إقـــرار

أنا الموقع أدناه مقدم الرسالة التي تحمل العنوان:

Relationship between Mental Health and Self Esteem Among Mothers of Children with Mental Disability in Gaza Governorates

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The work provided in this thesis, unless otherwise referenced, is the researcher's own work, and has not been submitted elsewhere for any other degree or qualification.

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نتيجة الحكم على أطروحة ماجستير

بناءً على موافقة عمادة الدراسات العليا بالجامعة الإسلامية بغزة على تشكيل لجنة الحكم على أطروحة الباحث/ **محمد زكي عبدالرحمن أبو ركبة** لنيل درجة الماجستير في **كلية *التربية*/ قسم صحة نفسية ومجتمعية-علوم التمريض** وموضوعها:

Relationship Between Mental Health and Self Esteem Among Mothers of Children With Mental Disability in Gaza Governorates

وبعد المناقشة العلنية التي تمت اليوم الأربعاء 06 ذو القعدة 1434هـ، الموافق 2013/09/11م الساعة العاشرة صباحاً بمبنى طيبة، اجتمعت لجنة الحكم على الأطروحة والمكونة من:

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وبعد المداولة أوصت اللجنة بمنح الباحث درجة الماجستير في **كلية *التربية*/قسم صحة نفسية ومجتمعية-علوم التمريض.**

واللجنة إذ تمنحه هذه الدرجة فإنها توصيه بتقوى الله ولزوم طاعته وأن يسخر علمه في خدمة دينه ووطنه.

والله ولي التوفيق،،،

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Dedication

I dedicate this work first of all to my dear parent, sisters, brothers who encouraged me across my life. Special thanks and admiration to my sweetheart (my wife) and my lovely trible twins children (Bashar.Haytham and Rahaf) for their patience, courage and endless support.

Mohammed Zaki Abo Rokba

Date: 2013

Declaration

I certify that this thesis submitted for the degree of master is the result of my own research, except where otherwise acknowledged, and that this thesis or any of its parts has not been submitted for higher degree to any other university or institution.

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Abstract

The overall aim of this study is to understand the relationship between self esteem and mental health among mothers of children with mental disabilities, to determine the level of self esteem and the level of mental health, and to explore the effect of some socio-demographic variables, such as mothers educational level, mothers chronological ages, children chronological ages, and children gender, on the level of self esteem among mothers. It is analytical descriptive study for 165 mothers of children with mental disabilities in three local nongovernmental societies, Khan younis rehabilitation society, Shamis society for care of the handicapped in Gaza town and Nuseirat social and training rehabilitation association. Self esteem tools were used to measure self esteem, and SCL-90-R was used to measure mental health. The results revealed low level of mental health among mothers of children with mental disability (29.07%) and high level of self esteem (60.81%), and the total level of psychological symptoms is (71.93%). The current results indicate that there are various factors that play positively in improving self esteem level among mothers of children with mental disability as culture, family support, spiritual support, and social support. Also, shows that the correlation coefficient between the level of mental health among mothers of children with mental disability and their level of self esteem equals −0.706 and the p-value (Sig.) equals 0.000. The p-value (Sig.) is less than 0.05, so the correlation coefficient is statistically significant at $\alpha = 0.05$, We conclude there exists a significant negative relationship between the level of mental health among mothers of children with mental disability and their level of self esteem and showed that there is significant difference among the respondents regarding to these fields due to Education level of mother. Conclusions of the study are that the respondents' Education level of mother has significant effect on these fields. Preparatory and less respondents have higher than other Education level of mother group, The study highlighted the importance of establishing a comprehensive awareness program at various sectors such as schools, universities, and other local community organizations. Added to that, improvements that appear on the abilities of their children with Mental disabilities reflect positively on the adaptation and well-being of mothers and other family members, thus low psycho-pathological symptoms appeared on mothers and families of children with Mental disability.

ملخص الدراسة

الهدف العام لهذه الدراسة الحالية هو فهم العلاقة بين تقدير الذات والصحة النفسية لدى أمهات الأطفال المعاقين عقليا. كما تهدف إلى تحديد مستوى تقدير الذات والصحة النفسية وتحاول الكشف عن أثر بعض المتغيرات الاجتماعية الديموغرافية مثل المستوى التعليمي للأم، العمر الزمني للأم، العمر الزمني للأطفال، وجنس الأطفال، على مستوى الصحة النفسية عند الأمهات. أستخدم الباحث في هذه الدراسة المنهج الوصفي التحليلي، وبلغت عينة الدراسة 165 من الأمهات اللواتي يتابعن أطفالهن المصابين بإعاقة عقلية في ثلاثة مراكز خاصة لتأهيل المعاقين عقلياً في محافظات غزة. أستخدم الباحث مقياس تقدير الذات ومقياس قائمة مراجعة الأعراض (SCL-90-R) لقياس الصحة النفسية. أظهرت النتائج الرئيسة مستوى منخفض من الصحة النفسية (29.07%)، وبلغ مستوى تقدير الذات (60.81%)، والمجموع الكلي للأعراض النفسية حوالي (71.93%). كما أظهرت ارتباطاً دالاً إحصائياً بين مستوى تقدير الذات والصحة النفسية لدى أمهات أطفال المعاقين عقلياً . كما أظهرت النتائج وجود فروق ذات دلالة إحصائية في مستوى الصحة النفسية لدى أمهات الأطفال تعزى إلى المستوى التعليمي للأمهات لصالح الأمهات اللاتي وصلن المرحلة الإعدادية وما دون. كما أظهرت النتائج عدم وجود فروق ذات دلالة إحصائية في مستوى الصلابة النفسية تعزى لكل من عمر الأم ، عمر الأطفال وجنس الأطفال. توصي الدراسة بأهمية البدء ببرنامج توعية شامل في مرافق مختلفة من مؤسسات المجتمع الفلسطيني مثل المدارس والجامعات والمؤسسات المجتمعية المحلية .

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List of Abbreviations:

AIDS	Acquired immunodeficiency syndrome
APA	American psychiatric association
ASD	Autism spectrum disorder
BDI	Beck depression inventory
DD	Developing delay
DNA	Deoxyribonucleic acid
DS	Down syndrome
HIV	Human immunodeficiency virus
ID	Intellectual disability
IQ	Intelligence quotient
MD	Mental disability
PCBS	Palestinian community basic studies
PKU	Phenylketonuria
SCL	Scale Symptom Chick List 90
SDT	Self determination theory
SEQ	Self esteem questionnaire
ST	Sociometer theory
TD	Typically developing
TMT	Terror management theory
UN	United nations
WHO	World health organization

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Chapter 1

*I*ntroduction

Chapter 1

1.1Background of the study:

The mental health problems are so special due to the unusual circumstances that the Palestinian people are living under. There are many forms of the suffering that the Palestinian people experience such as unemployment, poverty, security instability, and siege. All of these factors when combine together increase the mental health problems, additionally, There are other factors also contribute to increase the mental health problems, such as genetic, social, economic and biological factors ....etc.

Families raising children with disabilities are more expected to experience financial hardship. Not only are parent-careers less likely to be employed, they also face additional costs associated with specialized equipment and services. Little is known about how parents who are raising disabled children while living in poverty navigate social services, and practice resilience.

The researcher considers the birth of a baby is usually anticipated with great excitement and expectation of a future filled with happiness and success. This exuberance may become muted with the birth of a disabled infant. It does not matter if the handicap is blindness, mental retardation, Down syndrome, a physical abnormality. The family in which this child is born will change in some ways, that influence and alter the dynamics of family life.

Previous research has shown that having a child with a disability presents a unique set of challenges that impacts the entire family unit and individual family members' health, well-being, and experiences across the life span (Patterson, 2005; Turnbull, Turnbull, Erwin, & Soodak, 2006).

Social support has been cited as a contributing factor in counteracting the negative outcomes of stress. Social support develops from the relationships and interactions between the individual, family, peer group, and larger social systems (Boyd, 2002).

It is well-known that mental health is often said to be a state of well-being associated with happiness, contentment, satisfaction, achievement, optimism and hope (Stuart,2009).

Having a child with mental disability born into a family and grow into adulthood is one of the most stressful experiences a family can endure. Parental reaction that their child with mental disability usually include shock, depression, guilt, anger, sadness, and anxiety; and some of parents perceive the infant as an extension of themselves and may feel shame, social rejection, ridicule, or embarrassment (Gunderson, 1995). In addition parental reaction may be affected by economic status, personality traits, and marital stability (Beckman, 1999). That aimed to gain a deeper understanding of the adaptive strategies that families employ, and the resilience they practice. These stressors include challenges navigating the myriad of educational, medical, and behavioral services; financial hardships related to the cost of care; and emotional aspects of having a child with a disability (Plant & Sanders, 2007).

1.2Purpose of the study & problem statement:

Mental health problems affect entire population of Palestinian people. This problem affects the total society and interfere with the developmental process, the way which followed to treat such problem is biologically based which focus on disability rather than strength and empowerment, so there is a need to a new trends to address such issue.

The purpose of this study is to explore the relationship between Mental Health and Self Esteem among Mothers of Children with Mental Disability in Gaza Governorates, in order to enhance our understanding of the deleterious outcomes that mental disabilities of children may have effect on mental health and self esteem of mothers.

1.3Justification of the study:

Many of the previous studies deal with issues related to mental disabilities of children and the way to manage these problems, little information is available regarding mental health and self esteem among mothers of children with mental disability and its prevalence rate, so such study opens the door for researchers to study this phenomena from another perspective, This situation pushed the researcher to study this subject, so this study will attract the attention of decision makers in governmental and non governmental organization to the importance of giving special attention and awareness for these mothers, because these mothers complain of many of stress due to mental disabilities of their children. In other words this study will introduce new visions and suggestions in institutions dealing with such issues in order to find out ways to help these mothers and reach to high level of mental health and self esteem for them.

1.4General objective:

The current study aims to understand the relationship between Mental Health and Self Esteem among Mothers of Children with Mental Disability in Gaza Governorates**.**

1.4.1 Specific objectives:

- To determine the level of mental health among mothers of children with mental disability in Gaza governorates.
- To identify the level of self esteem among mothers of children with mental disability in Gaza Governorates.
- To explore relationship between the mental health among mothers of children with mental disability and their self esteem.
- To investigate the differences in mental health due to socio demographic status among Mothers of Children with Mental Disability in Gaza governorates.

1.5Research questions:

The main question:

What is the relationship between Mental Health and Self Esteem among Mothers of Children with Mental Disability?

To achieve the research objectives, the study attempted to answer the following research questions:

- What is the level of mental health among mothers of children with mental disability in Gaza governorates?
- What is the level of self esteem among mothers of children with mental disability in Gaza governorates?
- Are there statistical differences in the level of mental health among mothers of children with mental disability in Gaza governorates due to socio-demographic data ?
- Is there relationship between the level of mental health among mothers of children with mental disability and their level of self esteem?

1.6Research hypotheses:

- There is no statistically significant relationship between mental health and self esteem among mothers of children with mental disability.

- There is no statistically significant differences at (alpha less than or equal 0.05) in level of mental health among mothers of children with mental disability due to their socio-demographic data.

1.7Definitions:

1.7.1 Theoretical Definitions

1.7.1.1 Definition of mental health:

State of well- being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. (WHO, 2005).

1.7.1.2 Definition of mental disabilities :

Is a generalized condition appearing before adulthood, characterized by significantly impaired cognitive functioning and deficits in two or more adaptive behavior. It has historically been defined as an IQ score under 70. (WHO, 2005).

1.7.1.3 Definition of self esteem :

Self-esteem is usually broadly defined as a person's overall evaluation of, or attitude toward, her- or himself (Leary & MacDonald, 2003)**.**

1.7.2 Operational definitions :

1.7.2.1 Children with mental disability:

Those children who are under 18 years old and have decrease in cognitive abilities with I.Q. below 70 accompanied with decrease in adaptive skills.

1.7.2.2 Mothers of children with mental disability:

Are those mothers who have or raise a mental disability child and follow up them at Gaza institution**.**

1.8 Period of study:

The study was conducted in the period between January 2012 and June 2013

1.9 Place of study:

The study was carried out in three local nongovernmental societies, Khan younis rehabilitation society, Shamis society for care of the handicapped in Gaza town and Nuseirat social and training rehabilitation association.

1.10. Statistical analysis Tools:

The researcher would use data analysis both qualitative and quantitative data analysis methods. The Data analysis was made by utilizing (SPSS 20). The researcher would utilize the following statistical tools:

- Kolmogorov-Smirnov test of normality.
- Pearson correlation coefficient for Validity.
- Cronbach's Alpha for Reliability Statistics.
- Frequency and Descriptive analysis.
- Parametric Tests (One-sample T test, Independent Samples T-test, Analysis of Variance).

Chapter 2

Theoretical Framework

Chapter 2

2.1 Introduction:

In this chapter the researcher will present the conceptual framework which consists of three parts. The first part concerns with mental health, where as the second part talk about self esteem, and the third part concern with mental disabilities. In relation to mental health, the researcher will describe its definitions, its history, characteristics, and its importance .while the self esteem the researcher talk about its definition, categories, causes and consequences of self esteem. In accordance to mental disabilities, the researcher mentioned the definition, cause, its type and symptoms.

2.2 Theoretical framework

2.2.1 Self Esteem

Self-esteem is how we "see" ourselves; it influences much of what we do, including what we become. Feeling good about oneself gives a person the confidence to tackle life's many complex tasks and challenging pleasures. People who lack confidence, and avoid new or difficult experiences, may appear to lack ability. However, their low self-esteem probably caused them not to "try. The foundation for self-esteem in adulthood develops during childhood. The building of self-esteem happens in conjunction with the development of many different tasks, from learning to say "momma" to understanding the molecular structure of DNA. Childhood is certainly a time of discovery, and part of that discovery has to do with learning what oneself is capable of mastering (Koole, Dijksterhuis, & van Knippenberg, 2001).

2.2.2 Definition of self esteem

Self-esteem is usually broadly defined as a person's overall evaluation of, or attitude toward, her- or himself). However, vigorous disagreement exists regarding precisely what self-esteem is and why people experience it in the way that they do. Self-esteem is Confidence in our ability to think, confidence in our ability to cope with the basic challenges of life, and confidence in our right to be successful and happy, the feeling of being worthy, deserving, and entitled to assert our needs and

wants, achieve our values, and enjoy the fruits of our efforts. (James, 1890; Leary & MacDonald, 2003; Pyszczynski, Greenberg, Solomon, Arndt, & Schimel, 2004).

2.2.3 Three meanings of self-esteem

2.2.3.1 Global self-esteem.

Self-esteem is most commonly used to refer to the way people characteristically feel about themselves. Many psychologists call this form of self-esteem, global self-esteem or trait self-esteem, as it is relatively enduring, both across time and situations. In the remainder of this paper, we will use the term ‘‘self-esteem’’ (without any qualifiers) when referring to this variable. Attempts to define self-esteem have ranged from an emphasis on primitive libidinal impulses (Kernberg, 1975), to the perception that one is a valuable member of a meaningful universe (Solomon, Greenberg, & Pyszczynski, 1991.(We take a decidedly less exotic approach and define self-esteem in terms of feelings of affection for oneself (Brown, 1993, 1998; Brown & Dutton, 1995.(High self-esteem is characterized by a general fondness or love for oneself; low self-esteem is characterized by mildly positive or ambivalent feelings toward oneself. In extreme cases, low self-esteem people hate themselves, but this kind of self-loathing occurs in clinical populations, not in normal populations. (Baumeister, Tice, & Hutton, 1989).

2.2.3.2 Self-evaluations:

The term ‘‘self-esteem’’ has also been used to refer to the way people evaluate their various abilities and attributes. For example، many scales designed to assess self-esteem include subscales for measuring academic self-esteem, social self-esteem, or athletic self-esteem (Harter, 1986؛ Marsh, 1990; Shavelson, Hubner, & Stanton, 1976). The terms ‘‘self confidence’’ and ‘‘self-efficacy’’ have also been used to refer to these beliefs، and many people equate self-confidence with self-esteem. We prefer to call these beliefs self-evaluations or self-appraisals, as they refer to the way people evaluate or appraise their specific abilities and personality characteristics.

2.2.3.3 Feelings of self-worth:

Finally, self-esteem is also used to refer to rather momentary emotional states, particularly those that arise from a positive or negative outcome. This is what people

mean when they speak of experiences that bolster their self-esteem or threaten their self-esteem. For example, a person might say her self-esteem was sky-high after getting a big promotion, or a person might say his self-esteem plummeted after a divorce. Following William James (1890), we refer to these emotions as self-feelings or feelings of self worth. Feeling proud or pleased with ourselves (on the positive side), or humiliated and ashamed of ourselves (on the negative side) are examples of what we mean by feelings of self-worth. Many researchers use the term state self-esteem when referring to feelings of self-worth (Butler, Hokanson, & Flynn, 1994; Leary, Tambor, Terdal & Downs, 1995).

This term implies that the essential difference between global self-esteem and feelings of self-worth is that global self-esteem is more enduring. We disagree with this approach. In our mind, global self-esteem and feelings of self-worth are qualitatively different phenomena. To illustrate our thinking here, consider that most parents swell with pride when their children do something exemplary. But accomplishments of this sort do not change how much love parents feel for their children. The pride comes and goes, often in response to a particular event or achievement, but the love remains and is independent of whether something has or has not been achieved. This is how we think of the relation between global self-esteem and feelings of self-worth. Feelings of self-worth rise and fall in response to particular outcomes, but global self-esteem (or self-love) is enduring.

2.2.4 Categories of self-esteem:

There are a variety of categories of self-esteem, which include:

2.2.4.1 Global self-esteem:

Refers to the overall aggregated opinion of oneself at any one time, on a scale between negative and positive (Harter, 1993, p.88 as cited in Kling et al., 1999).

Domain specific: relates to one's self-esteem in regard of a particular area, such as sport.

2.2.4.2 Trait self-esteem:

Described as an individual's accumulated lifelong perception of social inclusion and exclusion (Leary, Tambor, Terdal & Downs, 1995).

2.2.5 Stability of Self-Esteem:

Another issue in the measurement and definition of self-esteem is whether it is best conceptualized as a stable personality trait or as a context-specific state. Most theories of self-esteem view it as a relatively stable trait: if you have high self-esteem today, you will probably have high self-esteem tomorrow. From this perspective, self-esteem is stable because it slowly builds over time through personal experiences, such as repeatedly succeeding at various tasks or continually being valued by significant others. A number of studies, however, suggest self-esteem serves as the dependent rather than the independent or classification variable (Wells & Marwell, 1976).

These studies assume that self-esteem can be momentarily manipulated or affected. Others suggest that self-esteem is not manipulable by definition. According to subsequent views, however, self-esteem can be viewed as a "state" as well as a trait (Heatherton & Polivy, 1991). Around a stable baseline are fluctuations; although we might generally feel good about ourselves, there are times when we may experience self-doubt and even dislike. Fluctuations in state self-esteem are associated with increased sensitivity to and reliance on social evaluations, increased concern about how one views the self and even anger and hostility (Kernis, 1993).

In general, those with a fragile sense of self-esteem respond extremely favorably to positive feedback and extremely defensively to negative feedback. (Robins, Hendin & Trzesniewski, 2001).

2.2.6 Gender Differences in Self-Esteem:

A number of studies suggest that boys and girls diverge in their primary source of self-esteem, with girls being more influenced by relationships and boys being more influenced by objective success. In terms of another salient gender difference in feelings about the self across the lifespan, women tend to have lower body image satisfaction than men. Women are more likely than men to evaluate specific body features negatively, to attempt weight loss, to report anxiety about the evaluation of their physical appearance, and to have cosmetic surgery (Heatherton, 2001).

Body image dissatisfaction among women usually is related to perceiving oneself to be overweight. More than three quarters of American women would like to lose weight and almost none would like to gain weight. Believing oneself to be

overweight, whether one is or is not, is closely related to body image dissatisfaction. Beginning in early adolescence, women compare their body shape and weight with their beliefs about cultural ideals. A discrepancy from the ideal often motivates people to undertake dieting to achieve a more attractive body size. Dieting is rarely successful, with less than 1% of individuals able to maintain weight loss over five years (NIH Technology Assessment Conference Panel, 1993).

Repeated failures may exacerbate body image dissatisfaction and low self-esteem (Heatherton & Polivy, 1992). Women with perfectionistic tendencies and low self-esteem are particularly affected by dissatisfaction, such that these personality traits in combination have been linked to increased bulimic symptoms (Vows, Bar done, Joiner, Abramson, & Heatherton, 1999).

Black women are less likely to consider themselves obese and are more satisfied with their weight than are White women despite the fact that Black women are twice as likely to be obese. These women also rate large Black body shapes more positively than do White women rating large White body shapes (Hebl & Heatherton, 1998).

In contrast to women, men are more likely view their bodies as instruments of action and derive self-esteem from self-perceived physical strength (Franzoi, 1995). Therefore, in terms of assessing personal feelings about body-esteem issues, researchers need to be sensitive to the differential determinants of body image for women and men. (Heatherton, 2001).

2.2.7 The Importance of Social Support in Self-esteem:

Self-esteem is an important factor that influences one's actions in life. A high self-esteem contributes to one's positive attitude toward oneself and toward life in general while the low self-esteem stops people from changing their situation, even if they are not very satisfied with it (Heyman, Swain, Gillman, Handyside & Newman, 1997).

The literature indicates that it is not disability itself that contributes to one's high or low self-esteem, but the level of social support. Social support is important for everybody; it is especially important for people with disabilities (Nosek, Hughes,

Swedlund, Taylor & Swank, 2003; Nosek & Hughes, 2001) because they are considered a minority population that has been stereotyped and isolated for centuries.

2.2.8 Building Blocks for Good Self-Esteem

To have good self-esteem, you need to understand and apply some basic building blocks to your relationships, with yourself and others.

2.2.8.1 Assertiveness

Without knowing how to be assertive, you cannot develop good self-esteem. Assertiveness means knowing how to ask for the things that you need, and not being afraid to stick up for your rights.

2.2.8.2 Boundaries

These are physical and emotional limits that you set for yourself and others. Being firm with what you are willing to do for both yourself and for other people is essential to feeling good within yourself.

2.2.8.3 Forgiveness

This is a very difficult task for many people, as forgiving mistakes and moving forward is a challenge even for those with good self-esteem. However, being kind to yourself when you feel down or make a mistake is essential to developing healthy relationships with others.

2.2.9 Sources of Self-Esteem

There are many theories about the source of self-esteem. For instance, William James (1890) argued that self-esteem developed from the accumulation of experiences in which people's outcomes exceeded their goals on some important dimension, under the general rule that self-esteem = success/pretensions. From this perspective, assessment has to examine possible discrepancies between current appraisals and personal goals and motives. Moreover, self-perceived skills that allow

people to reach goals are also important to assess. Thus, measures ought to include some reference to personal beliefs about competency and ability. Many of the most popular theories of self-esteem are based on Cooley's (1902) notion of the looking-glass self, in which self-appraisals are viewed as inseparable from social milieu. Mead's (1934) symbolic interactionism outlined a process by which people internalize ideas and attitudes expressed by significant figures in their lives. In effect, individuals come to respond to themselves in a manner consistent with the ways of those around him. Low self esteem is likely to result when key figures reject, ignore, demean, or devalue the person. Subsequent thinking by Cooper smith (1967) and Rosenberg (1965, 1979), as well as most contemporary self-esteem research, is well in accord with the basic tenets of symbolic interactionism. According to this perspective, it is important to assess how people perceive themselves to be viewed by significant others, such as friends, classmates, family members, and so on. Some recent theories of self-esteem have emphasized the norms and values of the cultures and societies in which people are raised. For instance, Crocker and her colleagues have argued that some people experience collective self-esteem because they are especially likely to base their self esteem on their social identities as belonging to certain groups (Luhtanen & Crocker, 1992).

2.2.10 Optimal Self-Esteem is Contingent

Intrinsic versus Extrinsic and Upward Versus Downward Contingencies Contrary to conventional wisdom, evidence for beneficial effects of high self-esteem is scarce (Baumeister, Campbell, Krueger, & Vohs, 2000)

People with high self-esteem tend to engage in all sorts of self-deception (for reviews, see Blaine & Crocker, 1993; Crocker & Park, and 2004). When confronted with failure or rejection, they tend to aggressively lash out at those who criticize or disrespect them (Baumeister, Smart & Boden, 1996); engage in excessive self-enhancement and downwards social comparisons to reaffirm the self (cf. Vohs & Heatherton, 2001, 2004); derogate others (e.g., Aberson, Healy, & Romero, 2000; Fein & Spencer, 1997); and cling to their own self-serving interpretations of events,

producing conflict with the (possibly also self-serving) interpretations of their friends, spouses, or colleagues (Gilovich, Kruger & Savitsky, 1999; Leary, 2002).

These negative effects are particularly strong for individuals with high contingent self-esteem, i.e., self-esteem based on meeting standards or attaining certain outcomes, such as social approval or successful performance (Crocker & Wolfe, 2001).

Contingent self-esteem requires continual validation; it can only be sustained if sufficient success, acceptance or approval is accomplished. As a result, it is a fragile form of self-esteem that requires a great deal of protection. Individuals with high contingent self-esteem are more likely (compared with high no contingent or low self-esteem individuals) to engage in maladaptive behaviour, such as disordered eating and binge drinking (Crocker, 2002).

Aggressive behaviour in response to ego threat this makes sense: When self-esteem depends on contingencies, there is a lot at stake (Baumeister, Bushman & Campbell, 2000).

2.2.12 Theories of Self-Esteem

2.2.12.1 Self-Determination Theory:

Self-Determination Theory (SDT) states that man is born with an intrinsic motivation to explore, absorb and master his surroundings and that true high self-esteem is reported when the basic psychological nutrients, or needs, of life (relatedness, competency and autonomy) are in balance).When social conditions provide support and opportunity to fulfill these basic needs, personal growth, vitality and well-being are enhanced. Relatedness was an addition to the original theory to account for people's inherent ability to make meaning and connect with others through the internalization of cultural practices and values. The SDT view of self also has implications for our understanding of self-esteem. The theory differentiates true from contingent self-esteem. True self-esteem is a deeply held feeling of being worthy. People with a high level of true self-esteem do not behave in order to feel worthy; rather, they are autonomously motivated and true self-esteem is a by-product of behaviors so motivated. Contingent self-esteem, in contrast, involves behaving in order to feel worthy; it is self-esteem that results from living up to introjected standards. Thus, contingent self-esteem is inherently unstable because people with contingent self-esteem have to keep satisfying their introjects in order to feel worthy. Failure to do so plunges them into feeling unworthy (Ryan & Deci, 2004).

2.2.12.2 Terror Management Theory:

In Terror Management Theory (TMT) in which self-esteem is seen as a culturally based construction derived from integrating specific contingencies valued by society into ones' own 'worldview'. TMT paints a somewhat morbid picture—high self-esteem promotes positive affect and personal growth, psychological well-being and coping as a buffer against anxiety in the knowledge of our eventual certain death, and reduces defensive anxiety related behavior According to the theory, the continual possibility of experiencing painful and tragic events (death being the ultimate such occurrence) is a constant source of anxiety. To minimize the perpetual terror that results from awareness of one's fragility and mortality in a dangerous and unpredictable world, people adopt views of themselves and of the world that attenuate their fears. Central to this anxiety-buffering process are individuals' beliefs that they

meet the social standards by which people are judged to be worthwhile and valuable. All cultures specify what it means to be a "good" person and promise either symbolic or literal immortality to those who meet standards of goodness. During development, children learn to associate meeting cultural standards with parental support, thereby establishing a link between living up to cultural standards (and the accompanying experience of self-esteem) and a sense of personal security. Self-esteem has an interpersonal basis, according to TMT, because social approval typically reflects the degree to which one is meeting cultural standards (Pyszczynski et al., 2004).

2.2.12.3 Sociometer Theory:

Sociometer Theory (ST) states that a minimum level of social inclusion or belonging is essential for humans to reproduce and survive with self-esteem functioning as a sociometer. The ability to efficiently determine others' reactions affecting an individual's status aids the creation and maintenance of a small number of meaningful relationships. To be excluded from a worthwhile relationship affects self-esteem more negatively than the positive impact of being included in increasing numbers of less meaningful relationships and inclusion is preferred to being just viewed positively (Leary, 1990; Leary & Downs, 1995 as cited in Leary et al., 1995).

An individual's scimitar also has the added complexity of being concerned about its inclusive status with groups that might be considered negatively or not worthwhile, all of which add to the building up or reducing of one's self-esteem (Balmiest & Tice, 1990 as cited in Leary et al., 1995).

The best evidence of changes in self-esteem may be one's mood (Heatherton & Policy, 1991 as cited in Leary et al., 1995) in the form of feelings of pride and high self-esteem, and shame with low self-esteem (Schiff, Ret zinger, & Ryan, 1989 cited Leary et al., 1995), translating as levels of anxiety to both trait and state self-esteem (Spivey, 1989 as cited in Leary et al., 1995).

2.2.12.4 Dominance Theory:

An often overlooked interpersonal perspective on self-esteem is offered by dominance theory (Barlow, 1980). Like scimitar theory, dominance theory assumes

that self-esteem monitors aspects of the social environment. However, whereas scimitar theory conceptualizes self-esteem as a monitor of relational value, dominance theory suggests that the self-esteem system evolved to monitor dominance (Barlow, 1980).

Because dominance was associated with increased reproductive success in the ancestral environment, systems evolved to monitor one's social standing and to motivate behaviors that increase one's dominance. According to the theory, self-esteem reflects the amount of attention, deference, and respect that one receives from other people. Although the dominance hypothesis has not attracted much research attention, evidence shows that perceptions of one's social influence and dominance correlate moderately with self-esteem as the theory predicts (Hamilton, 1971; Heaven, 1986; Ruskin, Novice, & Hogan, 1991).

2.2.12.5 Hierarchy of Needs Theory:

Abraham Maslow is known for establishing the theory of a hierarchy of needs, writing that human beings are motivated by unsatisfied needs, and that certain lower needs need to be satisfied before higher needs can be satisfied. Maslow studied exemplary people such as Albert Einstein, Jane Addams, Eleanor Roosevelt, and Frederick Douglas rather than mentally ill or neurotic people. This was a radical departure from two of the chief schools of psychology of his day: Freud and B.F. Skinner. Freud saw little difference between the motivations of humans and animals. We are supposedly rational beings; however, we do not act that way. Such pessimism, Maslow believed, was the result of Freud's study of mentally ill people, "The study of crippled, stunted, immature, and unhealthy specimens can yield only a cripple psychology and a cripple philosophy" (Motivation and Personality). Skinner, on the other hand, studied how pigeons and white rats learn. His motivational models were based on simple rewards such as food and water, sex, and avoidance of pain. Say "sit" to your dog and give the dog a treat when it sits, and-after several repetitions--the dog will sit when you command it to do so. Maslow thought that psychologists should instead study the playfulness, affection, etc., of animals. He also believed that Skinner discounted things that make humans different from each other. Instead, Skinner relied on statistical descriptions of people . Maslow's hierarchy of needs was an alternative to the depressing determinism of Freud and Skinner. He felt that people are basically

trustworthy, self-protecting, and self-governing. Humans tend toward growth and love. Although there is a continuous cycle of human wars, murder, deceit, etc., he believed that violence is not what human nature is meant to be like. Violence and other evils occur when human needs are thwarted. In other words, people who are deprived of lower needs such as safety may defend themselves by violent means. He did not believe that humans are violent because they enjoy violence. Or that they lie, cheat, and steal because they enjoy doing it . According to Maslow, there are general types of needs (physiological, safety, love, and esteem) that must be satisfied before a person can act unselfishly. He called these needs "deficiency needs." As long as we are motivated to satisfy these cravings, we are moving towards growth, toward self-actualization. Satisfying needs is healthy; blocking gratification makes us sick or evil. In other words, we are all "needs junkies" with cravings that must be satisfied and should be satisfied. Else, we become sick (Maslow, 1954).

2.2.13 Mental Health

2.2.13.1 Definitions of Mental health:

Mental health describes a level of psychological well-being, or an absence of a mental disorder... From the perspective of 'positive psychology' or 'holism', mental health may include an individual's ability to enjoy life, and create a balance between life activities and efforts to achieve psychological resilience Mental health can also be defined as an expression of emotions, and as signifying a successful adaptation to a range of demands (About.com, 2006).

The World Health Organization defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (World Health Organization,2005) It was previously stated that there was no one "official" definition of mental health. Cultural differences, subjective assessments, and competing professional theories all affect how "mental health" is defined. (World Health Organization, 2001).

2.2.14 History of mental disorders:

In the mid-19th century, William Sweeter was the first to clearly define the term "mental hygiene", which can be seen as the precursor to contemporary approaches to work on promoting positive mental health. Isaac Ray, one of thirteen founders of the American Psychiatric Association, further defined mental hygiene as an art to preserve the mind against incidents and influences which would inhibit or destroy its energy, quality or development. (JHSPH, 2007). An important figure to "mental hygiene", would be Dorothea Dix (1802–1887), a school teacher, who had campaigned her whole life in order to help those suffering of a mental illness, and to bring to light the deplorable conditions which they were put it in. This was known as the "mental hygiene movement". (Barlow, Durand, Steward, 2009). Before this movement, it was not uncommon that people affected by mental illness in the 19th century would be considerably neglected, often left alone in deplorable conditions, barely even having sufficient clothing. Dix's efforts were so great that there was a rise in the number of patients in mental health facilities, which sadly resulted in these patients receiving less attention and care, as these institutions were largely understaffed. Deplorable conditions, barely even having sufficient clothing. Dix's efforts were so great that there was a rise in the number of patients in mental health facilities, which sadly resulted in these patients receiving less attention and care, as these institutions were largely understaffed (Barlow, Durand, Steward, 2009). At the beginning of the 20th century, Clifford Beers founded the National Committee for Mental Hygiene and opened the first outpatient mental health clinic in the United States of America (Clifford Beers Clinic, 2006).

2.2.15 Significance of mental health:

Evidence from the World Health Organization suggests that nearly half the world's population is affected by mental illness with an impact on their self-esteem, relationships and ability to function in everyday life (Storrie, Ahern, Tuckett, 2010). An individual's emotional health can also impact physical health and poor mental health can lead to problems such as substance abuse. The importance of maintaining good mental health is crucial to living a long and healthy life. Good mental health can enhance one’s life, while poor mental health can prevent someone from living a normal life. “There is growing evidence that is showing emotional abilities are

associated with prosaically behaviors such as stress management and physical health". It was also concluded in their research that people who lack emotional expression lead to misfit behaviors. These behaviors are a direct reflection of their mental health. Self-destructive acts may take place to suppress emotions. Some of these acts include drug and alcohol abuse, physical fights or vandalism (Richards, Campania, Muse-Burke, 2010).

2.2.16 Cultural and religious considerations:

Mental health is a socially constructed and socially defined concept; that is, different societies, groups, cultures, institutions and professions have very different ways of conceptualizing its nature and causes, determining what is mentally healthy, and deciding what interventions, if any, are appropriate. Thus, different professionals will have different cultural, class, political and religious backgrounds, which will impact the methodology applied during treatment. Research has shown that there is stigma attached to mental illness... Many mental health professionals are beginning to, or already understand, the importance of competency in religious diversity and spirituality. The American Psychological Association explicitly states that religion must be respected. Education in spiritual and religious matters is also required by the American Psychiatric Association. (Richards, Bergin, 2000).

2.2.17 Mental health problems:

Mental health problems affect one in four of us at some point in our lives. Therefore experiencing mental health problems is common. They can range from the worries and grief we all experience as part of everyday life to more serious problems needing treatment and support from specialists. A mental health problem only becomes a serious problem when it interferes with our ability to cope or function on a day-to-day basis e.g. inability to concentrate; poor sleep patterns; withdrawal from people. The more extreme forms of mental distress can be very disturbing both for the person and for those around them. However, while mental distress can lead to considerable disruption and difficulty in people's lives, many people find ways of managing their problems and are able to lead fulfilling and active lives. Fortunately the majority of people who experience mental health problems do fully recover. Some people with more complex problems learn to live and cope with the illness, especially

if they get help early on. Effective treatments and support are available. (Ana and et al., 2002).

2.2.18 No health without mental health:

Problems in mental health constitute About 14% of the global burden of disease has been attributed to neuropsychiatry disorders, mostly due to the chronically disabling nature of depression and other common mental disorders, alcohol-use and substance-use disorders, and psychoses. Such estimates have drawn attention to the importance of mental disorders for public health. However, because they stress the separate contributions of mental and physical disorders to disability and mortality, they might have entrenched the alienation of mental health from mainstream efforts to improve health and reduce poverty. The burden of mental disorders is likely to have been underestimated because of inadequate appreciation of the connectedness between mental illness and other health conditions. Because these interactions are protean, there can be no health without mental health. Mental disorders increase risk for communicable and non-communicable diseases, and contribute to unintentional and intentional injury. Conversely, many health conditions increase the risk for mental disorder, and co morbidity complicates help-seeking, diagnosis, and treatment, and influences prognosis. Health services are not provided equitably to people with mental disorders, and the quality of care for both mental and physical health conditions for these people could be improved. We need to develop and evaluate psychosocial interventions that can be integrated into management of communicable and non-communicable diseases. Health-care systems should be strengthened to improve delivery of mental health care, by focusing on existing programmers and activities, such as those which address the prevention and treatment of HIV, tuberculosis, and malaria; gender-based violence; antenatal care; integrated management of childhood illnesses and child nutrition; and innovative management of chronic disease. An explicit mental health budget might need to be allocated for such activities. Mental health affects progress towards the achievement of several Millennium Development Goals, such as promotion of gender equality and empowerment of women, reduction of child mortality, improvement of maternal health, and reversal of the spread of HIV/AIDS. Mental health awareness needs to be integrated into all aspects of health and social policy, health-system planning, and delivery of primary and secondary general health care. Most of all, there needs to be

awareness amongst health providers and planners that mental health is an integral part of general health concerns, and that there can be no health without mental health (Prince et al, , 2007).

2.2.19 Good mental health:

Good mental health is not simply the absence of diagnosable mental health problems, although good mental health is likely to help protect against development of many such problems. Good mental health is characterized by a person's ability to fulfill a number of key functions and activities, including:

•The ability to learn

•The ability to feel, express and manage a range of positive and negative emotions

•The ability to form and maintain good relationships with others

•The ability to cope with and manage change and uncertainty (Tones & Gilford, 2001).

2.2.20 The intrinsic value of mental health:

Mental health contributes to all aspects of human life. It has both material and immaterial, or intrinsic, values: for the individual, society, and culture. Mental health has a reciprocal relationship with the well-being and productivity of a society and its members. Its value can be considered in several related ways:

- Mental health is essential for the well-being and functioning of individuals.
- Good mental health is an important resource for individuals, families, communities, and nations
- Mental health, as an indivisible part of general health, contributes to the functions of society, and has an effect on overall productivity.
- Mental health concerns everyone as it is generated in our everyday lives in homes, schools, workplaces, and in leisure activities.
- Positive mental health contributes to the social, human, and economic capital of every society.
- Spirituality can make a significant contribution to mental health promotion and mental health influences spiritual life
- Mental health can be regarded as an individual resource, contributing to the individual's quality of life, and can be increased or diminished by the actions

of society. An aspect of good mental health is the capacity for mutually satisfying and enduring relationships. There is growing evidence that social cohesion is critical for the economic prospering of communities and this relationship appears to be reciprocal. (Cooper, 1990).

2.2.21 Culture and mental health:

As already noted, although the qualities included in the concept of mental health may be universal, their expression differs individually, culturally, and in relation to different contexts. It is necessary to understand a particular community's concepts of mental health before engaging in mental health promotion. The broad nature of mental health also means that it is not just the preserve of the mental health professional. Each culture influences the way people understand mental health and their regard for it. An understanding of and sensitivity to factors valued by different cultures will increase the relevance and success of potential interventions. A Xhosa mother in apartheid era South Africa whose explanation for not comforting her crying son was to ensure he grew up strong enough to leave the country and join the armed struggle exemplifies this. Their reports of feeling different and having difficulty relating to others enabled tailored approaches to helping them adjust to peacetime society. Stigma is a major concern to people affected by HIV/AIDS. Efforts to understand this group's concepts of mental health make a major contribution to developing relevant intervention programmers. A culture-specific approach to understanding and improving mental health may be unhelpful, however, if it assumes homogeneity within cultures and ignores individual differences. Today, most cultures overlap and are heterogeneous. The beliefs and actions of groups need to be understood in their political, economic, and social contexts; culture is one of several factors to be considered (Tomlinson, 2001).

2.2.22 Mental health and human rights:

A climate that respects and protects basic civil, political, economic, social, and cultural rights is fundamental to the promotion of mental health. Without the security and freedom provided by these rights it is very difficult to maintain a high level of mental health. A human rights framework offers a useful tool for identifying and addressing the underlying determinants of mental health. The instruments which make up the United Nations (UN) human rights mechanism represent a set of universally

accepted values and principles which can guide countries in the design, implementation, monitoring, and evaluation of mental health policies, laws, and programmers. As legal norms and standards ratified by governments, they generate accountability for mental health and thus offer a useful standard against which government performance in the promotion of mental health can be assessed. Human rights empower individuals and communities by granting them entitlements that give rise to legal obligations on governments. They can help to equalize the distribution and exercise of power within society, thus mitigating the powerlessness of the poor (WHO 2002). The principles of equality and freedom from discrimination, which are integral elements of the international human rights framework, demand that particular attention be given to vulnerable groups. Furthermore, the right of all people to participate in decision-making processes, which is reflected in the Bill of Rights and other UN instruments, can help ensure that marginalized groups are able to influence health-related matters and strategies that affect them, and that their interests are considered and addressed. Mental health promotion is not solely the domain of ministries of health. It requires the involvement of a wide range of sectors, actors, and stakeholders. Human rights encompass civil, cultural, economic, political, and social dimensions and thus provide an intersect oral framework to consider mental health across the wide range of mental health determinants. (Gusting, 2001).

2.2.23 Promotion of mental health:

Mental health promotion remains the most underdeveloped area of health promotion although there is an increasing recognition that “there is no health without mental health”. Positive mental health includes self-esteem, the ability to solve problems and the ability to adapt to mental stresses. Mental health promotion works at three levels: and at each level, is relevant to the whole population, to individuals at risk, vulnerable groups and people with mental health problems.

2.2.23.1 Strengthening individuals:

Or increasing emotional resilience through interventions to promote self-esteem, life and coping skills, e.g. communicating, negotiating, relationship and parenting skills.

2.2.23.2 Strengthening communities:

This involves increasing social inclusion and participation, improving neighbourhood environments, developing health and social services which support mental health, anti-bullying strategies at school, workplace health, community safety, and childcare and self-help networks.

2.2.23.3 Reducing structural barriers to mental health:

Through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, services and support for those who are vulnerable. (Tang, USANi, and McQueen, 2003).

2.2.24 Mental health promotion strategies:

There are foundation for health promotion strategies and can be considered a guide for the promotion of mental health. It draws attention to individual, social, and environmental factors that influence health... Its main strategies are building healthy public policies, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services.

2.2.24.1 Building healthy public policies:

All public policies, not only those concerned with health, are considered relevant to health promotion. The Ottawa Charter recognizes that most societal structures and actions have an effect on health. Mental health promotion has an advocacy role to enhance the visibility and value of mental health to individuals and societies.

2.2.24.2 Creating supportive environments:

Environmental health strategies have long been recognized as important to health. However, the focus has been largely on tangible areas. More attention needs to be given to the social and macro environments and the mechanisms through which they exert their influence on health. The complex interactions between an individual and their environment are contextual and mediated by individual experiences and skills, and social and cultural factors. A challenge for the promotion of mental health is to recognize the effect of these factors on environments and to develop interventions to modify them and indicators to evaluate impact and outcome.

2.2.24.3 Strengthening community action:

Community action of people striving to achieve a mutual goal enhances social capital, creates a sense of empowerment, and increases the capacity and resilience of the community.

2.2.24.4 Developing personal skills:

Information and its dissemination are critical to improving people's understanding of mental health. The concepts of health literacy are being used as guides to mental health literacy and contribute to mental health promotion..."

2.2. 25 Theories of mental health:

Every theory of mental health theories aims to help the individual enjoy with good level of mental health.

2.2.25.1 Psychoanalysis and mental health:

The Freudian view of human nature is basically deterministic. According to him, the individual behavior is determined by irrational forces that are unaccepted socially, and always feels anxious from painful feelings and emotions that are hidden in unconscious to come out to conscious. Also, he sees that there is development in civilization and the life become more complex which increases the psychological conflict of the individual and the severity of his anxiety (Hall, 1954). According to the psychoanalytic view, the personality consists of three systems: the id, the ego, and the superego. These are the names of psychological structures and should not be thought of as manikins that separately operate the personality; one's personality functions as a whole rather than as three discrete segments. The id is the biological component, the ego is the psychological component, and the superego is the social component (Corey, 1996)). Psychoanalysts see that, the good mental health is represent in the ability of the ego to mediate between the different components of the personality and the reality requirements; or in the conflict resolution that occur between the personality components which Freud talked about. But they see that the individual can reach to partial achievement of his mental health. This concept of mental health is congruent with Freud view to human who find himself in continuous

conflict with himself between the contents of id and the superego; and the role of the ego is to resolute this conflict. When the ego cannot control the conflict or the anxiety by rational and direct methods, it relies on unrealistic one's namely ego defense behavior or ego defense mechanisms which have two characteristics in common: They either deny or distort reality, and they operate on an unconscious level. Too much use of these defense mechanisms will affect negatively the individual especially in his interaction with the life where he lives. Also such extreme use of these defense mechanisms will affect its basic functions in the protection of ego which will finally expose the individual to various emotional disorders. So individual behavior in psychoanalysis is considered the sum of relationships and interactions between the three systems of personality and the adjustment of the individual and wellness of his mental health depend on the power and the control of the ego to make adjustment between the id and the superego (Abdel-ghaffar, 1982).

2.2.25.2 Behaviorism and mental health:

Behaviorism stresses the role of experience in shaping behavior. An especially important part of experience, according to these views, is the consequences of our actions. We tend to repeat behaviors that have resulted in rewards or have allowed us to avoid unpleasant consequences. We tend to discontinue behaviors that do not have one of these two outcomes (Souse et. al., 1996). Since the behavior theorists believe that all behavior is learned, deviations from the norm are habitual responses that can be modified through application of learning theory. Learning occurs when a stimulus is presented, a response occurs, and the response is reinforced. The response so strengthened by the repetition of the learning sequence. From the behavioral point of view, deviations from behavioral norms occur when undesirable behavior has been reinforced (Stuart & Sundae, 1991). So, mental health in behaviorism seems in the individual acquiring of appropriate habits, his effectiveness in dealing with others, and his ability to take decisions in facing difficult situations. The appropriate habits are the habits that are suitable with the environment where the individual lives, and that are accepted by members of the society. Mentally healthy individuals are those who can acquired such positive habits, where as individuals who cant acquire such positive habits will have bad mental health, or will be emotionally disturbed (Abdel-ghaffar, 1982).

2.2.25.3 Humanistic and mental health:

The humanistic approach is considered one of the approaches in psychology which started to appear on 1950's, and still grew; and it occupies the third power in psychology. This approach is developed by Maslow and Rogers who developed extensive theories on the development and realization of human potential. Maslow describes the concept of "self-actualization" and Rogers emphasize the "fully functioning person". Both theories focus on the entire range of human adjustment. They describe a self engaged in a constant quest, always seeking new growth, development, and challenges. these theories focus on the total person and he (1) is adequately in touch with his own self to free the resources that are there; (2) has free access to his feelings and can integrate them with his intellectual and cognitive functioning; (3) is immobilized by inner conflicts and stresses or can interact freely or openly with his environment; (4) can share himself with other people and grow from such experiences (Stuart & Sundae, 1991). Mental health in the humanistic approach seems in the individual achievement of self actualization and in his ability to be fully functioning person; and as known individuals are differ in their achievement of self actualization and function, and as a result they have different levels of mental health (Abdel-ghaffar, 1982).

Maslow (1958), identified 15 personality characteristics that distinguish "self-actualized" individual (one moving in the direction of achieving his highest potential): (1) has accurate perception of the reality; (2) has a high degree of acceptance of self, others, and human nature; (3) exhibits spontaneity; (4) is problem-centered as opposed to self-centered; (5) has need for privacy; (6) demonstrates high degree of autonomy and independence; (7) has freshness of appreciation; (8) has frequent "mystic or peak" experiences; (9) shows identification with mankind; (10) shares intimate relationships with a few significant others; (11) has democratic character structures; (12) possesses strong ethical sense; (13) demonstrates unchastely sense of humor; (14) possesses creativeness; (15) exhibits resistance to conformity.

Rogers (1961), described seven essential personality traits of the "fully functioning person," (who similarly is moving toward self-growth and fulfillment): (1) moves away from facades that are not true to self; (2) moves away from others expectations of what "ought to be;" (3) moves away from pleasing others who impose artificial goals on him; (4) moves toward becoming autonomous, self-directing, and self-

responsible; (5) is open to change and exploring his potential; (6) is open to his own self and the lives of others; (7) trusts and values himself and dares to express himself in the new ways.

2.2.25.4 Existentialism and mental health:

Existentialist theories believe that behavioral deviations result when the individual is out of touch with him self or his environment. This alienation is caused by inhibitions or restrictions that the person has placed on him. He is not free to choose from among all alternative behaviors. Deviant behavior frequently is away of avoiding more socially acceptable, more responsible behavior. The person who is alienated from himself feels helpless, sad, and lonely. Lack of self awareness and self approbation prevents participation in authentic, rewarding relationships with others. Theoretically the person has innumerable choices in terms of behavior (Stuart & Sundae, 1991). However, Heidegger noted that people tend to avoid being real and instead yield to tradition and the demands of others. This believes has been accepted by the existentialist practitioners of mental health care (Acutely, 1970).

Black (1968) has described the psychiatric patient as a person who has lost or who never found the values that can give meaning to his existence. Hence the world seems absurd to him, and its demands seem invalid. Rather than accept the painful realities of life, he gives up. His lack of commitment may lead to a hazy identity and a sense of unreality that extends to his perception of other people. Existentialists view of mental health is that, life is meaningful when the person can fully experience and accept the self; recognizes his abilities; free to achieve what he wants; and recognizes his weaknesses, accept it, and strengthen these weaknesses (Abdel-ghaffar, 1982).

2.2.25.5 Mental health in Islamic religion:

Neatly (2004), in his study about the concept of mental health in the Holy Quran and the Hades mentioned that, man is made up of body and soul. Each of these components of man has its inmate needs. The body has its inmate needs that must be satisfied in order that the individual can live and the human species can survive. The soul has also its inmate needs that express themselves in man’s spiritual longing for knowing God, belief in Him and worshiping Him. Satisfaction of these spiritual needs

determines man's feeling of security and happiness. Conflict arises between these two components of man. This conflict is, in fact, the basic psychological conflict that the man suffers in his life. Perhaps, it is God's will that the way that man adopts in solving this conflict becomes the real test of man on this world. Those who really succeed in this test are those who can reconcile the material and the spiritual components of their responsibilities, and can establish the greatest amount of equilibrium between them. There for, they deserve the reward of being happy in this world and also in the later eternal life. Islamic follows in educating people a purposeful method that can establish equilibrium between the material and the spiritual components of their personalities in order to be normal persons who can enjoy mental health and happiness. Islam's method of education has two approaches. One is to strength the spiritual component in man by inviting him to believe in the only one God and to worship Him. The other approach is to ask man to dominate his material component by controlling his derives emotions and sensual desires. By these two approaches of education, Islam teaches people to attain equilibrium between the material and spiritual components of their responsibilities, and thus enjoy security, happiness and mental health.

2.2.26 Mental Disabilities

Introduction

Mental disability is a term used when a person has certain limitations in mental functioning and in skills such as communicating, taking care of him or herself, and social skills. These limitations will cause a child to learn and develop more slowly than a typical child. Children with mental disabilities may take longer to learn to speak, walk, and take care of their personal needs such as dressing or eating. They are likely to have trouble learning in school. They will learn, but it will take them longer. There may be some things they cannot teach (Baxter, Cummins & Dioletis, 2000).

People with an intellectual disability have difficulties with thought processes, learning, communicating, remembering information and using it appropriately, making judgments, and problem-solving. An intellectual disability is present if the level of intellectual functioning is significantly lower than average and there are limitations in two or more adaptive skills, in the areas of communication, self-care, home living, social skills, self-direction, health and safety, leisure and work. The

identification of intellectual functioning is based largely upon the intelligence quotient (IQ) test. Using this test, scores of 90-109 are classified as average. People who score less than 70 may be considered to be handicapped by an intellectual disability depending on how well they function in key areas of everyday life. An intellectual disability may become apparent early in life or in the case of people with a mild intellectual disability, not be diagnosed until school age or later. Many people with an intellectual disability also have physical disabilities (Alessandria, 1996).

2.2.27 Definition of intellectual disabilities:

Intellectual disabilities is defined by the World Health Organization (WHO) (1993) as "a condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence i.e. cognitive, language, motor and social abilities".

The American Psychiatric Association (2004) use the term mental retardation in place of intellectual disabilities and define it as "significantly sub average intellectual functioning with concurrent deficits or impairments in present adaptive functioning in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self direction, functional academic skills, work, leisure, health and safety, with onset before 18 years of age". Both these definitions, and most other used definitions of intellectual disabilities, have three essential criteria: intellectual impairment, impairment of adaptive behavior and onset during the developmental period. It is generally accepted (World Health Organization, 1993) that an IQ measurement more than two standard deviations below the norm i.e. <70, is indicative of significantly impaired intellectual functioning, that impairments in adaptive behavior are best measured within European and north American Cultures using the Vineland Adaptive Behavior Scales (Sparrow, 1984) and that the developmental period is defined as before 18 years of age.

2.2.28 Causes of mental Disabilities in children

Doctors have found many causes of mental disabilities. The most common are:

Genetic conditions: Sometimes a mental disability is caused by abnormal genes inherited from parents, errors when genes combine, or other reasons. Examples of genetic conditions are Down syndrome, fragile X syndrome, and phenylketonuria (PKU) Problems during pregnancy. mental disability can result when the baby does not develop inside the mother properly. For example, there may be a problem with the way the baby's cells divide as it grows. A woman who drinks alcohol or gets an infection like rubella during pregnancy may also have a baby with a mental disability.

Problems at birth: If a baby has problems during labor and birth, such as not getting enough oxygen, he or she may have mental disability.

Health problems: Diseases like whooping cough, the measles, or meningitis can cause mental disabilities. They can also be caused by extreme malnutrition (not eating right), not getting enough medical care, or by being exposed to poisons like lead or mercury (Balderas, 1999).

2.2.29 The Signs of mental Disabilities in children:

There are many signs of mental disability, children with mental disability may:

- Sit up, crawl, or walk later than other children
- Learn to talk later, or have trouble speaking
- Find it hard to remember things
- Not understand how to pay for things
- Have trouble understanding social rules
- Have trouble seeing the consequences of their actions
- Have trouble solving problems, and/or
- Have trouble thinking logically (Sobeys, 1994).

Chapter 3

Literature Review

Chapter 3

3.1 Introduction:

In this chapter the researcher view of previous studies which concerns about mothers of children with intellectual disabilities. The previous studies will be use in discussing the results of the current study either in case of supporting or opposing it.

3.2 Previous studies

Norlina and Bromberg (2011) examined predictive links between couple relationship factors (marital quality and co-parenting quality) and individual well-being. Data were obtained through self-report questionnaires completed by parents of children with ID (mothers, $n = 58$; and fathers, $n = 46$) and control children (mothers, $n = 178$; and fathers, $n = 141$). To test the hypothesis that couple relationship factors predicted individual well-being, multiple regression analyses were performed controlling for the following risk factors identified by previous research: child self-injury/stereotypic behavior, parenting stress, and economic risk. **Results** Marital quality predicted concurrent well-being, and co-parenting quality predicted prospective well-being. Mothers of children with ID reported lower well-being than other parents. **Conclusions** There is a continued need for investigation of the details of the links between couple relationship and individual well-being in parents of children with ID. Couple relationship factors should be given consideration in clinical interventions.

Tostada (2011) examined child behavior problems and maternal mental health in a British population-representative sample of 5 year-old children with an autism spectrum disorder (ASD), controlling for the presence of an intellectual disability (ID). Behavior problems were significantly higher in children with ASD with/out ID compared to typically developing children, but compared to children with ID only hyperactivity was significantly higher in children with ASD/ID. After controlling for ID and maternal mental health, the presence of ASD significantly increased the odds for hyperactivity, conduct problems and emotional symptoms. Negative maternal outcomes (serious mental illness, psychological distress, and physical health limitations) were not consistently elevated in ASD. The findings highlight the early

age at which behavior problems emerge in ASD, and suggest that at this age, there may not be a clear disadvantage for maternal mental health associated with having a child with ASD in the family, over and above that conferred by child behavior problems.

Yardarm and Başbakkal (2010) aimed to determine sociodemographic factors that play a role in depression among mothers of children and adult with an intellectual disability. The research was conducted in 24 special education and rehabilitation centers in Izmir (in Turkey) provincial centre in which intellectually disabled individuals are taught. A total of 355 mothers were reached in the research. Data were collected using face-to-face interviews. Two forms were used for data collection in the research: Family Description Questionnaire Form and Beck Depression Inventory. The mothers included in the study had mean depression scores of 16.7 ± 10.06 (minimum: 0, maximum: 49). There was a significant relation between depression scores of the mothers and education level of the mothers and their spouses and financial status of the families. Mothers with insufficient income and lower education levels were found to be at risk of depression.

Bistro, Bromberg, and Hwang, (2010) aimed to explore parents' reports of temperament in their young children with or without Intellectual disabilities, as well as positive and negative impact of the child on parents. Mothers and fathers of 55 children recently diagnosed with ID and 183 age-matched typically developing (TD) children completed the EASI Temperamental Survey and two scales of the Family Impact Questionnaire measuring positive and negative impact of the child on parents. Parents rated children with mixed ID/DD (developmental delay) as shyer and more impulsive, and less active and sociable when compared with TD children. Children with mixed ID/DD were also reported to have more negative and less positive impact on the family compared with the TD group. In subgroup analyses, children with Down syndrome and cerebral palsy/motor impairment were described as having less negative impact on parents and were described as low in negative emotionality. Children with autism spectrum disorder (ASD), ID/DD nose and other less common diagnoses had a similar pattern of temperament with high emotionality, shyness and impulsivity, and low activity and sociability. Parents of children with ASD and ID/DD reported the highest level of negative impact. Temperamental characteristics

such as high negative emotionality and impulsivity, which can be identified earlier than behavioral problems, could be indicators of negative impact on parents of young children with ID. Despite great variability in temperament among children with mixed ID/DD, results indicated common temperamental characteristics among children with ASD, ID/DD and other diagnosis.

Emerson &et al. (2010) aimed to determine within a nationally representative sample of young Australian children: (1) the association amongst intellectual disability, borderline intellectual functioning and the prevalence of possible mental health problems; (2) the association amongst intellectual disability, borderline intellectual functioning and exposure to social disadvantage; (3) the extent to which any between-group differences in the relative risk of possible mental health problems may be attributable to differences in exposure to disadvantageous social circumstances. The study included a secondary analysis of a population-based child cohort of 4,337 children, aged 4/5 years, followed up at age 6/7 years. The main outcome measure was the scoring within the 'abnormal' range at age 6/7 years on the parent-completed Strengths and Difficulties Questionnaire. When compared to typically developing children, children identified at age 4/5 years as having intellectual disability or borderline intellectual functioning: (1) showed significantly higher rates of possible mental health problems for total difficulties and on all five SDQ subscales at age 6/7 years (OR 1.98–5.58); (2) were significantly more likely to be exposed to socio-economic disadvantage at age 4/5 and 6/7 years. Controlling for the possible confounding effects of exposure to socio-economic disadvantage (and child gender) significantly reduced, but did not eliminate, between-group differences in prevalence. Children with limited intellectual functioning make a disproportionate contribution to overall child psychiatric morbidity. Public health and child and adolescent mental health services need to ensure that services and interventions fit to the purpose and are effective for children with limited intellectual functioning, and especially those living in poverty, as they are for other children.

Upland, Kauri, (2010) examines stress among parents of children with intellectual disability. 102 parents formed the sample of this study, 30 of whom had children without disability. A stress assessment test with internal validity of 0.608 was utilized. This test has two parts: physical and mental, former with 19 items and latter with 21

items. T test was applied to check differences in stress, gender differences, and differences in mental and physical stress. Results show that, most parents of children with intellectual disability experience stress, physical and mental stress are significantly correlated, gender differences in stress experienced occur only in the mental area, and parents have higher mental stress score as compared to physical stress.

Yueh-Ching Chou and et al , (2009) examines a structured interview survey was conducted in a major city in Taiwan to explore and compare older and younger family primary caregivers' well being and their future care giving plans for these adults with intellectual disability. The sample size was 315 caregivers who were 55 years or older and who cared for adults with intellectual disability and 472 similar caregivers who were under 55 years of age. The results indicated that the older caregivers compared with younger ones reported a lower quality of life, less family support, a more negative perception of having a family member with intellectual disability, and greater worries about the future care arrangements of the adult with intellectual disability. Statistical analysis showed that predisposing, enabling, and need factors influenced the caregivers' future care giving options.

Shelley, Veer, Karaj, and Garnets (2009) aimed to explore the cross-sectional and prospective relationships between cognitive coping strategies and parental stress in parents of children with Down syndrome. A total of 621 participants filled out questionnaires, including the Cognitive Emotion Regulation Questionnaire to measure cognitive coping and the Nijmegen Ouderlijke Stress Index—Corte Verse (A. J. L. L. De Brock, A. A. Vermeils, J. R. M. Geris, & R. R. Abiding, 1992) to measure parental stress. After 8 months, stress was measured again. Cross-section ally, using acceptance, rumination, positive refocusing, refocusing on planning, and catastrophizing to a greater extent was related to more stress, whereas using positive reappraisal more often was related to less stress. Prospectively, acceptance and catastrophizing were related to more stress, whereas positive reappraisal was related to less stress. Implications for future research and prevention and intervention activities are discussed**.**

Praia Galvani and Taylor (2008) aimed to explored mothers' experience of the birth of a child with Down syndrome within a sociocultural context. Nine mothers of children with Down syndrome were interviewed. Mothers discussed responses to their child's diagnosis as well as negative attitudes toward disability that were displayed by members of the medical community. The narratives highlight the process of meaning-making that these mothers engaged in, their resistance to the dominant discourse on disability, and their eventual transformations in perceptions of disability and motherhood. The study suggests that the meaning of Down syndrome may be culturally embedded and that mothers of children with Down syndrome locate their child's disability within a social environment.

McCone &teal (2008) aimed to (1) to describe across three different cultures—Irish, Taiwanese and Jordanian—the inter-relationships among three indicators of maternal well-being. (2) To identify the coping strategies of mothers and the professional and informal supports available to them. (3) To identify the variables that has a negative impact on maternal well-being and possible moderating influences on them. A survey approach with three groups of self-selected mothers. The characteristics of the child determined the inclusion criteria; namely aged 5–18 years with a diagnosis of intellectual disability of such severity that the children attended special schools or centers. In each country, the special services within particular geographical areas were approached and all families known to them were given the opportunity to participate. In all 206 mothers agreed to participate. Mothers were interviewed individually at home or in the day centre attended by their child. They completed various rating scales of known reliability and validity. In addition they described in their own words, the impact the child had on their lives and how they coped. **Results** In all three countries, mothers experienced poor mental health, increased levels of child-related stress and poorer family functioning which the qualitative data further illuminated. Their child's behavior problems were a major factor in this. The impacts on mothers' well-being were not alleviated by access to professional supports or use of coping strategies. **Conclusions** Health professionals need to adopt family-centered approaches that embrace the support needs of mothers. Similar strategies would apply across all cultures although they must be responsive to individual need.

Lloyd, and Hastings (2008) explored psychological variables (acceptance, mindfulness, avoidant coping) that may explain some variance in maternal distress. Questionnaire data were gathered from mothers of children attending special schools at two time points, 18 months apart (n = 91 at Time 1; n = 57 at Time 2). In addition to measures of the child's functioning, the questionnaire pack included: a measure of acceptance of unwanted thoughts/feelings; a measure of attention to the present (mindfulness); a measure of active avoidance coping; measures of maternal anxiety, depression and stress; and a measure of mothers' positive perceptions of their child. **Results** In cross-sectional analysis, acceptance was negatively associated with maternal anxiety, depression and stress, such that mothers who were generally more accepting reported fewer psychological adjustment problems. Longitudinal analysis showed that acceptance is bidirectional related to anxiety and depression. Mindfulness was not significantly related to maternal distress, and avoidance coping was positively cross-section ally associated with depression only. There were no associations between psychological variables and maternal positive perceptions.

Kermanshah et al (2008) in their study on perceptions of lives with children with intellectual disability found six major themes: challenging the process of acceptance, painful emotional reactions, the interrelatedness of mother's health and child's well being, struggles to deal with oneself or the child, inadequate support from the family and the community, and the anxiety related to child's uncertain future.

Blathered al (2007) examined parents' perceived positive impact of a child with Mental retardation / developmental delays. Study 1 involved 282 young adults with severe mental retardation; Study 2 involved 214 young children with, or without, developmental delays. In both studies, positive impact was inversely related to behavior problems. Moreover, positive impact moderated the relationship between behavior problems and parenting stress. Also, main and moderating effects of positive impact differed by parent ethnicity. Latina mothers reported higher positive impact than Anglo mothers did when the child had MR/DD. These findings are discussed in the context of cultural beliefs.

Salivate, Italian, and Linemen (2007) aimed to Explaining the parental stress of fathers and mothers caring for a child with intellectual disability: a Double ABCX

Model. Twenty variables based on the Double ABCX Model of adaptation and selected on the basis of previous research were chosen to explain the parental stress of the mothers (n = 116) and fathers (n = 120) of children with an intellectual disability (age range = 1– 10 years). Principal component analysis, rotated into Varian-criterion, was done separately for mothers and fathers. The solution containing eight factors was considered best for both groups. They accounted for more than 70% of the total variance of the original variables. These eight orthogonal components were then entered into a stepwise regression analysis that was done separately for mothers and fathers. **Results** The multiple regression equations obtained explained 72% of the variance in maternal stress and 78% of the variance in paternal stress. The equations for mothers and fathers contained six and seven components, respectively. **Conclusions** The variables used in the present study were highly successful in accounting for parental stress. The results confirm the importance of intervening factors in explaining the stress. The single most important predictor of parental stress was the negative definition of the situation. In mothers, the negative definition was associated with the behavioral problems of the child while, in fathers it was connected with the experienced social acceptance of the child**.**

Aztar and Bard (2006) in many Middle Eastern countries, including Lebanon, there is a stigma attached to families who have an intellectually impaired child. These families complain of isolation and lack of community resources that could help them cope with their circumstances to optimize the child's abilities. Health professionals and researchers should be cognizant of factors related to the process of stress adaptation to help families cope with their circumstances. The aim of this cross-sectional study was to identify factors that play a role in mothers' adaptation to the care of their intellectually impaired children. The results, based on a sample of 127 mothers from Lebanon, reveal that a high percentage of mothers had depressive symptoms. Multiple regression analysis demonstrates that by order of importance, the factors that determine maternal depression are family strain, parental stress, and family income. The conclusions about nursing implications from a cultural perspective are discussed and recommendations proposed**.**

Oelofsenand Richardson, (2006) aimed to explored relationships between parental stress, SOC, social support, and health in parents of preschool children with and

without DD. A secondary aim was to explore the relevance of the SOC construct to parental adjustment. Data were analyzed from 59 families with preschool children with DD and 45 families of typically developing preschoolers (children without DD) who completed the study questionnaire. **Results** Mothers and fathers of children with DD reported high levels of parenting stress, with 84% of mothers' and 67% of fathers' scores falling within the clinical range. Parents of children with DD consistently reported higher levels of parenting stress, weaker SOC, and, for mothers and parents in 2 - parent families, poorer health than parents of children without DD. Within families, mothers of children with DD reported poorer health, higher levels of parenting stress, and weaker SOC than their partners. There were no significant differences in reported health, parenting stress, or SOC between parents of children without DD. **Conclusions** The results supported previous findings on high levels of parental stress in parents of preschool children with DD. The weaker SOC of parents of children with DD is likely to be an indication of the pervasive impact on parents of their child's DD. These findings also indicated possible gender differences in parental adjustment to their child's DD. Overall, the findings of this study support the usefulness of SOC theory in understanding adaptation in parents of children with DD.

Richard & et al, (2006) Mothers of children with intellectual disability were assessed at two time points, 2 years apart (n = 75 at Time 1, n = 56 at Time 2). Data were gathered on maternal distress, mental health, expressed emotion, and the child's internalizing and externalizing behavior problems. Consistent with previous research with families of children who have intellectual disability, maternal distress and children's behavior problems entered into a bidirectional relationship over time. This relationship was found to be specific to externalizing problems. Exploratory analyses also suggest that maternal distress and depression had a bidirectional longitudinal relationship. In terms of maternal expressed emotion, criticism and not emotional over-involvement was cross-section ally but not longitudinally related to children's externalizing behavior problems and to maternal distress.

Emerson and et al, (2006) aimed to estimate the extent to which these differences may be accounted for by between-group differences in socio-economic position. This study involved secondary analysis of happiness, self-esteem and self-efficacy

variables in a nationally representative sample of 6954 British mothers with dependent children under the age of 17 years, 514 of whom were supporting a child with an ID. **Results** Mothers of children with IDs reported lower levels of happiness, self-esteem and self-efficacy than mothers of children without IDs. Statistically controlling for differences in socio-economic position, household composition and maternal characteristics fully accounted for the between-group differences in maternal happiness, and accounted for over 50% of the elevated risk for poorer self-esteem and self-efficacy. **Conclusions** A socially and statistically significant proportion of the increased risk of poorer well-being among mothers of children with IDs may be attributed to their increased risk of socio-economic disadvantage.

Florien and Finder, (2006) aimed to examines the contribution of the marital relationship to the well-being of both mothers and fathers of children with developmental disabilities. Parent well-being is conceptualized in terms of mental health, parenting stress and parenting efficacy. These analyses are based on data from 67 families participating in the Early Intervention Collaborative Study, an ongoing longitudinal investigation of the development of children with disabilities and the adaptation of their families. Multidimensional assessment techniques were used to collect data from married mothers and fathers and their child with a disability. Mother and father data were analyzed separately using parallel hierarchical regression models. **Results** For both mothers and fathers, greater marital quality predicted lower parenting stress and fewer depressive symptoms above and beyond socio-economic status, child characteristics and social support. In relation to parenting efficacy, marital quality added significant unique variance for mothers but not for fathers. For fathers, greater social support predicted increased parenting efficacy. Child behavior was also a powerful predictor of parental well-being for both mothers and fathers. **Conclusion** The findings support the importance of the marital relationship to parental well-being and illustrate the value of including fathers in studies of children with developmental disabilities**.**

Hassall1, Rose, and McDonald, (2005) investigated the relationships between parental cognitions, child characteristics, family support and parenting stress. The aspects of cognitions studied were: parenting self-esteem (including efficacy and satisfaction) and parental locus of control. The group studied consisted of 46

mothers of children with ID. The Vineland Adaptive Behavior Scales and Maladaptive Behavior Domain were administered by interview. Mothers also completed four questionnaires: the Family Support Scale, the Parenting Sense of Competence Scale, a shortened form of the Parental Locus of Control Scale and the Parenting Stress Index (Short Form). **Results** Data were analyzed using Pearson's correlation coefficients, partial correlations and a regression analysis. The results indicated that most of the variance in parenting stress was explained by parental locus of control, parenting satisfaction and child behavior difficulties. Whilst there was also a strong correlation between family support and parenting stress, this was mediated by parental locus of control. **Conclusions** The results demonstrate the potential importance of parental cognitions in influencing parental stress levels. It is argued that these results have implications for clinical interventions for promoting parents' coping strategies in managing children with ID and behavioral difficulties.

Duvdevany and Abound, (2005) examined the influence of a social support system on the level of stress and the sense of personal well-being of 100 Israeli Arab mothers of young children with special needs. Fifty mothers were served by the welfare services in the Nazareth area while 50 did not get help on a regular basis. A comparison was done between educated, urban mothers, and less-educated, rural mothers. **Results** The research results point to a relationship between informal support resources, and the marital and economic stress of the mothers: the higher the amount of the informal support resources, the lower the level of stress that was experienced by the mothers. A relationship between the amount of informal support and level of parental stress was not confirmed. A relationship between the amount of support resources and the personal well-being of the mothers was found: the higher the amount of informal support resources, the higher the sense of well-being of the mothers. A relationship between formal support (the welfare services), and level of stress or personal well-being was not found. Education and place of living were not related to level of stress or personal well-being. Educated mothers from urban areas used the formal support (the welfare services) less than less-educated mothers who lived in rural areas. **Conclusions** The findings are interpreted with respect to practice and previous studies**.**

Beck and et al, (2004) identified factors associated with maternal expressed emotion (EE) towards their child with intellectual disability (ID). A total of 33 mothers who had a child with ID and at least one child without disabilities between the ages of 4 and 14 years participated in the study. Mothers completed self-assessment questionnaires which addressed their sense of parenting competence, beliefs about child-rearing practices, and their reports of behavioral and emotional problems of their child with ID. Telephone interviews were conducted to assess maternal EE towards the child with ID and towards a sibling using the Five Minute Speech Sample, and also to assess the adaptive behavior of the child with ID using the Vineland Adaptive Behavior Scale. Results were Mothers with high EE towards their child with ID were more satisfied with their parenting ability, and their children had more behavior problems. Analysis of differential maternal parenting, through comparisons of EE towards their two children, showed that mothers were more negative towards their child with ID for all domains of the FMSS except dissatisfaction. **Conclusions** A small number of factors associated with maternal EE towards children with ID were identified. Differences in maternal EE towards their child with ID and their other child suggest that EE is child-driven rather than a general maternal characteristic. Implications of the data for future research are discussed**.**

Glidden and Schoolcraft, (2004) this present longitudinal study reports on an 11-year follow-up of adoptive and birth families rearing children with ID. Its focus was on depressive symptoms and how these changed over time in a sample of 187 mothers. In particular, the authors were interested in whether initial differences in depression between adoptive mothers who knowingly and willingly decided to rear their children with disabilities, and birth mothers for whom the diagnosis of disability was unexpected and frequently crisis-inducing, would persist over time. A longitudinal method with three times of measurement provided data which were analyzed with analysis of variance and regression techniques. Moreover, several other individual and family adjustment measures were examined with respect to their correlations with depression and an outcome variable that measured subjective well-being with regard to the child. Furthermore, mothers were classified as typical or atypical for their adoptive/birth group based on their depression scores at the first time of measurement. The authors predicted that later depression would be different based

on the earlier scores. **Results** Both adoptive and birth mothers reported low depression, not significantly different from each other, at the 11-year follow-up. The personality variable of neuroticism was the strongest predictor of depression for both adoptive and birth mothers, accounting for 24% and 23% of the variance, respectively, but it did not predict the mother's subjective well-being with regard to the child. Mothers classified as typical or atypical for their groups at initial measurement continued to report significantly different depression scores 11 years later. **Conclusions** The low depression scores, not significantly different for birth and adoptive mothers, portray the long-term prognosis for adjustment to rearing children with disabilities as primarily positive. Moreover, the predictive value of neuroticism suggests that general mental health is an important component influencing this adjustment. Nevertheless, a different pattern for a different outcome variable suggests that multiple measures are necessary to portray accurately the complexity of reaction over time.

Radwan, A, Rokba (2004) aims to investigate the relationship between psychological hardiness and mental health among mothers of children with Down syndrome, to determine the level of psychological hardiness and the level of mental health, and to explore the effect of some socio-demographic variables, such as mothers educational level, mothers chronological ages, children chronological ages, and children gender, on the level of psychological hardiness among mothers. It is analytical descriptive study for 180 mothers of Down syndrome children at the Right to Live Society at Gaza Strip. Psychological hardiness questionnaire was used to measure psychological hardiness, and SCL-90-R was used to measure mental health.

The main results revealed high level of both psychological hardiness and mental health, and showed significant correlation between the level of psychological hardiness and the level of mental health among mothers of children with Down syndrome. The ratio of the total psychological hardiness was (58.9%), and the mean of total mental health was (22.68%), and the correlation between psychological

hardiness and mental health was (0.434). Also, the results showed that there are statistically significant differences in the level of psychological hardiness due to educational level of mothers toward mothers who have university, secondary, and primary education. Also, the results showed that there are no statistically significant differences in the level of psychological hardiness due to chronological ages of mothers, chronological ages of children, and children gender.

Emerson, (2003) aimed of the present paper were to: (1) compare the socio-economic situation of mothers raising a child with ID to that of mothers of non-ID children; (2) assess the contribution of raising a child with ID to negative psychological outcomes for mothers; and (3) identify variables associated with negative psychological outcomes among mothers of children with ID. The 1999 Office for National Statistics survey, Mental Health of Children and Adolescents in Great Britain, 1999, collected information on a multistage stratified random sample of 10 438 children between 5 and 15 years of age across 475 postal code sectors in England, Scotland and Wales. Secondary analysis was undertaken of the social and economic circumstances, and stress reported by 245 mothers of sampled children with ID and a comparison group of 9 481 mothers of sampled children who did not have ID. The results indicate that: (1) families supporting a child with ID were significantly economically disadvantaged when compared with families supporting a child who did not have ID; (2) when compared with mothers of sampled children who did not have ID, mothers of sampled children with ID reported that their child's difficulties resulted in greater social and psychological impact; (3) having a child with ID marginally reduced the odds of mothers screening positive for having mental health problems (once all other variables were taken into account); and (4) among mothers of children with ID,

mental health problems were associated with the child's difficulties having a greater social impact, having a boy, the child experiencing more than one potentially stressful life event, poverty, receipt of means-tested welfare benefits and ‘unhealthy’ family functioning. These results highlight the importance of combating poverty among children with ID and their families, and the need to develop more complex models of understanding and intervention.

Shin, and Crittenden, (2003) provided explanations for well being of Korean and American mothers of children with intellectual disability. Causes of stress for the American mothers were specific to the individual variables. For Korean mothers, cultural values that carry social influence were strongly associated with their experience of stress.

He-man, (2002) examined the perspectives of parents of children with an intellectual, physical, or learning disability. Thirty-two parents were interviewed as to past, present, and the modes of coping. The questions examined various aspects of family ecology domains: parents' responses to the child's diagnosis; patterns of adjustment; family support and services used by parents; and parents' feelings and future expectations. Although, it was found that most parents had to make changes in their social life and expressed high levels of frustration and dissatisfaction, many try to maintain their routine life. The majority expressed the need for a strong belief in the child and in the child's future, an optimistic outlook, and a realistic view and acceptance of the disability. The study highlighted the importance of social resources and support, and the need for effective programs of intervention

Olsson, and. Hwang, (2001) investigated the prevalence and severity of parental depression in families of children with ID and in control families., Parental depression was assessed using the Beck Depression Inventory (BDI) in 216 families with children with autism and/or intellectual disability (ID), and in 214 control families. Mothers with children with autism had higher depression scores (mean = 11.8) than mothers of children with ID without autism (mean = 9.2), who in turn, had higher depression scores than fathers of children with autism (mean = 6.2), fathers of children with ID without autism (mean = 5.0), and control mothers (mean = 5.0) and fathers (mean = 4.1). Forty-five per cent of mothers with children with ID without autism and 50% of mothers with children with autism had elevated depression scores (BDI > 9), compared to 15–21% in the other groups. Single mothers of children with disabilities were found to be more vulnerable to severe depression than mothers living with a partner.

Hero, Ameren, and Wimbled, (2000) studied self perceived health in Swedish parents of children with Down Syndrome (DS). They found mothers of children with DS had significantly lower, less favorable scores on self perceived health than did the fathers of DS children and control group.

Sephardim, Vera, and Prasad, (2000) reported a direct relationship between the degree of perceived burden, social emotional burden, disruption of family routine and disturbance in family interactions for women with intellectually disabled children rather than men.

3.3 Summary of previous studies:

All of the literature reviews that the researcher found during searching supported the research hypothesis and give the same results that the researcher expected before getting the research results, in which it seems to be justifiable and discusses a relationship that looks to be realistic.

Lack of local studies that discussed mental disabilities and its effects on mental health and self esteem among their mothers, what made the present study mainly depends on foreign studies. The researcher found most of previous studies which talking about mental health and self esteem among mothers of children with mental disabilities ensure that mental health and self esteem of these mothers can be markedly affected. Also, the researcher found that most parents of children with intellectual disability experience stress, physical and mental stress are significantly correlated, gender differences in stress experienced occur only in the mental area, and parents have higher mental stress score as compared to physical stress, In all three countries, mothers experienced poor mental health, increased levels of child-related stress and poorer family functioning which the qualitative data further illuminated. Their child's behavior problems were a major factor in this. The impacts on mothers' well-being were not alleviated by access to professional supports or use of coping strategies. Mothers and fathers of children with DD reported high levels of parenting stress, with 84% of mothers' and 67% of fathers' scores falling within the clinical range. Parents of children with DD consistently reported higher levels of parenting stress, Mothers of children with IDs reported lower levels of happiness, self-esteem and self-efficacy than mothers of children without IDs. Statistically controlling for differences in socio-economic position, household composition and maternal characteristics fully accounted for the between-group differences in maternal happiness, and accounted for over 50% of the elevated risk for poorer self-esteem and self-efficacy.

Some of the researchers used tools as questionnaires, interviews, closed ended questions and observations.

The researcher took advantages of these previous studies and used it to develop questionnaires, select study design, definition of terms, and discussion. Finally, most of previous studies related to this study, the researcher found the results of previous studies as the following:

Marital quality predicted concurrent well-being, and co-parenting quality predicted prospective well-being. Mothers of children with ID reported lower well-being than other parents.

Older caregivers compared with younger ones reported a lower quality of life, less family support, a more negative perception of having a family member with intellectual disability, and greater worries about the future care arrangements of the adult with intellectual disability.

Mothers experienced poor mental health, increased levels of child-related stress and poorer family functioning which the qualitative data further illuminated. Their child's behavior problems were a major factor in this.

Mothers and fathers of children with DD reported high levels of parenting stress, with 84% of mothers' and 67% of fathers' scores falling within the clinical range. Parents of children with DD consistently reported higher levels of parenting stress.

Mothers of children with IDs reported lower levels of happiness, self-esteem and self-efficacy than mothers of children without IDs. Statistically controlling for differences in socio-economic position.

For both mothers and fathers, greater marital quality predicted lower parenting stress and fewer depressive symptoms above and beyond socio-economic status, child characteristics and social support.

Chapter 4

Methodology

Chapter 4

4.1 Overview:

This chapter presents issues which related to methodology used by the researcher to provide answers to the research questions. This chapter contains the following heading, study design, period of study, place of study, study population, sample size and sampling methods, eligibility, validity and reliability, pilot study, ethical consideration, data collection and data analysis.

4.2 Study design:

The analytical descriptive approach was used in this study to describe the relationship between self esteem and mental health among mothers of children with MD in Gaza Governorates. The independent variables include mental health; whereas the dependent variables include self esteem.

4.3 Study population:

The study population Includes all mothers with MD children in Gaza Governorates.

4.4 Personal information:

4.4.1. Age of the mother at child's birth:

Table No.(4.1) shows that 57.6% of the mothers are " Less than 20-30 " years old at child's birth, 35.8 % of the mothers are from "31-40 " years old at child's birth and 6.7% of the mothers are " more than 41" years old at child's birth. This result indicates that the Palestinian community is largely young as PCBS (2010) reported that the population of the Palestinian Territory is young, The researcher thinks that this result indicate to lack of Knowledge and understanding among mothers of children with mental disability about family regulation and planning.

Table (4.1):Age of the mother at child's birth

Age of the mother at child's birth	Frequency	Percent
less than 20-30	95	57.6
31-40	59	35.8
more than 41	11	6.7
Total	165	100.0

4.4.2.Education level of mother:

Table No.(4.2) shows that 6.7% of mothers have Primary education level, 35.2% of mothers have preparatory education level, 43.6% of mothers have secondary education level and 14.5% of mothers have university education level . This results of illiterate women in this study is consistent with the results of health survey report which assured that the ratio of Palestinian illiterate woman over 10 years old in the Palestinian community is (12.3%) and this support the evidence of early marriage of female prevent the wife from continuing her education . According to the results of the health survey results in relation to the primary, secondary, and university education of women, was not consistent with the results of the current study.

Table (4.2):Education level of mother

Education level of mother	Frequency	Percent
Primary	11	6.7
preparatory	58	35.2
secondary	72	43.6
university	24	14.5
Total	165	100.0

4.4.3.Age of the child:

Table No.(4.3) shows that 7.3% of the children are " Less than 0-6 " years old, 52.1% of the children are from "7-10 " years old and 40.6% of the children are " more than 11 years". This means that mothers and families with a child with mental disabilities become more aware and believe in the early intervention program, for that, they bring their children early to the Right to Live Society and this considered as an indication of accepting the disability of the child and helping them to have normal

life through the integration to all fields of the society. This requires improving mental health services and protections of mental dishabilles rights.

Table (4.3):Age of the child

Age of the child	Frequency	Percent
Less than 0-6	12	7.3
7-10	86	52.1
more than 11	67	40.6
Total	165	100.0

4.4.4 Gender of the child:

Table No.(4.4) shows that 50.3% of the children are Males and 49.7% of the children are Females. These results came in line with the results of the mental disabilities' persons in the Palestinian territory which assured that the ratio of disabled males is higher than the ratio of disabled females (Palestinian Central Bureau Statistics, 2012).

Table (4.4):Gender of the child

Gender of the child	Frequency	Percent
male	83	50.3
female	82	49.7
Total	165	100.0

4.4.5. Order of the child in the family:

Table No.(4.5) shows that 18.2% of the child Order in the family is One,24.8% of the child Order in the family is two, 19.4% of the child Order in the family is three and 37.6% of the child Order in the family is more than four. This explains the accepted level of both awareness and knowledge among parents of children with mental disabilities for early sings and symptoms of mental disabilities and seeking treatment and coming to the mental health clinics. since in the group of more than four, there are old sisters and brothers who share mothers in taking care of the mental disabilities child.

Table (4.5):Order of the child in the family

Order of the child in the family	Frequency	Percent
One	30	18.2
two	41	24.8
three	32	19.4
more than four	62	37.6
Total	165	100.0

4.4.6. Value of monthly income:

Table No.(4.6) shows that %71.5 of the sample has “Less than1500 NIS” monthly income, %25.5 of the sample has from 1500-3000 NIS monthly income and %3.0 of the sample has more than 3000 NIS monthly income . This mean that the economic level for the participants is low due to the closure and siege, which increases unemployment and poverty in Gaza strip. majority of the participants benefit from social affairs and were fully dependent on government funded support programs. And the value of their monthly income Less than 1500 NIS. This low income level was due to a high rate of unemployment and poverty in Gaza strip as PCBS (2010) reported that the unemployment rate in Gaza strip is 43.8%(PCBS, 2010:).this is agree with the percentage of Gaza people who live in deep poverty 43.0% in 2007(PCBS, 2010).

Table (4.6):Value of monthly income

Value of monthly income	Frequency	Percent
Less than1500 NIS	118	71.5
from 1500-3000 NIS	42	25.5
more than 3000 NIS	5	3.0
Total	165	100.0

4.4.7.Number of mentally retarded members in the family:

Table No.(4.7) shows that 69.1% of the families have" one " mentally retarded child, 23% of the families have "two" mentally retarded children , and 7.9% of the families have "more than" mentally retarded children, That means majority of the participants have one child with disability at the time of data collection.

Table (4.7):Number of mentally retarded members in the family

Number of mentally retarded members in the family	Frequency	Percent
one child	114	69.1
two	38	23.0
more than	13	7.9
Total	165	100.0

4.4.8. Number of family members:

Table No.(4.8) shows that 24.8% of the families have" 3-5 " family members, and 75.2 % of the families have" more than 6" family members. This agree with the nature of Gaza Strip and the population figures as PCBS said 1.6 million in the Gaza Strip. Of every 100 persons in the Palestinian Territory, about 44 are refugees 58 per 100 in the Gaza Strip. (PCBS, 2011).

Table (4.8):Number of family member

Number of family member	Frequency	Percent
3-5	41	24.8
more than 6	124	75.2
Total	165	100.0

4.4.9. Place of residence:

Table No.(4.9) shows that 13.3% of the place of residence of the sample is in the Northern governorate, 35.8% of the sample place of residence is in Gaza governorate, 20.6% of the sample place of residence is in Mid-area governorate, 18.2% of the sample place of residence is in Khanyounis governorate and 12.1% of the sample place of residence is in Rafah governorate . That means place of residence is distributed according to the numbers of mental disability children in each governorate.

Table (4.9): place of residence

place of residence	Frequency	Percent
Northern governorate	22	13.3
Gaza governorate	59	35.8
Mid-area governorate	34	20.6
Khanyounis governorate	30	18.2
Rafah governorate	20	12.1
Total	165	100.0

4.5Eligibility:

4.5.1. Inclusion criteria:

All registered mothers of MD children who following three local nongovernmental societies, Khan younis rehabilitation society, Shamis society for care of the handicapped in Gaza town and Nuseirat social and training rehabilitation association.were included in the study.

4.5.2. Exclusion criteria:

Any other accompany person as fathers, sister or brother with MD children's. Mothers of MD children who visit governmental and other nongovernmental community mental health organizations

4.6 Sample and sampling technique:

The study investigated the opinions of 165 mothers of children with mental disability about the relationship between mental health and self esteem in three local nongovernmental societies, Khan younis rehabilitation society, Shamis society for care of the handicapped in Gaza town and Nuseirat social and training rehabilitation association through accidental sample. In this study, the researcher used two scales to measure the level of mental health and self esteem and to find the relationship between mental health and self esteem among mothers of children with mental disability.

4.7. Ethical and administrative Consideration:

Approval from three local nongovernmental societies, Khan younis rehabilitation society, Shamis society for care of the handicapped in Gaza town and Nuseirat social and training rehabilitation association were obtained to conduct the study. The researcher was explained the purpose and objectives of the study to all mothers of MD. The participation in the study was optional and confidential. Neither name nor personal data were mentioned (anonymity).

4.8. Data Collection and tools:

It includes data about the MD children, their mothers and their families. These data includes mothers level of education; mothers current age; mothers age at the birth of the MD child, child age, gender, birth order and their numbers in the

family, number of family members, place of residence and family income level.

4.8.1 Research tools:

4.8.1.1 Mental Health Scale (SCL –90- R)

The Symptom Checklist-90-R (SCL-90-R) instrument helps evaluate a broad range of psychological problems and symptoms of psychopathology. The instrument is also useful in measuring patient progress or treatment outcomes.

The SCL-90-R instrument is used by clinical psychologists, psychiatrists, and professionals in mental health, medical, and educational settings as well as for research purposes. It can be useful in:

- Initial evaluation of patients at intake as an objective method for symptom assessment
- Measuring patient progress during and after treatment to monitor change
- Outcomes measurement for treatment programs and providers through aggregated patient information
- Clinical trials to help measure the changes in symptoms such as depression and anxiety. (Leonard R. Derogatis,2012)

The SCL-90-R is a 90-item self-report system inventory developed in the 1980s by Derogates and designed to reflect the psychological symptom patterns of community, medical and psychiatric respondents. The scale was translated to Arabic language by Egyptian Anglo Library and adapted to the Palestinian environment by Abu Hein (1992), by calculating the scale validity.

The SCL-90-R is consisting of 90 items which rated on a five-point scale of distress (0-4) ranging for “not at all” to “extremely.” The scale consists of nine primary symptom dimensions: summarization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychotics; in addition to the tenth symptom dimension which call additional item.

1- Psychosomatic : This dimension consists of 12 items and the number of these items on the mental health scale (SCL-90-R) are (1,4,12,27,40,42,48,49,52,53,56,58).

2- Obsessive compulsive : This dimension consists of 10 items and the number of these items on the mental health scale (SCL-90-R) are (3,9,10,28,38,45,46,51,55,65).

3- Interpersonal sensitivity : This dimension consists of 9 items and the number of these items on the mental health scale (SCL-90-R) are (6,21,34,36,37,41,61,69,73).

4- Depression : This dimension consists of 13 items and the number of these items on the mental health scale (SCL-90-R) are (5,14,15,20,22,26,29,30,31,32,54,71,79).

5- Anxiety : This dimension consists of 10 items and the number of these items on the mental health scale (SCL-90-R) are (2,17,23,33,39,57,72,78,80,86).

6- Hostility: This dimension consists of 6 items and the number of these items on the mental health scale (SCL-90-R) is (11, 24, 63, 67, 74, and 81).

7- Phobic anxiety : This dimension consists of 7 items and the number of these items on the mental health scale (SCL-90-R) are (13,25,47,50,70,75,82).

8- Paranoid ideation: This dimension consists of 6 items and the number of these items on the mental health scale (SCL-90-R) is (8, 18, 43, 68, 76, and 83).

9- Psychotics : This dimension consists of 10 items and the number of these items on the mental health scale (SCL-90-R) are (7,16,35,62,77,84,85,87,88,90).

10- Additional items : This dimension consists of 7 items and the number of these items on the mental health scale (SCL-90-R) are (19,44,59,60,64,66,89).

4.8.1.2 Self Esteem questionnaire (SEQ):

This questionnaire help to find out low self esteem that is often misunderstood, and it is even misdiagnosed by many therapists as being a secondary concern. Rather than being merely a symptom, low self esteem is frequently the root cause of many psychological, emotional, personal and relationship issues (Marilyn J Sorensen, 2005). This measure was used from an American institution and was later translated in Arabic by to official institutions and presented to the supervisor, where some modifications were applied on it and distribute it to three paragraphs, then was presented to the arbitrators, then were applied to the pilot sample.

SEQ is an instrument that gives quantitative assessment of the individual self esteem**,** this questionnaire will help find out low self esteem (LSE) (Marilyn J Sorensen, 2005). The instrument is consist of 44 statements that focus on the Self Esteem of the individual, and the answer of the questionnaire contains three levels (always – sometimes – never).

4.9. Validity of the questionnaire:

To ensure the validity of the questionnaire, two statistical tests were applied. The first test is Criterion-related validity test (Spearman test) which measures the correlation coefficient between each paragraph in one field and the whole field. The second test is structure validity test (Spearman 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.

4.9.1. Structure Validity of each dimension and the whole of questionnaire:

To test the appropriateness of data collection instrument, and standardize the suitable way for data collection, the researcher was conducted a pilot study concerning the instrument.

4.9.1.1 Pilot study:

A pilot study was carried out in three local nongovernmental societies, Khan younis rehabilitation society, Shamis society for care of the handicapped in Gaza town and Nuseirat social and training rehabilitation association through application of study instruments (self esteem questionnaire and SCL- 90-R) on a sample of 60

mothers of children with MD and this sample of mothers were not included in the study.

- Internal Validity for Mental Health Scale:

Table 4.10: Correlation coefficient of each paragraph of " Psychosomatic " and the total of this field

No.	Paragraph	Pearson Correlation Coefficient	P-Value (Sig.)
•	Persistent headache	.557	0.000*
•	Dizziness with yellowing	.707	0.000*
•	Pain in the chest and heart	.704	0.000*
•	low back pain	.677	0.000*
•	I have a lot of nausea and stomach disorders	.808	0.000*
•	My muscles cramping	.756	0.000*
•	Difficulty breathing	.820	0.000*
•	Heat and cold in my body	.665	0.000*
•	Numbness and tingling in the body	.696	0.000*
•	Feeling narrowing throat and inability to swallow	.751	0.000*
•	General weakness in different parts of my body	.812	0.000*
•	Feeling of heaviness both hands and both feet.	.801	0.000*

* Correlation is significant at the 0.01 level

Table (4.10) clarifies the correlation coefficient for each paragraph of the "**Summarization**" and the total of the field. The p-values (Sig.) are less than 0.01, so the correlation coefficients of this field are significant at $\alpha = 0.01$, so it can be said that the paragraphs of this field are consistent and valid to be measure what it was set for.

Table 4.11: Correlation coefficient of each paragraph of " Obsessive compulsive " and the total of this field

No.	Paragraph	Pearson Correlation Coefficient	P-Value (Sig.)
•	Occurrence of bad ideas	.770	0.000*
•	Difficulty remembering things	.809	0.000*
•	Discomfort due to neglect and lack of hygiene	.511	0.000*
•	I feel that things are not going well	.655	0.000*
•	I do things very slowly	.703	0.000*
•	I check what I do several times	.672	0.000*
•	I find it difficult to make decisions	.785	0.000*
•	The feeling of not being able to think	.795	0.000*
•	Difficulty concentrating	.743	0.000*
•	Re the same things several times	.570	0.000*

* Correlation is significant at the 0.01 level

Table (4.11) clarifies the correlation coefficient for each paragraph of the " **Obsessive compulsive** " and the total of the field. The p-values (Sig.) are less than 0.01, so the correlation coefficients of this field are significant at $\alpha = 0.01$, so it can be said that the paragraphs of this field are consistent and valid to be measure what it was set for.

Table 4.12 : Correlation coefficient of each paragraph of " Interpersonal sensitivity " and the total of this field

No.	Paragraph	Pearson Correlation Coefficient	P-Value (Sig.)
•	The desire to criticize others	.622	0.000*
•	Shyness and difficulty of dealing with others	.693	0.000*
•	I feel that others can easily hurt me	.798	0.000*
•	Feeling that others do not understand me	.746	0.000*
•	Feeling that others are not friendly	.878	0.000*
•	Compared to others, I feel less valuable of them	.806	0.000*
•	I feel upset when the presence of others and keep tabs on me	.687	0.000*
•	Excessive sensitivity in dealing with others	.729	0.000*
•	I feel the fear of being in public places	.720	0.000*

* Correlation is significant at the 0.01 level

Table (4.12) clarifies the correlation coefficient for each paragraph of the "**Interpersonal sensitivity**" and the total of the field. The p-values (Sig.) are less than 0.01, so the correlation coefficients of this field are significant at $\alpha = 0.01$, so it can be said that the paragraphs of this field are consistent and valid to be measure what it was set for.

Table 4.13 : Correlation coefficient of each paragraph of " Depression " and the total of this field

No.	Paragraph	Pearson Correlation Coefficient	P-Value (Sig.)
•	Loss of sexual desire or interest	.637	0.000*
•	Sense of slowness and loss of energy	.824	0.000*
•	Haunt me ideas to get rid of the life	.550	0.000*
•	Crying easily	.689	0.000*
•	I feel that I under arrest or tied up or handcuffed	.865	0.000*
•	Self-criticism for some things work	.631	0.000*
•	I feel lonely	.834	0.000*
•	"depression"I feel sad	.851	0.000*
•	Discomfort on things dramatically	.727	0.000*
•	Loss of important things	.713	0.000*
•	Loss of hope for the future	.814	0.000*
•	Each thing needs to posterity a great effort	.720	0.000*
•	I feel unimportant	.786	0.000*

* Correlation is significant at the 0.01 level

Table (4.13) clarifies the correlation coefficient for each paragraph of the "**Depression**" and the total of the field. The p-values (Sig.) are less than 0.01, so the correlation coefficients of this field are significant at $\alpha = 0.01$, so it can be said that the paragraphs of this field are consistent and valid to be measure what it was set for.

Table 4.14 : Correlation coefficient of each paragraph of " Anxiety " and the total of this field

No.	Paragraph	Pearson Correlation Coefficient	P-Value (Sig.)
•	jittering and shivering	.733	0.000*
•	I feel quivering	.793	0.000*
•	Fear suddenly and without a specific reason	.708	0.000*
•	Fear	.839	0.000*
•	Increased heart rate	.704	0.000*
•	I feel nervous	.842	0.000*
•	I feel cases of fear and fatigue	.749	0.000*
•	I feel Malaise and hyperactivity	.720	0.000*
•	I feel that bad things will happen to me	.876	0.000*
•	I have fantasies and strange ideas	.651	0.000*

* Correlation is significant at the 0.01 level

Table (4.14) clarifies the correlation coefficient for each paragraph of the " **Anxiety** " and the total of the field. The p-values (Sig.) are less than 0.01, so the correlation coefficients of this field are significant at $\alpha = 0.01$, so it can be said that the paragraphs of this field are consistent and valid to be measure what it was set for.

Table 4.15 : Correlation coefficient of each paragraph of " Hostility ″ and the total of this field

No.	Paragraph	Pearson Correlation Coefficient	P-Value (Sig.)
•	Others can easily keep me excited	.760	0.000*
•	Inability to control anger	.714	0.000*
•	I feel the desire to hurt others	.409	0.002*
•	The desire to cracking and breaking things	.717	0.000*
•	Frequent entry in sharp controversy and debate	.753	0.000*
•	Scream and throw things	.764	0.000*

* Correlation is significant at the 0.01 level

Table (4.15) clarifies the correlation coefficient for each paragraph of the " **Hostility** " and the total of the field. The p-values (Sig.) are less than 0.01, so the correlation coefficients of this field are significant at $\alpha = 0.01$, so it can be said that the paragraphs of this field are consistent and valid to be measure what it was set for.

Table 4.16 : Correlation coefficient of each paragraph of " Phobic anxiety " and the total of this field

No.	Paragraph	Pearson Correlation Coefficient	P-Value (Sig.)
•	Fear of public places and streets	.712	0.000*
•	I am afraid to go out of the house	.779	0.000*
•	Fear of travel	.661	0.000*
•	I avoid certain things	.535	0.000*
•	The fear of being in human populations	.728	0.000*
•	Feel quivering when am lonely	.684	0.000*
•	I am afraid that I lose consciousness in front of others	.773	0.000*

* Correlation is significant at the 0.01 level

Table (4.16) clarifies the correlation coefficient for each paragraph of the " **Phobic anxiety** " and the total of the field. The p-values (Sig.) are less than 0.01, so the correlation coefficients of this field are significant at $\alpha = 0.01$, so it can be said that the paragraphs of this field are consistent and valid to be measure what it was set for.

Table 4.17 : Correlation coefficient of each paragraph of " Paranoid ideation " and the total of this field

No.	Paragraph	Pearson Correlation Coefficient	P-Value (Sig.)
•	I think that others are responsible for my problems	.695	0.000*
•	Distrust of others	.641	0.000*
•	I feel observed by others	.780	0.000*
•	I have ideas that not exist in others	.617	0.000*
•	Others do not appreciate my work	.725	0.000*
•	I feel that others utilizing me	.664	0.000*

* Correlation is significant at the 0.01 level

Table (4.17) clarifies the correlation coefficient for each paragraph of the " **Paranoid ideation** " and the total of the field. The p-values (Sig.) are less than 0.01, so the correlation coefficients of this field are significant at $\alpha = 0.01$, so it can be said that the paragraphs of this field are consistent and valid to be measure what it was set for.

Table 4.18 : Correlation coefficient of each paragraph of " Psychotics " and the total of this field

No.	Paragraph	Pearson Correlation Coefficient	P-Value (Sig.)
•	The belief that others control my thoughts	.709	0.000*
•	I hear voices others do not hear	.575	0.000*
•	Others can easily read my own ideas	.738	0.000*
•	I have strange ideas	.680	0.000*
•	I feel lonely even when I'm with people	.769	0.000*
•	Bothers me to think about sexual matters	.813	0.000*
•	Haunt me ideas that others should punish me	.776	0.000*
•	I think that there is an imbalance in the body	.769	0.000*
•	I feel I am not close to and far from others	.745	0.000*
•	I have a problem in my mind, "myself"	.833	0.000*

* Correlation is significant at the 0.01 level

Table (4.18) clarifies the correlation coefficient for each paragraph of the "**Psychotics**" and the total of the field. The p-values (Sig.) are less than 0.01, so the correlation coefficients of this field are significant at $\alpha = 0.01$, so it can be said that the paragraphs of this field are consistent and valid to be measure what it was set for.

Table 4.19 : Correlation coefficient of each paragraph of " Additional items " and the total of this field

No.	Paragraph	Pearson Correlation Coefficient	P-Value (Sig.)
•	Loss of appetite	.731	0.000*
•	Difficulty sleeping	.632	0.000*
•	Fear of death	.649	0.000*
•	Excessive sleep	.491	0.000*
•	Woke up early	.578	0.000*
•	I suffer from interrupted sleep and Spam	.676	0.000*
•	Feeling guilty	.706	0.000*

* Correlation is significant at the 0.01 level

Table (4.19) clarifies the correlation coefficient for each paragraph of the "**Additional items**" and the total of the field. The p-values (Sig.) are less than 0.01, so the correlation coefficients of this field are significant at $\alpha = 0.01$, so it can be said that the paragraphs of this field are consistent and valid to be measure what it was set for.

- ***Structure Validity for Mental Health Scale:***

Table 4.20: Correlation coefficient of each field and the whole of *Scale*

No.	Field	Pearson Correlation Coefficient	P-Value (Sig.)
•	Psychosomatic	.912	0.000*
•	Obsessive compulsive	.927	0.000*
•	Interpersonal sensitivity	.921	0.000*
•	Depression	.963	0.000*
•	Anxiety	.944	0.000*
•	Hostility	.860	0.000*
•	Phobic anxiety	.883	0.000*
•	Paranoid ideation	.881	0.000*
•	Psychotics	.923	0.000*
•	Additional items	.897	0.000*

* Correlation is significant at the 0.01 level

Table (4.20) clarifies the correlation coefficient for each filed and the whole Scale. The p-values (Sig.) are less than 0.01, so the correlation coefficients of all the fields are significant at $\alpha = 0.01$, 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.

4.9. Reliability of the Questionnaire

- Reliability for Mental Health Scale:

(A) Cronbach's Coefficient Alpha

Table 4.21: Cronbach's Alpha for each filed of the scale

No.	Field	N	Cronbach's Alpha
•	Summarization	12	0.907
•	Obsessive compulsive	10	0.888
•	Interpersonal sensitivity	9	0.888
•	Depression	13	0.934
•	Anxiety	10	0.919
•	Hostility	6	0.791
•	Phobic anxiety	7	0.823
•	Paranoid ideation	6	0.775
•	Psychotics	10	0.910
•	Additional items	7	0.750
	All paragraphs of the questionnaire	90	0.986

Table (4.21) shows the values of Cronbach's Alpha for each filed of the scale and the entire scale. For the fields, values of Cronbach's Alpha were in the range from 0.750 and 0.934. This range is considered high; the result ensures the reliability of each field of the scale. Cronbach's Alpha equals 0.986 for the entire scale which indicates an excellent reliability of the entire scale.

(B) Split Half Method:

Table 4.22: Split-Half Coefficient for each filed of the scale

No.	Field	correlation coefficient	Spearman-Brown Coefficient
•	Summarization	0.874	0.933
•	Obsessive compulsive	0.824	0.903
•	Interpersonal sensitivity	0.820	0.901
•	Depression	0.875	0.933
•	Anxiety	0.888	0.941
•	Hostility	0.745	0.854
•	Phobic anxiety	0.584	0.738
•	Paranoid ideation	0.524	0.688
•	Psychotics	0.790	0.883
•	Additional items	0.528	0.691
	All paragraphs of the questionnaire	0.972	0.986

Table (4.22) shows the values of Split-Half Coefficient for each filed of the scale and the entire scale, values of correlation coefficient were in the range from 0.524 and 0.888., the result ensures of each field equal 0.972. Values of Spearman-Brown Coefficient were in the range from 0.688 and 0.941, the result ensures of each field equal 0.986. This correlation coefficient is statistically significant at $\alpha = 0.05$, so it can be said that the scale is consistent and valid to be measure what it was set for.

Thereby, it can be said that the researcher proved that the questionnaire was valid, reliable, and ready for distribution for the population sample.

Internal Validity

4.10 Internal Validity for Self Esteem Questionnaire:

Table 4.23: Correlation coefficient of each paragraph of " Self Esteem Questionnaire " and the total of this scale

No.	Pearson Correlation Coefficient	P-Value (.Sig)		No.	Pearson Correlation Coefficient	P-Value (Sig.)
1	.500	0.000*		23	.615	0.000*
2	.724	0.000*		24	.242	0.045**
3	.515	0.000*		25	.373	0.004*
4	.593	0.000*		26	.665	0.000*
5	.682	0.000*		27	0.179	0.107
6	.567	0.000*		28	.588	0.000*
7	.621	0.000*		29	.607	0.000*
8	.344	0.008*		30	.731	0.000*
9	.595	0.000*		31	.642	0.000*
10	.548	0.000*		32	.257	0.037**
11	.560	0.000*		33	.540	0.000*
12	.395	0.002*		34	.448	0.001*
13	.626	0.000*		35	.559	0.000*
14	.463	0.000*		36	.424	0.001*
15	.450	0.001*		37	.712	0.000*
16	.248	0.047**		38	.707	0.000*
17	.515	0.000*		39	.795	0.000*
18	.497	0.000*		40	.596	0.000*
19	.767	0.000*		41	-0.172	0.116
20	.615	0.000*		42	-0.110	0.223
21	.425	0.001*		43	.438	0.001*
22	.351	0.007*		44	.405	0.002*

* Correlation is significant at the 0.05 level
* Correlation is significant at the 0.01 level

Table (4.23) clarifies the correlation coefficient for each paragraph of the " **Self Esteem Questionnaire** " and the total of the **scale** The p-values (Sig.) are less than 0.01 or 0.05, so the correlation coefficients of this **scale** are significant at $\alpha = 0.01$ or 0.05, so it can be said that the paragraphs of this **scale** are consistent and valid to be

measure what it was set for. The p-values (Sig.) for the paragraphs No.(27, 41 and 42) are greater than 0.05, so the correlation coefficients of these paragraphs are statistically insignificant at $\alpha = 0.05$, so it can be said that these paragraphs must be deleted.

- ***Reliability for Self Esteem Scale***:

(A) Cronbach's Coefficient Alpha:

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. The value of Cronbach's Alpha equals 0.941. This value is considered high which indicates an excellent reliability of the entire scale.

(B) Split Half Method:

The correlation coefficient between the odd and even questions equal 0.902. The Spearman-Brown Coefficient equals 0.949. This correlation coefficient is statistically significant at $\alpha = 0.05$, so it can be said that the scale is consistent and valid to be measure what it was set for.

4.11 Limitations of the study:

There are a number of limitations are predicted to apply the study:

Difficulty finding literature reviews talking on the same topic in local, Arab countries and even in the Middle East.

No availability of documented statistics in mental health system about incidence and prevalence of Mental disability.

Continuous cutting off electricity affects the readiness of the research.

Little journals and books are available about mental health in Gaza Strip.

Difficulties in applying of the instruments on the sample, referred to stigma and shyness of the mothers.

Chapter 5

Results and Discussion

Chapter 5

5.1 Introduction:

In this chapter, the researcher will present the main study results based on the statistical analysis and discussed the research results which were achieved through application of self esteem questionnaire and mental health questionnaire (SCL- 90 – R). First of all, the main study results will be displayed. Then, the researcher will discuss these results on the light of the literature which was presented in chapter three,. Demographic data will be discussed first, then each study question will be discussed aside.

The study investigated the opinions of 165 mothers of children with mental disability and the relationship between mental health and self esteem in three local nongovernmental societies, Khan younis rehabilitation society, Shamis society for care of the handicapped in Gaza town and Nuseirat social and training rehabilitation association.

In this study, the researcher uses two scales to measure the level of mental health and self esteem and to find the relationship between mental health and self esteem among mothers of children with mental disability.

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

5.2 Results and discussion of the study:

The participants in this study represent 165 mothers of children with mental disability who treated in all community mental health clinics in 2013 year.

Test of Normality for each field:

Table (5.1) shows the results for Kolmogorov-Smirnov test of normality. From Table (5.1), the p-value is greater than 0.05 level of significance, then the distribution is normally distributed. Consequently, Parametric tests will be used to perform the statistical data analysis.

Table 5.1: Kolmogorov-Smirnov test

	Kolmogorov-Smirnov	
	Statistic	**P-value**
Self Esteem Scale	0.080	0.200
Mental Health Scale	0.118	0.078

5.3 Statistical analysis and discussion for research's questions. :

- **What is the level of mental health among mothers of children with mental disability in Gaza governorates?**

Table (5.2)"Mental Health Scale" and Rank for Mean, Std. Deviation:

	N	Total	Mean	Std. Deviation	%	Rank
Psychosomatic	12	48	13.25	9.49	27.61	8
Obsessive compulsive	10	40	13.89	7.86	34.73	1
Interpersonal sensitivity	9	36	10.29	7.04	28.59	7
Depression	13	52	17.62	11.23	33.88	2
Anxiety	10	40	12.08	8.52	30.21	4
Hostility	6	24	6.90	4.75	28.76	6
Phobic anxiety	7	28	6.53	5.36	23.31	9
Paranoid ideation	6	24	7.02	4.99	29.27	5
Psychotics	10	40	7.96	7.55	19.91	10
Additional items	7	28	9.10	5.18	32.51	3
Mental Health Scale	**90**	**360**	104.66	63.77	**29.07**	

We can calculate weigh proportional by divide the mean on the total and multiply the result by 100

Table (5.2) shows that the mean of "Mental Health Scale" equals 104.66 (29.07%), a standard deviation equals 63.77. We conclude that the respondents disagree of "Mental Health Scale ".

Table (5.2) showed that the ten dimensions of (SCL-90-R) were ranked prospectively from the highest to the lowest psychological symptoms as follow:

Obsessive compulsive (34.73), followed by depression (33.88), Additional items (32.51) and Anxiety (30.21), Paranoid ideation (29.27), Hostility (28.76), Interpersonal sensitivity (28.59), Summarization (27.61), Phobic anxiety (23.31),

Psychotics (19.91). which means the level of mental health among mothers of children with mental disabilities is (29.07%). and the total level of psychological symptoms is (71.93%).

The researcher thinks many factors which affect on mental health status such as physical problems, social conflict, environment, spiritual and disease or disability person in the family, So in this study the level of mental health is very low "29.07%". The differences between disorders depend on the differences of factors that develop mental health problems because the human is very complex all one different from other.

This study found that the high level of psychological symptoms is Obsessive compulsive among mothers of children with mental disability is (34.73), the researcher thinks that the responsibility on family are increase that lead to developing more thoughts toward children so they need more care for them, especially keep safe of environment and toilet training that need more efforts.

Also, this study found that depression level among mothers of children with mental disabilities (33.88), this study result agree with Report of JICA (on Brazil, Columbia, Malaysia and Thailand) in 2007 indicates that depression was observed in 47% of parents having children with disabilities. Another study by Lioyd, and Hastings (2008) showed high level of depression among mothers of children with mental disabilities, this study result disagree with another study conducted by Florien and Finder, (2006) showed low level of depressive symptoms among parents of children with mental disabilities, this study result congruent with another study by Olsson, and. Hwang, (2001) showed that mothers with children with ID had higher depression scores than mothers of children without ID.

From the researcher view, Maternal depression is associated with an increased likelihood of attachment disturbances in Children with mental disabilities and this result agree with the nature of depression disease as well know Depressive illness is strongly associated with life threatening or chronic physical illness, low social support and other adverse social circumstances.

The researcher thinks depressive episodes are more common in women because psychosocial stressors more in women (sadock, 2007). This result agrees with the statement which said females emotionally weak and more likely to be exposed to depression.

This study found that anxiety among mothers of children with mental disability is (30.21) this study agree with another study conducted by Gupta and Kaur (2010) found most parents of children with intellectual disability experience stress, physical and mental stress and also agree with another study conducted by Lioyd, and Hastings (2008) appeared that in cross-sectional analysis, acceptance was negatively associated with maternal anxiety .another study by McCone &teal (2008**)** showed high level of anxiety and stress among mothers of children with mental disabilities. The study of Kermanshah et al (2008), showed that in their study on perceptions of lives with children with intellectual disability high level of anxiety related to child's uncertain future.

From the researcher view, this high level of anxiety according to this study result is normal, because Anxiety disorders are associated with significant morbidity and often are chronic and resistant to treatment, any woman have mental disability child will fear from the future about her children health and had difficulties to treat such children, the researcher think that this mothers required mental health and social support to facing their challenges' and bear their responsibilities.

Finally other psychological symptoms appearing clearly on those mothers caring children with mental disabilities, The findings of the study of Bayat et al (2011) supports and assures the results of the current study, showed that parents with intellectual disabilities children experienced more psychological problems as compared with those having normal children and their difference as regards hostility, Anxiety, obsessive compulsive, interpersonal senility, psychotics, summarization and depression were significant and as regards phobic-and paranoid states.

This study result disagree with study by A, Rokba (2004) clarified that revealed high level of both psychological hardiness and mental health, and showed significant correlation between the level of psychological hardiness and the level of

mental health among mothers of children with Down syndrome. found and the mean of total psychological symptoms was (22.68%).

The researcher considers that mental health problem is a conditioned response to a specific environmental stimulus, psychosocial stressors and physical disability, mothers of children with mental disabilities have a high risk of developing additional mental health problems that can go unrecognized and have a major effect on general well-being, personal independence, productivity, and quality of life, as well as impacting on family and other careers.

- **What is extent socio demographic data affect the level of mental health among mothers of children with mental disability in Gaza governorates?**

1-**Age of the mother at child's birth**:

Table(5.3):Independent Samples T-test for Mental Health Scale –Age of the mother at child's birth

Mental Health Scale	Age	N	Mean	Std. Deviation	Test value	Sig. (P-value)
Psychosomatic	**20-30**	95	12.36	8.93	-1.418	0.158
	more than 30	70	14.47	10.14		
Obsessive compulsive	**20-30**	95	13.51	7.52	-0.733	0.465
	more than 30	70	14.41	8.33		
Interpersonal sensitivity	**20-30**	95	9.92	6.65	-0.797	0.427
	more than 30	70	10.80	7.55		
Depression	**20-30**	95	17.25	10.66	-0.486	0.628
	more than 30	70	18.11	12.03		
Anxiety	**20-30**	95	11.60	7.94	-0.851	0.396
	more than 30	70	12.74	9.27		
Hostility	**20-30**	95	6.39	4.26	-1.625	0.106
	more than 30	70	7.60	5.30		
Phobic anxiety	**20-30**	95	5.71	4.51	-2.220	0.028*
	more than 30	70	7.64	6.19		
Paranoid ideation	**20-30**	95	6.71	4.84	-0.956	0.341
	more than 30	70	7.46	5.20		
Psychotics	**20-30**	95	7.19	6.78	-1.542	0.125
	more than 30	70	9.01	8.41		
Additional items	**20-30**	95	8.78	4.74	-0.935	0.351
	more than 30	70	9.54	5.74		
Mental Health Scale	**20-30**	95	99.40	57.53	-1.236	0.218
	more than 30	70	111.80	71.18		

* The mean difference is significant a 0.05 level

Table (5.3) shows that the p-value (Sig.) is smaller than the level of significance = 0.05 for the field “Phobic anxiety”, then this is significant difference among the respondents regarding to this field due to age of the mother at child's birth. We conclude that the respondents’ age of the mother at child's birth has significant effect on this field. more than 30 years respondents have higher than respondents 20-30 years. The researcher clarified this result, the phobic anxiety need to specific stimulus e,g fear from darkness.

Table (5.3) shows that the p-value (Sig.) is greater than the level of significance = 0.05 for the other fields, then there is insignificant difference among the respondents regarding to these fields due to age of the mother at child's birth. We conclude that the respondents’ age of the mother at child's birth has no effect on these fields.

According to the current study, psychological symptoms pervasive and prevalent in majority of participants of all ages, the researcher believes that the mental health level is affected by the psychological symptoms due to suffering from mental disabilities in all mothers' ages. The mental health problems depend on size of stimulus and stressors which impact on mental health status, So any period of the age affect according the stressor.

From the researcher's view, the high level of psychological symptoms among mothers of children with mental disability with regard to their ages means that younger mothers as well as older mothers can adapt well in response to raising a child with mental disability, Assured that results, the results of the study of Van Riper (1999) on mothers (aged 26-52years) with a child with Down syndrome. The findings confirmed that the more positive and family-centered a mother viewed her relationship with health care providers, the more satisfied they were with the care their child was receiving and they were more likely o seek help from the care provider.

This study results agree with study by A, Rokba (2004) found that there are no statistically significant differences at (alpha less than or equal 0.05) in the level of psychological hardiness and in the level of it’s two dimensions (commitment and

challenge) among mothers of children with Down syndrome due to chronological ages of mothers.

2- Educational level of mother:

Table(5.4):ANOVA for Mental Health Scale- Education level of mother

		Sum of Squares	df	Mean Square	Test value	Sig. (P-value)
Summarization	**Between Groups**	1,403.44	2	701.72	8.501	0.000*
	Within Groups	13,371.87	162	82.54		
	Total	14,775.31	164			
Obsessive compulsive	**Between Groups**	987.65	2	493.82	8.743	0.000*
	Within Groups	9,150.39	162	56.48		
	Total	10,138.04	164			
Interpersonal sensitivity	**Between Groups**	543.77	2	271.89	5.814	0.004*
	Within Groups	7,576.26	162	46.77		
	Total	8,120.04	164			
Depression	**Between Groups**	1,996.07	2	998.03	8.651	0.000*
	Within Groups	18,688.88	162	115.36		
	Total	20,684.95	164			
Anxiety	**Between Groups**	770.72	2	385.36	5.604	0.004*
	Within Groups	11,140.09	162	68.77		
	Total	11,910.81	164			
Hostility	**Between Groups**	138.70	2	69.35	3.151	0.045*
	Within Groups	3,565.75	162	22.01		
	Total	3,704.45	164			
Phobic anxiety	**Between Groups**	281.23	2	140.61	5.145	0.007*
	Within Groups	4,427.90	162	27.33		
	Total	4,709.13	164			
Paranoid ideation	**Between Groups**	67.64	2	33.82	1.363	0.259
	Within Groups	4,020.26	162	24.82		
	Total	4,087.90	164			
Psychotics	**Between Groups**	671.19	2	335.59	6.273	0.002*
	Within Groups	8,666.60	162	53.50		
	Total	9,337.78	164			
Additional items	**Between Groups**	296.98	2	148.49	5.853	0.004*
	Within Groups	4,110.27	162	25.37		
	Total	4,407.25	164			
Mental Health Scale	**Between Groups**	59,192.57	2	29,596.28	7.889	0.001*
	Within Groups	607,786.43	162	3,751.77		
	Total	666,978.99	164			

* The mean difference is significant a 0.05 level

Table (5.4) shows that the p-value (Sig.) is greater than the level of significance = 0.05 for the field “Paranoid ideation”, then this is insignificant

difference among the respondents regarding to this field due to education level of mother. We conclude that the respondents' Education level of mother has no effect on this field .

Table (5.4) shows that the p-value (Sig.) is smaller than the level of significance = 0.05 for the other fields, then there is significant difference among the respondents regarding to these fields due to Education level of mother. We conclude that the respondents' Education level of mother has significant effect on these fields. Preparatory and less respondents have higher than other Education level of mother group.

The findings in this study are completely different with the Study conducted by Dion et al (1992) assured that improving the mental health level was associated with several background likely to facilitate successful coping with adaptation to Toronto, such as a higher level of education. This result is inconsistent with the results of the current study.

This study results disagree with study by A, Rokba (2004) found that there are statistically significant differences at (alpha less than or equal 0.05) in the level of psychological hardiness among mothers of children with Down syndrome toward mothers of primary, secondary, and university education.

According to the researcher's knowledge there are no previous studies relating to the educational level among parents of children with mental disability, but there are little studies examined the educational level of parents in the field of other disabilities, and the results of these studies were contradicted with the results of current study.
The researcher pointed to the family with child have disability may be exposed the same stressors but the dealing with stressors different, so education level may be affect on mental health.

Table(5.5): Scheffe test for Mental Health Scale -Education level of mother

Group		Mean Difference	Sig. (P-(value
Preparatory and less	**Secondary**	32.542	0.008
	University	49.278	0.004
Secondary	**University**	16.736	0.512

3-Age of the child:

Table(5.6):Independent Samples T-test for Mental Health Scale - Age of the child

Mental Health Scale	Age of the child	N	Mean	Std. Deviation	Test value	Sig. (P-value)
Summarization	**Less than 10**	98	12.13	8.08	-1.745	0.084
	more than 10	67	14.90	11.10		
Obsessive compulsive	**Less than 10**	98	13.16	6.83	-1.368	0.174
	more than 10	67	14.96	9.12		
Interpersonal sensitivity	**Less than 10**	98	9.80	6.14	-1.037	0.302
	more than 10	67	11.01	8.17		
Depression	**Less than 10**	98	16.92	9.98	-0.923	0.358
	more than 10	67	18.64	12.86		
Anxiety	**Less than 10**	98	11.08	7.35	-1.745	0.084
	more than 10	67	13.55	9.87		
Hostility	**Less than 10**	98	6.91	4.41	0.017	0.987
	more than 10	67	6.90	5.25		
Phobic anxiety	**Less than 10**	98	5.76	4.64	-2.153	0.033*
	more than 10	67	7.66	6.13		
Paranoid ideation	**Less than 10**	98	7.19	4.78	0.527	0.599
	more than 10	67	6.78	5.32		
Psychotics	**Less than 10**	98	7.24	6.81	-1.485	0.139
	more than 10	67	9.01	8.45		
Additional items	**Less than 10**	98	8.65	4.92	-1.352	0.178
	more than 10	67	9.76	5.51		
Mental Health Scale	**Less than 10**	98	98.85	54.54	-1.340	0.183
	more than 10	67	113.16	74.90		

* The mean difference is significant a 0.05 level

Table (5.6) shows that the p-value (Sig.) is smaller than the level of significance = 0.05 for the field "Phobic anxiety", then this is significant difference among the respondents regarding to this field due to Age of the child. We conclude that the respondents' Age of the child has significant effect on this field. more than 10years respondents have higher than respondents Less than 10 years.

Table (5.6) shows that the p-value (Sig.) is greater than the level of significance = 0.05 for the other fields, then there is insignificant difference among the respondents regarding to these fields due to Age of the child. We conclude that the respondents' Age of the child has no effect on these fields.

The study showed that there were no significant differences in mental health related to child's age, that's means that child's age is not play role in level of mental health.

The researcher thinks about this result the family support and treatment not stopping because the society is cohesion, cooperative and family committed in carry the responsibility toward mothers of children with mental disability.

This result is partially consistent with study conducted by A, Rokba (2004) found that there are no statistically significant differences at (alpha less than or equal 0.05) in the level of psychological hardiness among mothers of children with Down syndrome due to chronological ages of their children with Down syndrome. Also commitment, control, and challenge as dimensions of psychological hardiness were not statistically significant.

4- Gender of the child:

Table(5.7):Independent Samples T-test for Mental Health Scale - Gender of the child

Mental Health Scale	Gender of the child	N	Mean	Std. Deviation	Test value	Sig. (P-value)
Summarization	male	83	14.01	8.04	1.030	0.305
	female	82	12.49	10.76		
Obsessive compulsive	male	83	14.77	7.17	1.452	0.149
	female	82	13.00	8.46		
Interpersonal sensitivity	male	83	10.36	6.31	0.129	0.898
	female	82	10.22	7.74		
Depression	male	83	18.70	10.17	1.246	0.215
	female	82	16.52	12.18		
Anxiety	male	83	13.12	8.01	1.578	0.117
	female	82	11.04	8.94		
Hostility	male	83	6.98	4.50	0.198	0.844
	female	82	6.83	5.03		
Phobic anxiety	male	83	6.73	4.72	0.500	0.618
	female	82	6.32	5.96		
Paranoid ideation	male	83	7.57	4.68	1.407	0.161
	female	82	6.48	5.26		
Psychotics	male	83	8.34	6.65	0.638	0.524
	female	82	7.59	8.38		
Additional items	male	83	9.82	4.71	1.798	0.074
	female	82	8.38	5.56		
Mental Health Scale	male	83	110.40	55.71	1.164	0.246
	female	82	98.85	70.89		

Table (5.7) shows that the p-value (Sig.) is greater than the level of significance = 0.05 for each field, then there is insignificant difference in respondents' answers

toward each field due to Gender of the child. We conclude that the characteristic of the respondents Gender of the child has no effect on each field.

Researcher thinks that Palestinians' culture support the ones who suffers from physical or mental disease either they men or women because our religion "Islam" no differences in human right between male and female.

5- Order of the child in the family:

Table(5.8):ANOVA for Mental Health Scale- Order of the child in the family

		Sum of Squares	df	Mean Square	Test value	Sig. (P-value)
Summarization	**Between Groups**	338.90	3	112.97	1.260	0.290
	Within Groups	14,436.41	161	89.67		
	Total	14,775.31	164			
Obsessive compulsive	**Between Groups**	79.02	3	26.34	0.422	0.738
	Within Groups	10,059.02	161	62.48		
	Total	10,138.04	164			
Interpersonal sensitivity	**Between Groups**	116.80	3	38.93	0.783	0.505
	Within Groups	8,003.23	161	49.71		
	Total	8,120.04	164			
Depression	**Between Groups**	194.85	3	64.95	0.510	0.676
	Within Groups	20,490.10	161	127.27		
	Total	20,684.95	164			
Anxiety	**Between Groups**	186.16	3	62.05	0.852	0.467
	Within Groups	11,724.65	161	72.82		
	Total	11,910.81	164			
Hostility	**Between Groups**	152.79	3	50.93	2.309	0.078
	Within Groups	3,551.66	161	22.06		
	Total	3,704.45	164			
Phobic anxiety	**Between Groups**	82.75	3	27.58	0.960	0.413
	Within Groups	4,626.38	161	28.74		
	Total	4,709.13	164			
Paranoid ideation	**Between Groups**	29.30	3	9.77	0.387	0.762
	Within Groups	4,058.60	161	25.21		
	Total	4,087.90	164			
Psychotics	**Between Groups**	130.29	3	43.43	0.759	0.518
	Within Groups	9,207.49	161	57.19		
	Total	9,337.78	164			
Additional items	**Between Groups**	9.98	3	3.33	0.122	0.947
	Within Groups	4,397.27	161	27.31		
	Total	4,407.25	164			
Mental Health Scale	**Between Groups**	6,766.13	3	2,255.38	0.550	0.649
	Within Groups	660,212.86	161	4,100.70		
	Total	666,978.99	164			

Table (5.8) shows that the p-value (Sig.) is greater than the level of significance = 0.05 for each field, then there is insignificant difference in respondents' answers toward each field due to order of the child in the family. We conclude that the characteristic of the respondents order of the child in the family has no effect on each field. That means that mental health related to child's order doesn’t play role in level of mental health.

6- Value of monthly income:

Table(5.9):Independent Samples T-test for Mental Health Scale- Value of monthly income

Mental Health Scale	income	N	Mean	Std. Deviation	Test value	Sig. (P-value)
Summarization	Less than1500	118	13.53	9.66	0.598	0.551
	1500 and more	47	12.55	9.11		
Obsessive compulsive	Less than1500	118	14.45	7.85	1.450	0.149
	1500 and more	47	12.49	7.79		
Interpersonal sensitivity	Less than1500	118	10.95	7.18	1.920	0.057
	1500 and more	47	8.64	6.44		
Depression	Less than1500	118	18.57	11.52	1.731	0.085
	1500 and more	47	15.23	10.20		
Anxiety	Less than1500	118	13.13	8.65	2.530	0.012*
	1500 and more	47	9.47	7.67		
Hostility	Less than1500	118	7.32	4.85	1.807	0.073
	1500 and more	47	5.85	4.38		
Phobic anxiety	Less than1500	118	6.92	5.45	1.479	0.141
	1500 and more	47	5.55	5.03		
Paranoid ideation	Less than1500	118	7.49	5.06	1.921	0.057
	1500 and more	47	5.85	4.66		
Psychotics	Less than1500	118	8.69	7.64	1.990	0.048*
	1500 and more	47	6.13	7.06		
Additional items	Less than1500	118	9.65	5.18	2.182	0.031*
	1500 and more	47	7.72	4.98		
Mental Health Scale	Less than1500	118	110.70	64.95	1.945	0.054
	1500 and more	47	89.49	58.67		

* The mean difference is significant a 0.05 level

Table (5.9) shows that the p-value (Sig.) is smaller than the level of significance = 0.05 for the fields "Anxiety, Psychotics and Additional items", then there is significant difference among the respondents regarding to these fields due to Value of monthly income. We conclude that the respondents' Value of monthly income has significant effect on these fields. Less than 1500 NIS respondents have the greater than respondents 1500 NIS and more.

Table (5.9) shows that the p-value (Sig.) is greater than the level of significance = 0.05 for the other fields, then there is insignificant difference among the respondents regarding to these fields due to Value of monthly income. We conclude that the respondents' Value of monthly income has no effect on these fields, that's means that mental health related to family income is not play role in level of mental health.

The researcher thinks the family and social support of mothers of children with mental disability by support money and socioeconomic support present from governmental and the non governmental organization support this mother.

This study result disagree with study conducted by Sharac et al (2008) found mental illness was found to impact negatively on employment, income, public views about resource allocation and healthcare costs. so this study found the majority of participants have low economic level.

7- Number of mentally retarded members in 9the family:

Table(5.10):Independent Samples T-test for Mental Health Scale - Number of mentally retarded members in the family

Mental Health Scale		N	Mean	Std. Deviation	Test value	Sig. (P-value)
Summarization	one	114	12.97	9.63	-0.567	0.571
	two and more	51	13.88	9.24		
Obsessive compulsive	one	114	12.82	7.59	-2.652	0.009*
	two and more	51	16.27	8.02		
Interpersonal sensitivity	one	114	9.70	7.07	-1.616	0.108
	two and more	51	11.61	6.85		
Depression	one	114	16.13	10.71	-2.586	0.011*
	two and more	51	20.94	11.75		
Anxiety	one	114	11.89	8.49	-0.427	0.670
	two and more	51	12.51	8.66		
Hostility	one	114	6.52	4.62	-1.565	0.120
	two and more	51	7.76	4.97		
Phobic anxiety	one	114	6.18	5.44	-1.263	0.208
	two and more	51	7.31	5.14		
Paranoid ideation	one	114	7.01	5.38	-0.066	0.947
	two and more	51	7.06	4.04		
Psychotics	one	114	7.24	7.35	-1.864	0.064
	two and more	51	9.59	7.79		
Additional items	one	114	8.75	5.25	-1.327	0.186
	two and more	51	9.90	4.98		
Mental Health Scale	one	114	99.21	64.11	-1.650	0.101
	two and more	51	116.84	61.91		

* The mean difference is significant a 0.05 level

Table (5.10) shows that the p-value (Sig.) is smaller than the level of significance = 0.05 for the fields “Obsessive compulsive and Depression”, then there is significant difference among the respondents regarding to these fields due to Number of mentally retarded members in the family. We conclude that the respondents’ Number of

mentally retarded members in the family has significant effect on these fields. two and more children respondents have higher than respondents one child.

The researcher clarified this result by the impact of negative thoughts toward child number of services and future, these thoughts make frequent anxiety and lead to depression and obsessive compulsive.

Table (5.10) shows that the p-value (Sig.) is greater than the level of significance = 0.05 for the other fields, then there is insignificant difference among the respondents regarding to these fields due to Number of mentally retarded members in the family. We conclude that the respondents' Number of mentally retarded members in the family has no effect on these fields, that's means that mental health related to number of mentally retarded children in the family is not play role in level of mental health.

The researcher explained that status of mental health may be changed from time to time. The psychotic symptoms lead to disturbance in the mental health.

8- Number of family member:

Table(5.11):Independent Samples T-test for Mental Health Scale - Number of family member

Mental Health Scale	Number of family member	N	Mean	Std. Deviation	Test value	Sig. (P-value)
Summarization	**3-5**	41	10.98	7.33	-1.785	0.076
	6 and more	124	14.01	10.02		
Obsessive compulsive	**3-5**	41	13.17	7.81	-0.675	0.500
	6 and more	124	14.13	7.90		
Interpersonal sensitivity	**3-5**	41	10.34	6.94	0.053	0.958
	6 and more	124	10.27	7.09		
Depression	**3-5**	41	16.88	10.34	-0.486	0.628
	6 and more	124	17.86	11.54		
Anxiety	**3-5**	41	11.24	7.19	-0.728	0.468
	6 and more	124	12.36	8.93		
Hostility	**3-5**	41	6.95	4.67	0.075	0.941
	6 and more	124	6.89	4.80		
Phobic anxiety	**3-5**	41	5.63	4.33	-1.233	0.219
	6 and more	124	6.82	5.64		
Paranoid ideation	**3-5**	41	7.37	4.50	0.504	0.615
	6 and more	124	6.91	5.16		
Psychotics	**3-5**	41	7.49	7.04	-0.465	0.643
	6 and more	124	8.12	7.73		
Additional items	**3-5**	41	8.88	5.26	-0.320	0.750
	6 and more	124	9.18	5.18		
Mental Health Scale	**3-5**	41	98.93	57.16	-0.663	0.508
	6 and more	124	106.56	65.92		

Table (5.11) shows that the p-value (Sig.) is greater than the level of significance = 0.05 for each field, then there is insignificant difference in respondents' answers toward each field due to Number of family member. We conclude that the characteristic of the respondents Number of family member has no effect on each field, that's means that mental health related to number of family members is not play role in level of mental health.

The number of family may does not have the big of interaction but need to be interested one more than the number.

9- Place of residence:

Table(5.12):ANOVA for Mental Health Scale- Place of residence

		Sum of Squares	df	Mean Square	Test value	Sig. (P-value)
Summarization	**Between Groups**	1,440.49	4	360.12	4.321	0.002*
	Within Groups	13,334.82	160	83.34		
	Total	14,775.31	164			
Obsessive compulsive	**Between Groups**	904.68	4	226.17	3.919	0.005*
	Within Groups	9,233.35	160	57.71		
	Total	10,138.04	164			
Interpersonal sensitivity	**Between Groups**	674.34	4	168.58	3.623	0.007*
	Within Groups	7,445.70	160	46.54		
	Total	8,120.04	164			
Depression	**Between Groups**	2,621.84	4	655.46	5.806	0.000*
	Within Groups	18,063.10	160	112.89		
	Total	20,684.95	164			
Anxiety	**Between Groups**	1,827.02	4	456.76	7.247	0.000*
	Within Groups	10,083.79	160	63.02		
	Total	11,910.81	164			
Hostility	**Between Groups**	411.86	4	102.96	5.003	0.001*
	Within Groups	3,292.59	160	20.58		
	Total	3,704.45	164			
Phobic anxiety	**Between Groups**	542.78	4	135.70	5.211	0.001*
	Within Groups	4,166.34	160	26.04		
	Total	4,709.13	164			
Paranoid ideation	**Between Groups**	213.17	4	53.29	2.201	0.071
	Within Groups	3,874.74	160	24.22		
	Total	4,087.90	164			
Psychotics	**Between Groups**	1,414.26	4	353.56	7.140	0.000*
	Within Groups	7,923.52	160	49.52		
	Total	9,337.78	164			
Additional items	**Between Groups**	499.69	4	124.92	5.115	0.001*
	Within Groups	3,907.55	160	24.42		
	Total	4,407.25	164			
Mental Health Scale	**Between Groups**	84,436.78	4	21,109.20	5.798	0.000*
	Within Groups	582,542.21	160	3,640.89		
	Total	666,978.99	164			

* The mean difference is significant a 0.05 level

Table (5.12) shows that the p-value (Sig.) is greater than the level of significance = 0.05 for the field "Paranoid ideation", then this is insignificant difference among the respondents regarding to this field due to Place of residence. We conclude that the respondents' Place of residence has no effect on this field.

Table (5.13) shows that the p-value (Sig.) is smaller than the level of significance = 0.05 for the other fields, then there is significant difference among the respondents regarding to these fields due to Place of residence. We conclude that the

respondents' Place of residence has significant effect on these fields. Mid-area governorate respondents have higher scores than other Place of residence group, that means it doesn't play role in level of mental health.

The researcher see the place of residence is very important because make facilities to reach to organization and community out clinics. That help to more follow up and encourage to continuity of care.

Table(5.13): Scheffe test for Mental Health Scale- Place of residence

Place of residence		Mean Difference	Sig. (P-(value
Northern governorate	Gaza governorate	17.508	0.853
	Mid-area governorate	-39.852	0.218
	Khanyounis governorate	7.600	0.995
	Rafah governorate	24.000	0.798
Gaza governorate	Mid-area governorate	-57.361	0.001
	Khanyounis governorate	-9.908	0.970
	Rafah governorate	6.491	0.996
Mid-area governorate	Khanyounis governorate	47.452	0.047
	Rafah governorate	63.852	0.009
Khanyounis governorate	Rafah governorate	16.400	0.926

- **Is there relationship between the level of mental health among mothers of children with mental disability and their level of self esteem?**

Table (5.14): Correlation coefficient between the level of mental health among mothers of children with mental disability and their level of self esteem

	N	Pearson Correlation Coefficient	P-Value (Sig.)
Summarization	165	-.589	0.000*
Obsessive compulsive	165	-.604	0.000*
Interpersonal sensitivity	165	-.693	0.000*
Depression	165	-.638	0.000*
Anxiety	165	-.672	0.000*
Hostility	165	-.532	0.000*
Phobic anxiety	165	-.644	0.000*
Paranoid ideation	165	-.574	0.000*
Psychotics	165	-.701	0.000*
Additional items	165	-.542	0.000*
Mental Health Scale	165	-.706	0.000*

* Correlation is statistically significant at 0.05 level

Table (5.14) shows that the correlation coefficient **between the level of mental health among mothers of children with mental disability and their level of self esteem** equals −0.706 and the p-value (Sig.) equals 0.000. The p-value (Sig.) is less than 0.05, so the correlation coefficient is statistically significant at $\alpha = 0.05$, We conclude there exists a significant negative relationship **between the level of mental health among mothers of children with mental disability and their level of self esteem**.

The researcher see that the self esteem is one element of mental health because self esteem reflects person value, emotions and self respect, that feeling at the center of your being of self-worth, self-confidence, and self. High self esteem means that you feel good about yourself.

- **What is the level of self esteem among mothers of children with mental disability in Gaza governorates?**

Table (5.15): Mean, Std. Deviation and Rank for " Self Esteem Questionnaire"

	N	Total	Mean	Std. Deviation	%
Self Esteem Questionnaire	41	123	74.80	14.12	60.81

We can calculate weigh proportional by divide the mean on the total and multiply the result by 100

Table (5.15) shows that The mean of "Self Esteem Questionnaire" equals (60.81%) 74.80, a standard deviation equals 14.12, We conclude that the respondents agreed of "Self Esteem Questionnaire."

The result shows the level of self esteem is 60.81% among mothers of mentally retarded children.

The findings of Emerson et al, (2006) support the results of this study. found that mothers of children with IDs reported lower levels of happiness, self-esteem and self-efficacy than mothers of children without IDs. Statistically controlling for differences in socio-economic position, household composition and maternal characteristics fully accounted for the between-group differences in maternal happiness, and accounted for over 50% of the elevated risk for poorer self-esteem and self-efficacy. A socially and statistically significant proportion of the increased risk of poorer well-being among mothers of children with IDs may be attributed to their increased risk of socio-economic disadvantage.

These results disagree with the study by Perkins et al (2002) found self-esteem was in the low range of the scale and the ratio is 20%. also found, If the child has an avoidant or anxious/ambivalent attachment to the mother, self-esteem tends to be lower.

From the researcher view, the current result indicates that there are various factors that play positively in improving self esteem level among mothers of children with mental disability as culture, family support, spiritual support, and social support.

Chapter 6

Conclusion and Recommendations

Chapter 6

6.1 Introduction:

This chapter introduced the recommendations for further research will be provided on the basis of the results of the current study and conclusion of the study.

6.2Conclusion:

Great findings of the study were appeared from the results as it highlights on concentrating our efforts on the following:

The research results showed high level of total psychological symptoms which means low level of mental health and high level of self esteem among mothers of children with Mental disabilities.

The results also showed that the ten dimensions of (SCL-90-R) were ranked prospectively from the most to the least psychological symptoms as follow : obsessive compulsive, depression, additional items, anxiety, Paranoid ideation, Hostility, Interpersonal sensitivity, Summarization, Phobic anxiety and Psychotics. The researcher attributes this high level of psycho-pathological symptoms and low level of mental health either in the total psycho-pathological symptoms or in each dimension a side among mothers of children with Mental disabilities, to the availability of the comprehensive rehabilitation services that are provided at Rehabilitation societies which philosophy is consistent with the international movement in improving the life of people with disability through the provision of comprehensive habilitation services which reflects positively on care givers of children with Mental disabilities particularly their mothers and other family members.

In accordance to the knowledge and experience of the researcher on this field, Rehabilitation societies start offering such comprehensive rehabilitation services from birth to young adulthood. Such early intervention programs which provided freely and continue to adulthood, let mothers of children with Mental disabilities and other's

family members to get knowledge and training about Mental disabilities and participate in the activities that designed for the child, for that, mother is considered a member of the habilitation team; in addition it allows mothers to meet with each others and to exchange feelings and experiences.

Added to that, improvements that appear on the abilities of their children with Mental disabilities reflect positively on the adaptation and well-being of mothers and other family members, thus low psycho-pathological symptoms appeared on mothers and families of children with Mental disability.

So, it's important to focus our attention on these mothers and trying to develop special institutions and societies for providing special care and support under professional framework.

6.3 Study Recommendations:

Practical recommendations:

- Establishing a data base program at all Gaza Strip to research the actual number of children with Mental disability.
- Insisting ministry of health to record and numerate the children who born with Mental disability, which will help in determining the number of born children with Mental disability every 1000 live birth child and comparing this rate with the international rate.
- Establishing community awareness program to support the families and their children with Mental disability, which will help in accepting them by people and deal with them normally.
- Supporting the policy of the Rehabilitation Societies in providing comprehensive habilitation services including training and counseling programs for mothers and family members.

- Involving other family members particularly fathers in the follow up process, and considering parents meetings with each others as a part of the Rehabilitation Societies policy.

- Establishing an awareness program about Mental disability at governmental and nongovernmental institutions including schools and universities to support integration of children with Mental disability with other normal children.

- Working on implementing the law of people with disabilities directly through the Palestinian legislative council to ensure quality life for them.

- Establishing the role of mass media program for Mental disability and other people with disabilities.

- Encouraging and supporting further studies and researches on the field of Mental disability, which well help in determining the main needs and resources for children with Mental disability and their families.

Research recommendations:

1- Self esteem among parents of children with and without Mental disability.

2- Additional, more robust research is required to support the present findings.

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Annexes

Annex 1
Participation letter

This Questionnaire aims to collect necessary data for the research about:
Self esteem and mental scale (SCL-90-R) questionnaire

Seeking your generous cooperation in filling up this Questionnaire which is a part of my research study of master degree in community mental health, nursing science .

your opinion would be very effective towards this successful study which will enhance community mental health services.

The first questionnaire (self esteem) contains three choices of answers (always, sometimes, never) The second questionnaire(mental health) contains five choices of answers (not existed absolutely, existed, moderately existed, greatly existed, very greatly existed), So please try to choose the accurate one. If you accept to join this study, you have the right to withdraw from the study at any time .

However : your answers will be respected and confidentiality will be taken in consideration, as it will be used for the study purposes only. You don't have to write your name .

Thanks for your participation

Annex 2
Questionnaire

Date : / / 2012. Number----------

(For the researcher only)

Personal information:

Please put (x) in the appropriate square:

1- Age of the mother at child's birth----------years.

less than 20-30 ☐ 31-40 ☐ more than 41 ☐

2- Education level of mother:

☐ Primary ☐ preparatory ☐ secondary ☐ university

3- Age of the child:

Less than 0-6 ☐ 7-10 ☐ more than 11 ☐

4- Gender of the child: ☐ male ☐ female

5-Order of the child in the family:

☐ One ☐ two ☐ three ☐ more than four

6-Value of monthly income:

☐ Less than1500 NIS ☐ from 1500-3000 NIS ☐ more than 3000 NIS

7- Number of mentally retarded members in the family:

one child ☐ two ☐ more than ☐

8-Number of family member:

3-5 ☐ more than 6 ☐

9- Place of residence:

☐ Northern governorate ☐ Gaza governorate ☐ Mid-area governorate

☐ Khanyounis governorate ☐ Rafah governorate

Self Esteem Questionnaire

No	Items	always	sometime	never
1-	I fear of new social relations that do not know what is expected of them.			
2-	I find it difficult to hear criticism about myself			
3-	I fear to make me my child's disability that I act a fool			
4	I tend to magnify my mistakes and reduce my achievements			
5-	I embarrassing myself in front of others because of my child's disability.			
6-	I have periods in which I feel depressed			
7-	I feel of anxiety and fear.			
8-	When someone mistreats me I think that I must have done something to deserve it.			
9-	I find difficulty knowing who to trust and when to trust because of my child's disability			
10-	I feel that I do not know the right thing to do or say.			
11-	I am very concerned about my appearance			
12-	I think that others prey on me errors			
13-	I fear making a mistake which others might see.			
14-	I feel depressed about things I did or failed to do.			
15-	I avoid doing a change in my life, lest I fall into the error or failure.			
16-	I defend and reviewing myself when criticized.			
17-	I have not a accomplished what I am capable of due to fear and avoidance.			
18--	tend to let fear and anxiety to controls in many of my decisions.			
19--	I tend to think negatively much of the time because of my child's disability.			
20	I think that some people are lucky.			
21	I find it difficult to practice my sexuality.			
22	I disclose my personal information easily.			
23	I am concerned I do not know what to say when I see my child's disability.			
24	I try to avoid conflict and confrontation.			
25	I am very sensitive.			
26-	I feel inferior and incompetent.			

27	I tend to think that I have higher standers than others.			
28	I feel that I do not know what is expected of me.			
29	I often compare myself to others			
30-	I think negative thoughts about myself and others.			
31	I feel that others mistreats me or take advantage of me.			
32	I review and analyzing what I did and what others did to me during the day.			
33	I work to please others without my satisfaction			
34	I think that others do not respect me			
35	I refrain from sharing my opinions , my ideas and my feelings to others			
36	I'm fearful that I will say or do something that will make me look stupid or incompetent.			
37	I'm fearful that I will say or do something that will make me look stupid or incompetent.			
38	I'm easily discouraged due to talking about my child's disability			
39	I'm not very aware of my feelings because I have child's disability.			
40	I think life is harder for me than for most other people			
41	I avoid situations that make me uncomfortable			
42	I love to be completely and do things completely			
43	I feel embarrassed to eat out alone or to attend movies and other activities by myself.			
44	I find myself angry or hurt by the behavior or the words of others.			

Mental Health Scale (SCL-90-R)

NO	Items	not existed absolutely	existed	moderately existed	greatly existed	very greatly existed
1	Persistent headache					
2	jittering and shivering○○○○					
3	Occurrence of bad ideas					
4	Dizziness with yellowing					
5	Loss of sexual desire or interest					
6	The desire to criticize others					
7	The belief that others control my thoughts					
8	I think that others are responsible for my problems					
9	Difficulty remembering things					
10	Discomfort due to neglect and lack of hygiene					
11	Others can easily keep me excited					
12	Pain in the chest and heart					
13	Fear of public places and streets					
14	Sense of slowness and loss of energy					
15	Haunt me ideas to get rid of the life					
16	I hear voices others do not hear					
17	I feel quivering					
18	Distrust of others					
19	Loss of appetite					
20	Crying easily					
21	Shyness and difficulty of dealing with others					
22	I feel that I under arrest or tied up or handcuffed					
23	Fear suddenly and without a specific reason					
24	Inability to control anger					
25	I am afraid to go out of the house					
26	Self-criticism for some things work					
27	low back pain					
28	I feel that things are not going well					
29	I feel lonely					
30	I feel sad "depression"					
31	Discomfort on things dramatically					
32	Loss of important things					
33	Fear					
34	I feel that others can easily hurt me					
35	Others can easily read my own ideas					

36	Feeling that others do not understand me					
37	Feeling that others are not friendly					
38	I do things very slowly					
39	Increased heart rate					
40	I have a lot of nausea and stomach disorders					
41	Compared to others, I feel less valuable of them					
42	My muscles cramping					
43	I feel observed by others					
44	Difficulty sleeping					
45	I check what I do several times					
46	I find it difficult to make decisions					
47	Fear of travel					
48	Difficulty breathing					
49	Heat and cold in my body					
50	I avoid certain things					
51	The feeling of not being able to think					
52	Numbness and tingling in the body					
53	Feeling narrowing throat and inability to swallow					
54	Loss of hope for the future					
55	Difficulty concentrating					
56	General weakness in different parts of my body					
57	I feel nervous					
58	Feeling of heaviness both hands and both feet.					
59	Fear of death					
60	Excessive sleep					
61	I feel upset when the presence of others and keep tabs on me					
62	I have strange ideas					
63	I feel the desire to hurt others					
64	Woke up early					
65	Re the same things several times					
66	I suffer from interrupted sleep and Spam					
67	The desire to cracking and breaking things					
68	I have ideas that not exist in others					
69	Excessive sensitivity in dealing with others					
70	The fear of being in human populations					

71	Each thing needs to posterity a great effort					
72	I feel cases of fear and fatigue					
73	I feel the fear of being in public places					
74	Frequent entry in sharp controversy and debate					
75	Feel quivering when am lonely					
76	Others do not appreciate my work					
77	I feel lonely even when I'm with people					
78	I feel Malaise and hyperactivity					
79	I feel unimportant					
80	I feel that bad things will happen to me					
81	Scream and throw things					
82	I am afraid that I lose consciousness in front of others					
83	I feel that others utilizing me					
84	Bothers me to think about sexual matters					
85	Haunt me ideas that others should punish me					
86	I have fantasies and strange ideas					
87	I think that there is an imbalance in the body					
88	I feel I am not close to and far from others					
89	Feeling guilty					
90	I have a problem in my mind, "myself"					

الطالب/ محمد زكى أبو ركبة
رقم الجوال/ 0599-993799

Annex 3
Participation letter in Arabic

بسم الله الرحمن الرحيم

الأخت الكريمة / والدة الطفل..... المحترمة.

رقم الاستمارة ---------- .

السلام عليكم و رحمة الله و بركاته ،

آمل من سيادتكم قراءة فقرات الاستمارة و الإجابة عليها بدقة و موضوعية وذلك رغبة منا في الحصول علي بعض المعلومات حيث أن ذلك سيعمل علي تحسين الوضع النفسي لدي أمهات الأطفال المعاقين عقليا ، و الذي سينعكس بشكل إيجابي علي تحسين نوعية الخدمات المقدمة للأطفال في المؤسسات الحكومية. كما سيعمل علي إيجاد علاقة مميزة بين الأمهات و الأبناء و بين العاملين معهم في جوانب عديدة.

شاكرين لكم حسن تعاونكم معنا ،،

<u>الرجاء الإجابة علي الأسئلة التالية :</u>

1. عمر الأم عند ولادة الطفل: أقل من 20–30 ( ) ، 21 –40 ( ) ،أكثر من 41 ( )
2. المستوى التعليمي للأم : بدون تعليم( ) ، أساسي( ) ، ثانوي ( ) ،جامعي( )
3. عمر الطفل : من0– 6 ( ) ، 7–10 ( ) ،أكثر من 11 ( )
4. جنس الطفل : ذكر ( ) ، أنثي ( )
5. ترتيب الطفل في الأسرة : الأول ( ) ، الثاني( ) ، الثالث ( ) ، الرابع فما فوق ( )
6. دخل الأسرة:أقل من 1500 شيقل ( ) ، 1500–3000 ( ) ، أكثر من 3000 ( )
7. عدد المعاقين بالأسرة : طفل واحد ( ) ، اثنان ( ) أكثر( )
8. عدد أفراد الأسرة: 3 –5 ( ) ، 6 فأكثر ( )
9. مكان السكن : محافظة الشمال ( ) ، غزة ( ) ، الوسطى( )، خانيونس( ) ، رفح( )

الأخت الكريمة / والدة الطفل

تحية طيبة و بعد :

أمامكِ عدد من العبارات التي تمثل رؤيتكِ وتقديرك لذاتكِ في مواجهة عدد من المواقف والمطلوب منكِ أن تقرئي كل عبارة بعناية ثم تضعي علامة (x) في إحدى الخانات الثلاث المقابلة للعبارة فإن كانت تنطبق عليكِ دائماً فضعي علامة (x) تحت خانة تنطبق دائماً، وإذا كانت العبارة تنطبق عليكِ أحياناً فضعي علامة (x) في خانة تنطبق أحياناً، وإذا لم تنطبق العبارة عليكِ فضعي علامة (x) أمام لا تنطبق أبداً .

ونأمل أن لا تتركي عبارة واحدة دون أن تجيبي عليها مع ملاحظة أنه لا توجد عبارة صحيحة و أخري خاطئة، فالإجابة تعتبر صحيحة عندما تعبر عن حقيقة ما تشعري به تجاه المعني الذي تتضمنه العبارة.

اسم الباحث : محمد زكي أبو ركبة

رقم الجوال : 0599993799

Annex 4
الاستبانة باللغة العربية
مقياس تقدير الذات

الرقم	العبـــــــــــــارة	دائماً	أحياناً	أبداً
1	أخاف من العلاقات الاجتماعية الجديدة التي لا أعرف ما هو متوقع منها.			
2	أجد صعوبة لسماع انتقادات عن نفسي.			
3	أخشى أن تجعلني إعاقة طفلي أن أتصرف بشكل أحمق..			
4	أميل إلى تضخيم أخطائى وتقليل انجازاتي.			
5	أنا محرجة من نفسي أمام الآخرين بسبب إعاقة طفلي.			
6	لدى فترات اشعر فيها باكتئاب.			
7	اشعر بالقلق و الخوف.			
8	عندما يسيء شخص ما لي أعتقد انه يجب أن أكون فعلت شيئا يستحق ذلك.			
9	أجد صعوبة في تحديد بمن أثق ومتى أثق بسبب إعاقة طفلي.			
10	اشعر بأنني لا أعرف الشيء الصحيح لكي افعله أو أقوله.			
11	أنا قلقة جدا حول مظهري.			
12	أعتقد أن الآخرين يتصيدون لي الأخطاء.			
13	أخاف من صنع خطا ربما يراه الآخرون.			
14	اشعر بالاكتئاب عن اشياء فعلتها او فشلت في فعلها.			
15	أتجنب فعل تغير في حياتي لئلا أقع في الخطأ أو الفشل.			
16	أدافع وأراجع نفسي عندما أنتقد .			
17	لا أستطيع إكمال ما أنا قادرة على فعله نتيجة الخوف والتجنب.			
18	أميل للسماح للخوف والقلق ليتحكم في كثير من قراراتي.			
19	أميل للتفكير بسلبية أكثر معظم الوقت بسبب إعاقة طفلي.			
20	أعتقد أن بعض الناس محظوظون.			
21	أجد صعوبة في ممارسة حياتي الجنسية.			
22	أنا أكشف بياناتي الشخصية بسهولة.			
23	اشعر بقلق ولا اعرف ما أقول عندما أرى طفلي المعاق.			
24	أحاول تجنب النزاع والمواجهة.			
25	أنا حساسة جدا.			
26	أشعر باننى اقل شأنا وغير كفئة.			
27	أميل للتفكير لأني أعلى مستوى من الآخرين			
28	اشعر بأنني لا اعرف ما هو متوقع منى.			
29	أنا عادة أقارن نفسي مع الآخرين.			
30	أفكر بأفكار سلبية عن نفسي وعن الآخرين.			
31	اشعر بان الآخرين يسيئون لي أو يستغلونني.			
32	أراجع يومي واحلل ما فعلت و ما فعله الآخرون معي خلال اليوم.			
33	أقوم بأعمال لإرضاء الآخرين دون ارتياح منى.			
34	اعتقد أن الآخرين لا يحترمونني.			
35	امتنع عن مشاركة أرائي وافكارى ومشاعري مع الآخرين.			

الرقم	العبـــــــــــــارة	دائماً	أحياناً	أبداً
36	اخشي من قول أو فعل شيء ما يجعلني اظهر بصورة غبية أو غير كفئة.			
37	وجود طفلي المعاق يسبب لي صعوبة في تحديد اهدافى في المستقبل .			
38	أحبط بسهولة بمجرد الحديث عن طفلي المعاق.			
39	غير مدركة جيدا لمشاعري لان لدى طفل معاق..			
40	اعتقد أن الحياة أصعب لي من اغلب الناس الآخرين.			
41	أتجنب المواقف التي تجعلني غير مرتاحة.			
42	أحب أن أكون مكتملة وافعل الأشياء بشكل مكتمل.			
43	أشعر بالحرج لتناول الطعام وحدي أو لحضور الأفلام وغيرها من الأنشطة بنفسي.			
44	أجد نفسي غضبانة أو متأذية من سلوك أو كلمات الآخرين.			

مقياس الصحة النفسية

يهدف هذا الاستبيان للتعرف علي رأيك حول بعض القضايا الشخصية الرجاء التكرم بالإجابة وذلك بوضع دائرة حول رمز الإجابة المناسبة لوجهة نظرك حول وجود هذه المشاكل خلال الأسبوع الماضي ، حيث يوجد أمامك عدد من المشكلات التي قد تعاني منها – يرجى اختيار رمز الإجابة التي تنطبق عليك فإذا كنت لا تعاني أبدا" عليك اختيار رمز صفر وهكذا ..

(مثال توضيحي علي ذلك الاستبيان)

-1	الصداع المستمر	0	1	2	3	4

" 0 " : لا توجد إطلاقا

" 1 " : توجد

" 2 " : توجد بشكل متوسط

" 3 " : توجد بشكل كبير

" 4 " : توجد بشكل كبير جدا

مقياس الصحة النفسية

الرقم	خلال الأسابيع الأخيرة أعاني من	لا توجد إطلاقا	توجد	توجد بشكل متوسط	توجد بشكل كبير	توجد بشكل كبير جداً
1	الصداع المستمر	0	1	2	3	4
2	النرفزة والارتعاش	0	1	2	3	4
3	حدوث أفكار سيئة	0	1	2	3	4
4	الدوخان مع الاصفرار	0	1	2	3	4
5	فقدان الرغبة أو الاهتمام الجنسي	0	1	2	3	4
6	الرغبة في انتقاد الآخرين	0	1	2	3	4
7	الاعتقاد بأن الآخرين يسيطرون علي أفكاري	0	1	2	3	4
8	أعتقد بأن الآخرين مسئولين عن مشاكلي	0	1	2	3	4
9	الصعوبة في تذكر الأشياء	0	1	2	3	4
10	الانزعاج بسبب الإهمال وعدم النظافة	0	1	2	3	4
11	يسهل استثارتي بسهولة	0	1	2	3	4
12	الألم في الصدر والقلب	0	1	2	3	4
13	الخوف من الأماكن العامة والشوارع	0	1	2	3	4
14	الشعور بالبطيء وفقدان الطاقة	0	1	2	3	4
15	تراودني أفكار للتخلص من الحياة	0	1	2	3	4
16	أسمع أصوات لا يسمعها الآخرون	0	1	2	3	4
17	أشعر بالارتجاف	0	1	2	3	4
18	عدم الثقة بالآخرين	0	1	2	3	4
19	فقدان الشهية	0	1	2	3	4
20	البكاء بسهولة	0	1	2	3	4
21	الخجل وصعوبة التعامل مع الآخرين	0	1	2	3	4
22	أشعر باني مقبوض أو ممسوك أو مكبل	0	1	2	3	4

الرقم	خلال الأسابيع الأخيرة أعاني من	لا توجد إطلاقا	توجد	توجد بشكل متوسط	توجد بشكل كبير	توجد بشكل كبير جداً
23	الخوف فجأة وبدون سبب محدد	0	1	2	3	4
24	عدم المقدرة علي التحكم في الغضب	0	1	2	3	4
25	أخاف أن أخرج من البيت	0	1	2	3	4
26	نقد الذات لعمل بعض الأشياء	0	1	2	3	4
27	الألم في أسفل الظهر	0	1	2	3	4
28	أشعر بان الأمور لا تسير علي ما يرام	0	1	2	3	4
29	أشعر بالوحدة	0	1	2	3	4
30	أشعر بالحزن " الاكتئاب "	0	1	2	3	4
31	الانزعاج علي الأشياء بشكل كبير	0	1	2	3	4
32	فقدان الأهمية بالأشياء	0	1	2	3	4
33	الشعور بالخوف	0	1	2	3	4
34	أشعر بأنه يسهل إيذائي	0	1	2	3	4
35	اطلاع الآخرين علي أفكاري الخاصة بسهولة	0	1	2	3	4
36	الشعور بأن الآخرين لا يفهمونني	0	1	2	3	4
37	الشعور بأن الآخرين غير ودودين	0	1	2	3	4
38	أعمل الأشياء ببطيء شديد	0	1	2	3	4
39	زيادة ضربات القلب	0	1	2	3	4
40	ينتابني غثيان واضطرابات في المعدة	0	1	2	3	4
41	مقارنة بالآخرين أشعر باني أقل قيمة منهم	0	1	2	3	4
42	عضلاتي تتشنج	0	1	2	3	4
43	أشعر بأني مراقب من قبل الآخرين	0	1	2	3	4
44	صعوبة النوم	0	1	2	3	4
45	أفحص ما أقوم به عدة مرات	0	1	2	3	4
46	أجد صعوبة في اتخاذ القرارات	0	1	2	3	4
47	الخوف من السفر	0	1	2	3	4
48	صعوبة التنفس	0	1	2	3	4
49	السخونة والبرودة في جسمي	0	1	2	3	4

الرقم	خلال الأسابيع الأخيرة أعاني من	لا توجد إطلاقا	توجد	توجد بشكل متوسط	توجد بشكل كبير	توجد بشكل كبير جداً
50	أتجنب أشياء معينة	0	1	2	3	4
51	الشعور بعدم القدرة علي التفكير	0	1	2	3	4
52	الخدر والنمنمة في الجسم	0	1	2	3	4
53	الشعور بانغلاق الحلق وعدم المقدرة علي البلع	0	1	2	3	4
54	فقدان الأمل في المستقبل	0	1	2	3	4
55	صعوبة التركيز	0	1	2	3	4
56	ضعف عام في أعضاء جسمي	0	1	2	3	4
57	أشعر بالتوتر	0	1	2	3	4
58	الشعور بالثقل باليدين والرجلين	0	1	2	3	4
59	الخوف من الموت	0	1	2	3	4
60	الإفراط في النوم	0	1	2	3	4
61	اشعر بالضيق عند وجود الآخرين ومراقبتهم لي	0	1	2	3	4
62	توجد عندي أفكار غريبة	0	1	2	3	4
63	اشعر بالرغبة في إيذاء الآخرين	0	1	2	3	4
64	استيقظ من النوم مبكرا"	0	1	2	3	4
65	إعادة نفس الأشياء عدة مرات	0	1	2	3	4
66	أعاني من النوم المتقطع والمزعج	0	1	2	3	4
67	الرغبة في تكسير وتحطيم الأشياء	0	1	2	3	4
68	توجد لدي أفكار غير موجودة عند الآخرين	0	1	2	3	4
69	حساسية زائدة في التعامل مع الآخرين	0	1	2	3	4
70	الخوف من التواجد في التجمعات البشرية	0	1	2	3	4
71	كل نشئ يحتاج إلى مجهود كبير	0	1	2	3	4
72	اشعر بحالات من الخوف والتعب	0	1	2	3	4
73	اشعر من الخوف من التواجد في الأماكن العامة	0	1	2	3	4
74	كثرة الدخول في الجدل والنقاش الحاد	0	1	2	3	4
75	أشعر بالنرفزة عندما أكون وحيدا"	0	1	2	3	4
76	الآخرون لا يقدرون أعمالي	0	1	2	3	4

الرقم	خلال الأسابيع الأخيرة أعاني من	لا توجد إطلاقا	توجد	توجد بشكل متوسط	توجد بشكل كبير	توجد بشكل كبير جداً
77	اشعر بالوحدة حتى عندما أكون مع الناس	0	1	2	3	4
78	الشعور بالضيق وكثرة الحركة	0	1	2	3	4
79	اشعر بأني غير مهم	0	1	2	3	4
80	اشعر بأن أشياء سيئة سوف تحدث لي	0	1	2	3	4
81	الصراخ ورمي الأشياء	0	1	2	3	4
82	أخاف من أن افقد الوعي أمام الآخرين	0	1	2	3	4
83	اشعر بان الآخرين سيستغلونني	0	1	2	3	4
84	يزعجني التفكير في الأمور الجنسية	0	1	2	3	4
85	تراودني أفكار بأنه يجب معاقبتي	0	1	2	3	4
86	توجد عندي تخيلات وأفكار غريبة	0	1	2	3	4
87	اعتقد بأنه يوجد خلل في جسمي	0	1	2	3	4
88	اشعر باني غير قريب وبعيد من الآخرين	0	1	2	3	4
89	الشعور بالذنب	0	1	2	3	4
90	عندي مشكلة في عقلي " نفسي "	0	1	2	3	4

تمت بحمد الله.

Annex 5
Permission letter

بسم الله الرحمن الرحيم

الجامعة الإسلامية – غزة
The Islamic University - Gaza

كلية التمريض
Faculty of Nursing

هاتف داخلي: 2700

الرقم Ref ج س غ/7/2013
18 جمادى أول 1434هـ
التاريخ Date 30 مارس 2013

الأخ المحترم / مدير جمعية تأهيل المعاقين في الهلال الأحمر "خانيونس" حفظه الله

السلام عليكم ورحمة الله وبركاته،،،

الموضوع/ تسهيل مهمة طالب لأجل البحث

أرجو التكرم بالعمل على تسهيل مهمة طالب ماجستير "تمريض الصحة النفسية المجتمعية/ علوم تمريض"/ ا. محمد زكي أبو ركبة وذلك لتطبيق استبانة تتعلق بالإعاقة العقلية عند الأطفال ، وذلك كمتطلب بحثي لرسالة الماجستير، وذلك فيما لا يتعارض مع سياسة مؤسستكم الموقرة.

شاكرين لكم حسن تعاونكم،،،

عميد كلية التمريض

د. عبد الكريم رضوان

صورة لـ:
للملف

P.O. Box 108, Rimal, Gaza, Palestine ص.ب 108 الرمال غزة فلسطين
Tel: +970 (8) 286 0700 هاتف Fax: +970 (8) 286 0800 فاكس
public@iugaza.edu.ps www.iugaza.edu.ps

بسم الله الرحمن الرحيم

الجامعة الإسلامية – غزة
The Islamic University - Gaza

كلية التمريض
Faculty of Nursing

هاتف داخلي: 2700

الرقم ج س غ/7/2013 Ref
18 جمادى أول 1434هـ
التاريخ 30 مارس 2013 Date

الأخ المحترم / مدير جمعية التأهيل والتدريب الاجتماعي "النصيرات" حفظه الله

السلام عليكم ورحمة الله وبركاته،،،

الموضوع/ تسهيل مهمة طالب لأجل البحث

أرجو التكرم بالعمل على تسهيل مهمة **طالب ماجستير "تمريض الصحة النفسية المجتمعية/ علوم تمريض"/ ا. محمد زكي أبو ركبة** وذلك لتطبيق استبانة تتعلق بالإعاقة العقلية عند الأطفال ، وذلك كمتطلب بحثي لرسالة الماجستير، وذلك فيما لا يتعارض مع سياسة مؤسستكم الموقرة.

شاكرين لكم حسن تعاونكم،،،

عميد كلية التمريض

د. عبد الكريم رضوان

صورة لـ:
للملف

ص.ب. 108 الرمال غزة فلسطين هاتف +970 (8) 286 0700 Tel: فاكس +970 (8) 286 0800 Fax: P.O. Box 108, Rimal, Gaza, Palestine
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بسم الله الرحمن الرحيم

الجامعة الإسلامية – غزة
The Islamic University - Gaza

كلية التمريض
Faculty of Nursing

هاتف داخلي: 2700

الرقم Ref ج س غ/7/2013
18 جمادى أول 1434هـ
التاريخ 30 مارس 2013 Date

الأخ المحترم / مدير جمعية شمس لرعاية المعوقين في قطاع غزة حفظه الله

السلام عليكم ورحمة الله وبركاته،،،

الموضوع/ تسهيل مهمة طالب لأجل البحث

أرجو التكرم بالعمل على تسهيل مهمة **طالب ماجستير "تمريض الصحة النفسية المجتمعية/ علوم تمريض"/ ا. محمد زكي أبو ركبة** وذلك لتطبيق استبانة تتعلق بالإعاقة العقلية عند الأطفال ، وذلك كمتطلب بحثي لرسالة الماجستير، وذلك فيما لا يتعارض مع سياسة مؤسستكم الموقرة.

شاكرين لكم حسن تعاونكم،،،

عميد كلية التمريض

د. عبد الكريم رضوان

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للملف

ص.ب 108 الرمال غزة فلسطين هاتف +970 (8) 286 0700 فاكس +970 (8) 286 0800
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Annex 6

List of arbitrators:

1- Dr. Yousif EL- Jeesh. (Islamic University)

2- Dr. Yousif Awadh Allah. Psychiatrist in the M.O.H.

3- Dr. Ayda Saleh. Lecturer in ALAqsa university.

4- Dr. Atef AlAgha. (Islamic University)

5- Dr. Omar EL-Buhaisi. Psychiatrist in the M.O.H.

Annex 7
Location Map of the Gaza