعد الصدمة و العكس صحيح و كذلك توجد علاقة ايجابية بين مقياس الدعم الاجتماعي و مقياس الدعم الأسري أي كلما زاد الدعم الاجتماعي زاد الدعم الأسري و العكس صحيح بينما توجد علاقة سلبية أي عكسية بين مقياس دافيدسون لأعراض الصدمة و مقياس الدعم الاجتماعي أي انه كلما زاد الدعم الاجتماعي قلت أعراض الصدمة و العكس صحيح