The Islamic University

Faculty of Education \ Nursing

Master of community mental health Nursing

Psychiatric symptoms among physical handicapped persons, who are victims of the last war on Gaza

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قال تعالى:

(يَرْفَعِ اللَّهُ الَّذِينَ آمَنُوا مِنكُمْ وَالَّذِينَ أُوتُوا الْعِلْمَ دَرَجَاتٍ)

المجادلة (12)

Dedication

To all who enlightened with his knowledge others' minds.

Or directed with his answer a lost seeker

And showed with his generosity the humbleness of the scientists

I give this humble work to my father who never held anything from me

To my mother which gave me compassion and love

I tell them, you gave me life and raised me on the passion of knowledge

To my wife, my companion, this stood with me all the period of preparation and stayed up late in the nights.

To my dear sons, Lamar and Baraa' god bless them

To my brothers and sisters

To my friends and colleagues, and specially the staff of Rafah Psychological Clinic

Then, to all who taught me a single letter, and showed me the way.

Acknowledgement

Praise be to Allah who by his grace righteous acts complete, and who with the light of his face darkness fade away, praise be to him. I thank him that he allowed me to complete this work. As if I succeed them it's from Allah, and if I fail then it's my own failure.

قال تعالي : "رَبِّ أَوْزِعْنِي أَنْ أَشْكُرَ نِعْمَتَكَ الَّتِي أَنْعَمْتَ عَلَيَّ وَعَلَى وَالِدَيَّ وَأَنْ أَعْمَلَ صَالِحًا تَرْضَاهُ وَأَدْخِلْنِي بِرَحْمَتِكَ فِي عِبَادِكَ الصَّالِحِينَ ". (النمل 19)

وقال الرسول صلي الله عليه وسلم :"من لا يشكر الناس لا يشكر الله" . (الترمذي 1954)

I here thank sincerely,

Who overwhelmed me with grace, and accepted humbly supervising on my study, my teacher Dr. Nabil Dokhan.

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I pray to Allah for their success and safety, and to open all the unlocked doors for them. Amin

The researcher

Psychiatric symptoms among physical handicapped persons who are victims of the last war on Gaza

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Abstract

The study aimed to measure the psychiatric symptoms among physical handicapped persons who are victims of the last war on Gaza. In this study, the researcher used the analytical descriptive approach. The sample of the study was purposive sample consisted of (125) of handicapped persons of males and females, while the age group was between age (18-50) in all Gaza governorate. The researcher designed a measuring tool (questionnaire) to measure the psychiatric symptoms of handicapped persons; the questionnaire included SCL-90 scale and a part that measures the demographic variables. The measure was applied on a pilot sample of 50 persons of handicapped persons in all Gaza governorates on (2011-2012). The reliability and validity calculations of the measure were obtained by statistician and the data were analyzed by (SPSS) using the appropriate statistical methods ending up with the findings.

The results showed that the most common dimension was the Anxiety with percentage weight equals 68.5%, and this implies how high degrees of Anxiety the sample have, then comes the dimension of Paranoid ideation with percentage weight equals 47.9%. Then the Interpersonal Sensitivity with percentage weight equals 44.7%. The least common dimension was the Phobic Anxiety with percentage weight equals 30.7%. Also the results showed that there were no significant differences at ($\alpha \leq 0.05$) in Psychiatric symptoms due to gender, age, qualification, monthly incomes and marital status.

There were statistically significant differences in degrees of interpersonal sensitivity in terms of marital status toward those handicapped that are divorced; means they have the least degrees of interpersonal sensitivity than other marital statuses. Moreover, the result showed there were significant differences between the degrees of Obsessive Compulsive, Interpersonal Sensitivity and Hostility in terms the area of living toward who live in Gaza that have the highest digress of Obsessive Compulsive and Hostility, but the differences in Interpersonal Sensitivity were toward the handicapped that lived in Rafah. There were significant differences between the degrees of Somatization, Interpersonal Sensitivity, Anxiety and Paranoid Ideation, in terms of the working status toward the not working persons who have the highest degrees of Somatization, Interpersonal Sensitivity, Anxiety and Paranoid Ideation. Significant differences in Interpersonal Sensitivity, Phobic Anxiety, Paranoid Ideation, psychotics, due to the type of handicap toward those persons that have other types of handicaps; this means that they have the most degrees of Interpersonal Sensitivity, Phobic Anxiety, Paranoid Ideation, and Psychosis than these that who are finger amputated, leg amputated.

Some of the recommendation that the researcher concluded is the developing rehabilitation programs for disability and amputation and keep up what is new, and providing guidance programs generally for disabled cases and especially for amputation to reduce psychological problems.

الأعراض النفسية لذوي الإعاقة الحركية ، ضحايا الحرب الأخيرة علي غزة

إعداد

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اشراف

د/نبيل دخان د/سمير قوتة

ملخص الدراسة

هدفت الدراسة إلي قياس الأعراض النفسية لذوي الإعاقة الحركية ، ضحايا الحرب الأخيرة علي غزة. اعتمد الباحث في هذه الدراسة المنهج الوصفي التحليلي. تكونت العينة الحقيقية لهذه الدراسة من (125) شخصًا معاقًا من كلا الجنسين (الذكور والإناث)، بينما الفئة العمرية كانت من (18–50) سنة في جميع محافظات غزة. صمم الباحث أداة القياس (الاستبانة) لقياس الأعراض النفسية للأشخاص المعاقين والتي تشتمل علي قائمة الأعراض النفسية(SCL-90)، و يقيس الجزء الاخر الأبعاد الديموغرافية. تم تطبيق المقياس علي عينة استطلاعية (تجريبية) تكونت من خمسين شخصًا من جميع محافظات غزة في الفترة (2011–2012). وتم حساب عاملي الصدق والثبات للمقياس من خلال أخصائي في هذا المجال، حيث تم تحليل البيانات عن طريق برنامج (SPSS)، مستخدمًا الأساليب الإحصائية المناسبة إنتهاء بإظهار النتائج.

أظهرت النتائج أن البعد الأكثر شيوعاً هو القلق حيث مثل نسبة 68,5 %، وهذا يعني أن أعلي درجة كانت القلق لدي عينة الدراسة. ثم يأتي البعد الثاني وهو البارانويا حيث مثل نسبة 47,9 %، ثم الحساسية التفاعلية بنسبة 44,7 %، بينما كان البعد الأقل شيوعًا هو قلق الرهاب حيث كانت نسبته 30,7 % من عينة الدراسة. كذلك أظهرت نتائج الدراسة أنه لا توجد فروق ذات دلالة إحصائية عند مستوي دلالة ($\alpha \leq 0.05$) في الأعراض النفسية لدي متغير الجنس، العمر، المؤهل العلمي، الراتب الشهري و الحالة الاجتماعية.

وجدت فروق ذات دلالة إحصائية في درجة الحساسية التفاعلية لمتغير الحالة الاجتماعية لدي فئة المعاقات المطلقات. بمعني أن لديهن أقل درجة من الحساسة التفاعلية عن نظيراتها (المتزوجات، الأرامل، الانسات).

علاوة علي ذلك أظهرت النتائج وجود فروق ذات دلالة احصائية بين درجات الوسواس القهري، الحساسية التفاعلية، العداوة من حيث (مكان السكن) للأشخاص الذين يعيشون في مدينة غزة. حيث أن لديهم درجة أكبر(أعلي) من الوسواس القهري ، العداوة. لكن الاختلاف في الحساسية التفاعلية حيث كانت النسبة الأعلي للأشخاص الذين يعيشون في مدينة رفح.

هناك فروق ذات دلالة احصائية بين درجات الجسدنة، الحساسية التفاعلية، القلق، البارانويا من حيث (طبيعة العمل) لصالح الأشخاص الغير عاملين حيث أن لديهم درجة أعلي من أعراض الجسدنة، الحساسية التفاعلية، القلق، البارانويا .

توجد فروق في الحساسية التفاعلية، قلق الرهاب، البارانويا والفصام يرجع ذلك إلي (حجم الإعاقة الحركية) لصالح الأشخاص الذين لديهم حجم أكبر من الإعاقة (أكثر من نوع من الإعاقة الحركية) . وهذا يعني أن لديهم درجة أكبر من الحساسية التفاعلية، قلق الرهاب، البارانويا و الذهانية عن الأشخاص الذين لديهم نوع واحد من الإعاقة (بتر أصبع، بتر ساق).

ختامًا شملت بعض التوصيات التي خلص إليها الباحث تطوير برامج التأهيل للمعاقين و المبتورين ومواكبة كل ما هو جديد ، كذلك توفير برامج موجهة لحالات المعاقين عمومًا وبشكل خاص للمبتورين للتقليل و الحد من المشاكل النفسية.

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Chapter One

Background of the Study

Introduction

Work is the infrastructure of life we live on our planet where we created to build it to satisfy our needs. It considers the main source of living and sustenance required by every human being on earth. Man without work is an ineffective and unproductive individual in the society and be a reason for destruction to his /her own community.

Work determines cultural, social, and economical level of life and shaped the basic features of every member life. The apical rights are representing through people work and their interaction in the society.

Disabled people should cooperate and interact with everyone in the community, the government and the responsible organization to provide them with all amenities they need to live a decent life and to be an active member of the community.

In our religion Islam clarified the importance and the essential of ensure the individual a stable and a comfortable life. The holly Quran full of texts confirm and clarified all rules of life, also in many of the precious verses of the Hadith our prophet recommends the importance of good life for human dignity.

We can notice the importance of work and human rights in life as it said by our Prophet Muhammad (Peace Be Upon Him).

Abu Musa, May Allah be pleased with him, reported: Allah's Messenger (may peace be upon him) said: "A believer to another believer is like a wall of bricks supporting each other". (Muslim & El-Bokhary2446).

Living in war-torn areas is a dark and painful reality many people face throughout the world (Qouta & El-Sarraj, 2004)*. Hundreds of thousands are affected every year, including victims of global conflicts and crisis. Our relatives or friends could be part of wars victim. We live in a homeland suffering the scourge of war every day. Although precise figures on the numbers of children and families affected are unknown, it has been estimated that in the decade expanded from 1990 to 2000, over ten million children have been traumatized by wars around the world. (United Nations, 2000).

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* **The first number indicates the year publishing and the second for the page number.**

Studies on the effect of war against civilians began after the Second World War, whilst recent studies have focused on contemporary conflicts in the Middle East, South Africa, Ireland and Bosnia, as well as the effect of urban violence targeted against American children. There is a long history of descriptive reports of children's psychological reactions to wartime stress in many regions including Cambodia (Realmuto, et.al, 1992), (Sack et.al, 1995), Afghanistan (Mghir, Freed, Raskin, & Katon, 1995), South Africa (Dawes et.al,1989, 1990), Bosnia-Hercegovina (Smith et.al, 2001), Balkans (Ajdukovic, 1998), (Zivcic, 1993), Kuwait (Nader et.al, 1993), Palestine (Qouta & El-Sarraj, 2004), (Hawajri, 2003), (El-Khosondar, 2004), Lebanon (Sibai & Sen, 2000), and Iraq. (Ahmad et. al, 2000).

People who have a handicap can still have a normal life. They may not be able to do what they would like to do much less of doing regular activities like others. However, they have the rights of being happy and productive. Many facing discrimination or getting treated as second class citizens seen as a "poor soul." Or worse. As a result, there were reportedly over 19,000 charges filed in 2008 claiming discrimination from disabled workers.

People often mistaken between the two concepts disabled or handicapped and vice versa. Although both refer to someone being at a disadvantage, they are not the same. A disability is the limitations of a function due to injury or illness such as being paralyzed or blind, many examples of someone with a handicap are not having the speed to make a track relay squad or the size and power to make a football team.

A person suffering from a physical handicap that severely impairs someone's judgment and ability can become a hazard to himself as well as others. Those who have a handicap that causes them to have problems on seeing, hearing or talking clearly may hinder a person's capability to drive or operate machinery. People with these impairments should seek medical help before engaging in any activity or situation that could possibly become serious. (Noel, 2010)

Many of Palestinian are suffering from at least one physical handicap. Someone's limitations from the handicap can range from barely being noticeable to an obstructive in everyday affairs. A person can be born with a physical handicap or develop it over his/her

life span. These disadvantages have led to legal action such as the Palestinian with disabilities act preferred parking and modified entrances in buildings.

Research showed that handicapped people living in wars zones are at high risk of developing types of psychopathology, predominantly and Post Traumatic Stress Disorders (PTSD) (Thabet et.al,2004), (Husain, 2005), (Mohlen et.al, 2005).

The exploratory cross-sectional multicenter survey reported primarily to investigate the prevalence of Psychiatric symptoms among physical handicapped people who are victims of the last war on Gaza. An additional aim was to investigate personal and environmental factors that may contribute to it.

Problem Statement:

The problem of the study can be stated in the following major question:

What are the Psychiatric symptoms among physical handicapped persons, who are victims of the last war on Gaza?

The following nine questions emanate from the above major one:

1. What is the level of Psychiatric symptoms to be suspended somatization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobia, paranoia and psychotic among physical handicapped people who are victims of the last war on Gaza?
2. Are there statistically significant differences in Psychiatric symptoms due to gender?
3. Are there statistically significant differences in Psychiatric symptoms due to age?
4. Are there statistically significant differences in Psychiatric symptoms due to qualification?
5. Are there statistically significant differences in Psychiatric symptoms due to marital status?
6. Are there statistically significant differences in Psychiatric symptoms due to area of living?
7. Are there statistically significant differences in Psychiatric symptoms due to working status?

8. Are there statistically significant differences in Psychiatric symptoms due to monthly income?
9. Are there statistically significant differences in Psychiatric symptoms due to the type of physical handicap?

Hypotheses of the Study:

The following hypotheses:

1. There are no statistical significant differences at ($\alpha \leq 0.05$) in Psychiatric symptoms due to gender.
2. There are no statistical significant differences at ($\alpha \leq 0.05$) in Psychiatric symptoms due to the age.
3. There are no statistical significant differences at ($\alpha \leq 0.05$) in Psychiatric symptoms due to qualification.
4. There are no statistical significant differences at ($\alpha \leq 0.05$) in Psychiatric symptoms due to marital Status.
5. There are no statistical significant differences at ($\alpha \leq 0.05$) in Psychiatric symptoms due to area of living.
6. There are no statistical significant differences at ($\alpha \leq 0.05$) in Psychiatric symptoms due to working status.
7. There are no statistical significant differences at ($\alpha \leq 0.05$) in Psychiatric symptoms due to monthly income.
8. There are no statistical significant differences at ($\alpha \leq 0.05$) in Psychiatric symptoms due to the type of physical handicap.

Objectives study:

A) General objective:

This study will investigate the prevalence of Psychiatric symptoms among physically handicapped persons who are victims of the last war on Gaza.

B) Specific objective:

This study will investigate the contributions of personal and demographics factors to Psychiatric symptoms among physically handicapped persons.

Importance of the study

The importance of this research stems out from:

1. This research gains its importance from the subject matter itself, because it opens the scope for the officials to conduct Psychiatric symptoms as a very important issue among physical handicapped persons who are victims of the last war on Gaza.
2. This research is considered as one of the most important studies as an Analytical Approach to investigate the level of Psychiatric symptoms among physical handicapped persons who are victims of the last war on Gaza
3. The lack of the previous studies that deal immediately with the same subject matter.

Definitions of terms:

The researcher adopted these definitions:

Psychiatric symptoms:

Symptoms are subjective experiences, such as a person's complaint of feeling depressed. (Kaplan & Sadock's, 2007: 272).

Operational definition:

The term "psychiatric symptoms" refers to a large group of symptoms that occur in many -but not all- individuals of people. In early stages of the disease, people may experience irritability, anxiety or depression. In later stages, other symptoms may occur, including: Sleep disturbances, Physical or verbal outbursts, Emotional distress, Restlessness, pacing, shredding paper or tissues and yelling, Delusions (firmly held belief in things that are not real), and Hallucinations (seeing, hearing or feeling things that are not there).

Researcher intended a psychological symptom is a group of symptoms consisting of nine symptoms, namely (Somatization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobia, paranoia, psychosis).

Somatization:

A broad group of illness that have bodily signs and symptoms as a major component characterized by many physical complaints affecting many organ symptoms.

(Kaplan & Sadock's, 2007: 634)

Operational definition:

Somatization disorder is a psychiatric condition in which the sufferer experiences multiple physical symptoms that are not explained by disease.

Obsessive compulsive:

Group of symptoms that include intrusive thought, rituals, preoccupation, and compulsion.

(Kaplan & Sadock's, 2007: 604)

Operational definition:

A type of anxiety disorder characterized by recurrent, persistent, unwanted, and unpleasant thoughts (obsessions) or repetitive, purposeful, ritualistic behaviors that the person feels driven to perform (compulsions).

Interpersonal sensitivity:

Interpersonal sensitivity refers to the accuracy and/or appropriateness of perceptions, judgments, and responses we have with respect to one another.

(http://wiki.answers.com)

Operational definition:

Undue and excessive awareness of and sensitivity to, the behavior and feelings of others.

Depression:

Patients with depressed mood experience a loss of energy and interest, feelings of guilt, difficulty in concentrating, loss of appetite, and thoughts of death or suicide.

(Kaplan & Sadock's, 2007: 527)

Operational definition:

Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration.

Hostility:

Is a form of angry internal rejection or denial in psychology. It is a part of personal construct psychology**.** (http://en.wikipedia.org/wiki/Hostility)

Operational definition:

It is a feeling, which caused a person to feel negative emotions such as hatred and hostility against others.

Phobia:

A persistent fear of an object or situation in which the sufferer commits to great lengths in avoiding, typically disproportional to the actual danger posed, often being recognized as irrational. (http://en.wikipedia.org)

Operational definition:

A phobia is defined as an irrational, intense fear of an object or situation that poses little or no actual danger**.**

Paranoia:

An unfounded or exaggerated distrust of others, sometimes reaching delusional proportions. (http://medical-dictionary.thefreedictionary.com)

It is type of schizophrenia characterized mainly by the presence of delusions of persecution or grandeur. (Kaplan & Sadock's, 2007: 476)

Operational definition:

A psychotic disorder characterized by delusions of persecution with or without grandeur, often strenuously defended with apparent logic and reason.

Psychosis:

Psychosis is a symptom or feature of mental illness typically characterized by radical changes in personality, impaired functioning, and a distorted or nonexistent sense of objective reality. (http://medical-dictionary.thefreedictionary.com)

Operational definition:

Syndrome which characterized by disturbance of cognition, perception, emotion and behavior.

A physical handicap:

The group of people, which have physical restrictions in access to normal environment without structural adaptation due to particular disease or syndrome.

(Blakiston, 1984)

Operational definition:

A physical handicap is a physical or mental disability making participation in certain of the usual activities of daily living more difficult.

Last Gaza War or AL Forqan Operation:

Operation Cast Lead is the name the Israeli military gave its 2008 assault on the Palestinian Gaza Strip. Israel launched the attack on Dec. 27, 2008 and ceased fire in the war on Jan. 18, 2009 after "one of the most violent episodes in the recent history of the Palestinian territory," according to a report by the United Nations Office for the Coordination of Humanitarian Affairs. (http://middleeast.about.com)

Gaza Strip :

A strip of territory in Palestine, on the southeastern Mediterranean coast, including the town of Gaza; population 1,551,900. Administered by Egypt from 1949 and occupied by Israel from 1967, it became a self-governing enclave under the PLO-Israeli accord of 1994 and elected its own legislative council in 1996.

(Oxford dictionaries).

Also "A coastal region at the southeastern corner of the Mediterranean bordering. It was occupied by Israel during the 1967 six day war". (The area was occupied by Egypt from 1948-1967). Now it is under the Palestinian authority after Israel evacuation in 12-09-2005.

Limitations of the Study

The study will focus only on the physical handicapped people who are victims of the last war on Gaza.

Time limit: From 2011-2012.

Place limit: The study will cover all the governorates of Gaza Strip.

Human limit: The study will cover all the handicapped of Gaza Strip due to the last war on Gaza.

Age limit: The age of those handicapped persons will range from 18 to 50 years

Chapter Two

Theoretical Framework

Introduction

When Allah Almighty founded causes for happiness and pleasure to help his creatures explore goodness and create a better habitat and universe to be able to reap its fruits. He Almighty then imposed upon humankind worships to better understand to their religion and how to deal with life matters. Once people disobey the teachings of Allah, problems start to arise, inevitably.

Therefore, we say that the psychological distress is only the product of multiple things, whether from stresses in life or the stresses resulting from a brutal war, or other like.

Living in war-torn areas is a reality that many people face throughout the world (Qouta & El-Sarraj, 2004:10). Hundreds of thousands are affected every year, including the victims of the conflicts, their relatives and friends. Although precise figures on the numbers of children and families affected are not known, it has been estimated that in the ten years from 1990 to 2000 over ten million people have been traumatized by war around the world. (United Nations, 2000)

The researcher believes that the Palestinian people live wars and psychological trauma for more than 60 years, and this would increase the number of cases exposed to trauma.

Studies on the effect of war on civilians began after the Second World War, while recent studies have focused on contemporary conflicts in the Middle East, South Africa, Ireland and Bosnia, as well as the effect of urban violence targeted The American people.

Research showed that people living in war zones are at high risk of developing types of psychopathology, predominantly Post-Traumatic Stress Disorders (PTSD).

(Thabet et.al, 2004); (Husain, 2005); (Mohlen et.al, 2005).

War often brings destruction and desolation of people. The Palestinian people is one of affected people, such war brought about calamities, with the last war on Gaza described as one of the fiercest wars. This war began on 28th, December 2008 and lasted for 22 days, and was carried out by the Israeli forces which have acted aggressively. The war was aggravated by hundreds of injured and martyrs. The indiscriminate attacks

against everybody were repeatedly carried out. Everything was targeted by the Israeli forces.

Although handicapped expression is widely used in both law and everyday speech to refer to people having physical or mental disabilities, these are described by the word tend to prefer the expressions disabled or people with disabilities. Handicapped may imply a helplessness that is not suggested by more forthright disabled. It is also felt that some stigma may attach to the word handicapped because of its origin in the phrase hand in cap, actually it derived from a game of chance but sometimes mistakenly believed to involve the image of a beggar. The word handicapped is a better reserved to describe a disabled person who is unable to function owing to some property of the environment. Thus people with a physical disability requiring a wheelchair may or may not be handicapped, depending on whether wheelchair ramps are made available to them. (The American Heritage, Dictionary of the English Language, 2009:15)

The war ended by a large catastrophe include all kind of life , literally, much destruction and a lot of people were left hampered and disabled by the Israeli offence.

There are many forms of disabilities that have been observed in the aftermath of the war, we will try, in this chapter, to make a quick review for these forms, then focusing and talking at length about the study subject “motor disability”.

The results of Israeli Cast Lead operation are still being calculated as: more than 1500 Gazans were killed, more than 5500 were wounded, thousands of homes were destroyed and still haven’t been rebuilt, many public buildings lie in ruins for lack of steel, concrete and cement to fix them but what remains for many Gazans is the unspoken internal damage .It is the effect on population's mental health. The estimates from several organizations hold that between 30 and 40 percent of Gaza population are suffering from signs of PTSD "Post-traumatic Stress Disorder ".

A study by Gaza Community for Mental Health Program in June found that, tow third of Gaza's children are traumatized.

On the first days of the war, we knew that, the main aim of the Cast Lead was to spread fear and terror among Gaza's population, which will lead to create more mental disorders, especially on women and children.

The history of health care in Islam:

The spread of Islam:

In order to understand how health care developed in the Middle Ages, we have to look back at history and to find out the important things that happened during the Seventh Century.

In 570 A.D. (Anno Domini), a man was born in a small city in the Arabian Peninsula, called Mecca, his name was Mohammed. In 610 A.D., he declared a new religion, Islam. In 632 A.D., he died after uniting the Arab tribes who had been torn by revenge, rivalry, and internal fights. Out of these mostly illiterate nomadic people, he produced a strong nation that encountered and conquered, simultaneously, the two known empires at that time, namely, the Persian and Byzantine Empires.

(Abdelhadi, 1990:15).

In a man's life-time, the Islamic Empire extended from the Atlantic Ocean on the West, to the borders of China on the East. In 711 A.D., only 80 years after the death of their prophet, the Arabs crossed to Europe to rule Spain for more than 700 years. The expansion of the Muslims in Europe was not limited to those from North Africa and Spain. Muslims under the Ottoman Empire invaded Europe from the East. They occupied a good part of Middle Europe and besieged Vienna twice, once during the reign of Sulayman1 (1520-1566 A.D.) and the other during the reign of Mohammed IV (1648-1687 A.D.) (Meqati, 2009:52).

Islam and the promotion of culture and Science:

As Muslims challenged the civilized world at that time, they preserved the cultures of the conquered countries. On the other hand, when the Islamic Empire became weak, most of the Islamic contributions in art and science were destroyed.

The difference between Arabs and other cultures was the teachings of Islam.

(Al Thiab, 2010: 40-50).

1. Stressed the importance and respect of learning.

For example, the first word revealed to Moslems' prophet Mohammed was "Read". In Mohammed's era, a captured enemy was freed if he paid a ransom or taught ten Moslems writing and reading. In their holy book, the Qur'an, the importance of knowledge has been repeatedly stressed as it says "Those who know and those who do not are not equal." The prophet Mohammed stressed learning by saying. "One hour of teaching is better than a night of praying." (Alhydar, 2006:24).

2. Forbade destruction.

On conquering Mecca, the prophet Mohammed Strongly stated that no homes, animals, or trees should be destroyed.

His followers abided with these principles when conquering other countries.

(Shalash, 2009:137).

3. Encouraged cleanliness and personal hygiene.

Islam instructed them to approach God in their prayers five times a day with bodies and clothes spotlessly clean (Elamly, 1991:140).

4. Developed in them the respect of authority and discipline.

For example, realizing the scourges and terror of plague, Prophet Mohammed (Peace Be Upon Him P.B.U.H.) decreed that "no man may enter or leave a town in which plague broke out."

And to make this law more binding and effective, he promised the blessing of heaven to those who die of plague by stating that if a man died of plague he would be considered a martyr. Thus Mohammed (P.B.U.H.) laid for the Moslems the laws governing cordon and quarantine for the first time in history and made it work.

(Abuelazayem, 1994:90).

5. Tolerated other religions.

The Islamic religion recognizes Christianity and Judaism and considers their followers to be people with holy books like Moslems. Moreover, they candidly treated the Jews at an era when the latter were persecuted in Europe. The Arabs were assimilated by the vast new countries they reached. From this marriage of genuine characters and righteousness with the ancient and well established civilizations, a great new nation was born. It is difficult to identify this new breed as Arabs. Although the language was Arabic, all the scientists were not necessarily from the Arabian Peninsula. It is also equally difficult to describe it as Islam because although the majority of the scientists were Moslems, sponsored by Moslem rulers, and governed by the Islamic law, yet some scientists were Christians or Jews, especially at the early phase of the Islamic civilization (Al Thiab, 2010:P40-50).

Medicine and Psychiatric Nursing before Islam:

In order to comprehend the contributions of Arabs to medicine and nursing, we must have in our minds a picture of the condition of medicine before they arrived to the scene. Generally two elements are required for medical practice. (Elamly, 1991:13).

Medical and nursing ethics in Islam:

The medical profession was a well-respected specialty and its Leaders kept it this way by laying down proper ethics.

Al-Tabari, the chief physician in 970 A.D., described the Islamic code of ethics as follows (Abuelazayem, 1994: 78).

I. Personal characters of the physician and the nurse:

The Physician and the nurse ought to be modest, virtuous, merciful, and Unaudited to liquor. He should wear clean clothes, be dignified, and have well-groomed hair and beard. He should not join the ungodly and scoffers, nor sit at their table. He should select his company to be persons of good reputation (Allehyan, 2009:55).

II. The obligation towards patients:

They ought not to lose their temper when patient keeps asking questions, but should answer gently and compassionately. They should treat rich and poor the same, the master

and the servant, the powerful and the powerless, the elite and the illiterate. God will reward him if he helps people in need. The physician and the nurse should not be late for his rounds or his house calls. They should be punctual and reliable.

(Caruso, 2004:79).

III. His obligation towards the community:

The physician and the nurse should speak no evil of reputable men of the community or be critical of any one's religious belief.

These ethics was before any European think of any ethics, medicine or nursing.

(DeLaune, 2011:170).

Health Situation in Gaza Strip

The popular masses face hardship in the West Bank and Gaza Strip are many ways of suffering in terms of care and health services.

(Reports monitoring, (WHO) special monitoring Gaza, 2010:1).

Access to health is a fundamental human right, included the Palestinian Authority as part of its many infrastructure projects specific to the conditions of health and hospitals in the West Bank and Gaza, but that the implementation of these projects are subjected to many constraints and obstacles that have prevented the achievement of those projects, especially in rural areas as in Rafah. This situation existed until the division between the West Bank and Gaza Strip because of the bloody conflict in the mid of June 2007. Also the health situation in the sector to further deterioration and suffering of patients because of the Zionist blockade against Gaza Strip, which led to the death of hundreds of patients due to lack of medicines or equipment or preventing them from traveling for treatment in abroad. (Ghazi Sourani, 2011:3).

1. Reported Morbidity:

1.1 *Communicable Diseases:*

Palestine succeeded in preventing many fatal and disfiguring diseases as schistosomiasis, leprosy, diphtheria, plague, poliomyelitis, rabies, but it still working

toward control of other infectious diseases, such as Meningococcal Meningitis, Brucellosis, HIV\AIDS, Hepatitis, Tuberculosis, Diarrhea, and Pneumonia (Ministry of Health, PHIC, Health Status in Palestine 2010, April 2011: 25).

1.2 *Vaccine Preventable Diseases:*

The target of the Palestinian health care system allows every child to receive a safe vaccine for each childhood vaccine-preventable disease. In Palestine, immunization coverage remains high. (Reports monitoring, WHO special monitoring Gaza, 2010:3).

1.3 *Non Communicable Diseases*

1.3.1 Cancer:

Breast cancer ranked first, with (254) reported cases, (18.8%) from all reported cases are lung cancer which ranked second, (146) reported cases and (10.8%) from all reported cancers (Ministry of Health, PHIC, Health Status in Palestine 2010, April 2011: 27).

2. Reported Mortality:

In 2010, the total number of reported deaths in Palestine was (10,733); (5,660) males and (5,073) females, (6,757) out of them were in West Bank (3,563) males and (3,194) females, (3,967) deaths reported in Gaza Strip (2,097) males and (1,879) females. (Ghazi Sourani, 2011: 7).

Health Status in Palestine:

In Gaza Strip there are (59) primary health care centers, and in the West bank there are (394) primary health care centers. The health services are distributed throughout Palestine. Also the MOH provides a number of specific health programs as: health education/community involves school health, immunization, human resources development, and referral of patients to non – MOH facilities (when services are not available in governmental facilities) (Ghazi Sourani, 2011: 9).

1. Health services

1.1 *Health Services Providers:*

In Gaza strip, there are (134) primary health centers run by three main providers:

1- Government: (59) primary health care centers.

2- UNRWA: (18) primary health care centers.

3- NGOs: (57) primary health care centers

(Reports monitoring, WHO special monitoring Gaza, 2010: 5).

1.2 *Woman and Child health:*

The main contraceptive method used in Palestine in 2010 between the new beneficiaries was IUDs with total of (6,996) women used it with percentage (36.6%); (31.3%) in Gaza Strip and (39.8%) in West Bank, where (5,662) women used Pills with percentage of (29.7%); (26.7%) in Gaza Strip and (31.4%) in West Bank.

(Ghazi Sourani, 2011: 21).

1.3 *Secondary and Tertiary Health Care:*

The hospital services are operated by the government and non-government sectors. Hospitals in both sectors have improved in terms of facilities, technical and support services over the years by adding new departments and diagnostic equipment, as well as providing continuous professional training. (Ministry of Health, PHIC, Health Status in Palestine, 2011: 39).

Mental health in Gaza Strip:

Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community.

(WHO, 2010)

Indicators of Mental Health Need:

The World Health Report 2001 produced by WHO, reviews a variety of factors which determine the prevalence, onset and course of mental and behavioral disorders. These include social and economic factors, demographic factors such as age and sex, serious threats such as conflicts and disasters, the presence of major physical diseases, and the

family environment. The overall prevalence of mental and behavioral disorders does not seem to be different among men and women. However, anxiety and depressive disorders are more common among women, while substance use disorders and anti-social personality disorders are more common among men (Gold, 1998: 56).

Almost all studies show a higher prevalence of depressive and anxiety disorders among women, the usual ratio being between 1.5:1 and 2:1. These findings have been seen in most developed and developing countries. Sex differences in depression are strongly age-related; the greatest differences occur in adult life, with no reported differences in childhood and few in the elderly (El Sarraj & Qouta, 2004: 3).

Mental Health Needs of the Population:

Considered together, the international evidence for increased prevalence of mental health disorders and the demographic and environmental evidence described in this report suggest a higher than average incidence of common mental disorders (including Post-Traumatic Stress Disorder "PTSD") in the Palestinian population. Specific indicators of high population mental health need in the Palestinian population are as follows:

- The continuing conflict situation.
- A significant proportion of the population living as refugees in camps (particularly in Gaza).
- A high population density in Gaza.
- High levels of unemployment, social deprivation and poverty especially for those living in camps.
- Significant direct experience of trauma, injury, humiliations and bereavement to individuals (and other violations of human rights).The likely implications of these environmental factors would be higher levels of depressive and anxiety disorders and other disorders related to trauma (E.G. PTSD)

(Steering Committee on Mental Health, 2004: 15-16).

The Reality Mental health in Gaza Strip:

Related studies by the mental health of Palestinian society in Gaza Strip show the difficulties faced by the sector working in the field, especially with regard to easily provide information and statistics on the level of psychological morbidity in Palestine. This may be due to the recent research in the field of mental health in Palestine, the scarcity of data on the level of proliferation linked to social difficulties faced by the sector and related social stigma.

(Ministry of Health, PHIC, Health Status in Palestine, 2011: 25).

In a review of the literature relating to versions of the World Health Organization, shows limited and poor statistics on mental disorders. According to the (WHO) reports, the ideological situation of mental health in Palestine is not available. It is difficult to get rates and accurate figures reflect the situation ideological mental health in Gaza Strip. Also it is founded that there is an urgent need to work with patients with chronic diseases (such as schizophrenia and severe depression, bipolar disorder, and disorders psychotic) to the possibility of interference with them and reduce the possibility (burden of disease) (http://www.who.int).

Early intervention reduces non-productive, which is associated with these diseases, as research has shown the World Health Organization and the international Labor Organization that depression and chronic mental illnesses are five out of ten diseases lead to disability and lack of productivity. For other category of people with mental illnesses account for up 10-20% go to primary health clinics have physical complaints of a psychosocial origin. The other class of disorders is reactive symptoms, especially children, adolescents, and handicapped where the mechanisms are working with them most often in the form of a first and a preventive (Ghazi Sourani, 2011: 7).

In a review of the local and international literature about the reality of mental health in Gaza Strip, **the results can be summarized as follows**:-

1. Survey of mental health for children aged 5-17 year indicated that 11% of children are suffering from irritable and screaming, fear of dark, fear of isolation. 8.4% of the children are suffering from bad nightmares, and the symptoms of irritable. Nightmares are higher in males while females rose with symptoms of fear of loneliness and fear of dark, either from the display of increased thoughts about death, 4.3% of children and equal with the proportion of people suffering from crying for no reason. It also pointed

to a survey of children's behavioral symptoms, such as arson, beatings, insults and cracking, it is experienced by 5.8% of the children. Isolation and away from the family came by 2.2%, loss of concentration 9.9% and 7.1% attaches exaggerated parental, clearly from the results of the behavioral problems there is high except when males display excessive attachment to pain had the highest female . As the survey indicated that 68.8% of children had received psychological help and counseling, male children received more aid than females, male 71.5% versus 65.5%.

2. Shows through a study of the Gaza Community Mental Health clarified that 32% of adolescents aged 10-19 suffer from symptoms of post-traumatic stress ratio especially in males than in females 58% males and 42% females. A study (Zakrison, 2004) said 42% of children suffer from psychological problems (emotional and behavioral). As for the study of Treatment and Rehabilitation Center for Torture Victims showed that 38.1% suffer from symptoms of PTSD, 3.1% from sharp tension, and in the psychological evaluation conducted by Save the Children in collaboration with the Secretariat of the National Plan indicate that 93% of children who have examined the feel insecure and fearful, not only on themselves but on their families**.** (http://www.who.int/publications/en/).

3. Data were collected 4 years of the Palestinian Ministry of Health (2006, 2007, 2008, 2009) On their way to receive psychological services, the results showed that 36% of the bound suffering from neurotic disorders and 31% heading of suffering from emotional disorders and affective disorder, 27% of heading suffer from schizophrenia and psychotic disorders, 5% of heading suffer from personality disorders and 1% non-specific diagnosis.

(Ministry of Health, PHIC, Health Status in Palestine, 2011: 28).

4. As for the statistics for the Palestinian Counseling Center has shown the results of travelling to Psychiatry during the last three years (2007, 2008, and 2009) as follows: 25% of traveling with different kinds of anxiety and 22% mood disorder. The schizophrenia and psychotic disorders constitute 18% of the bound and 11% adjustment disorder, 8% personality disorder. While the terms of the psychological orientation of the guide (2008, 2009) was ranked first 27% (relational problem) from

traveling because of problems within the family relations of anxiety and 16% mood disorder and 13% of the heading of psychological counseling. As for personality disorders has formed 6% of the heading (Ghazi Sourani, 2011: 6).

5. As for the statistics of the Centre for Treatment and Rehabilitation of Victims of Torture Statistics were collected three consecutive years (2007, 2008, 2009) show that approximately 500 beneficiaries per year for guidance 64% of heading suffer from anxiety disorders including PTSD, followed by mood disorder , a 29% from then psychotic disorders and constitute 3% of the bound either for self-loss and physical problems, personality disorders together constitute 1% of the heading and 3% suffer from addiction.

(Treatment &Rehabilitation, Center for Victims of Torture: 2009: 24).

The data above shows that a high percentage are on their way to receive the extension service and Psychiatry complain of anxiety disorders, followed by disorders of mood and psychotic disorders.

The impact of mental illness on the family and society:

Family is the source of safety, warm and security for humans contributes to the formation of his personality, which develops the future.

The literature emphasizes the importance of parents enjoy the positive psychological health because of its large and positive impact in the development and maintenance personal together to sons. Family social support gives a positive effect on the mental health of family members. It is important to say that the social fabric of a harmonious and coherent for each individual feels the other and belong to him.

(Hendrick, 2000: 49).

In some cases the family suffering from difficulties caused by suffering of one of its members of a problem or a narrow or illness leaves a great impact on the family members especially if the psychologically disease left the patient without treatment and the fact that mental illness is often translated into behaviors and emotions , any person with mental illness act in a manner harass such as irritable mood swings and severe psychotic symptoms, which in turn lead to negative reactions and

counter-productive members of the family around him, it generates anger and frustration, and even negative feelings for the patient and family members around him.

In many cases, brothers affected negatively and the feeling of neglect, anxiety and tension , in the case was the brother of a patient accounts for the attention of parents and feels that he preferred, he starts to treat parents with Highlight, which affects the harmony within the family and leads to generate conflicts inside the family.

(Saafan, 2007: 60).

Literature indicating the impact of psychiatric community in terms of productivity and work where the disease affects the psychological health of individuals, this becomes a performance career for them low. In a study of the World Health Organization and the International Labor Organization (WHO, ILO, 2002) shown on a scale (Disability Adjusted Life Years) of disability and lack of production that mental illnesses account for 5 out of 10 diseases affecting the productivity of individuals, including depression, bipolar disorder, schizophrenia, obsessive-compulsive disorder , injury that causes them to make these patients are unable to work effectively and make them productive, which makes these patients the burden on the community based on the reports of the World Health Organization is the burden in the inability to production and delivery arising from injury mental illness and its impact on the quality specifications of life, where the proportion of the burden of mental and neurological diseases,10.6% of the total combined diseases can also cause the loss of 33% of years of life for patients who suffer from it.

(WHO, 2009, http://www.who.int/publications/en/).

From the above, the researcher believes that the health sector in Gaza Strip is suffering from a big problem and a serious deterioration adversely affect the level of health, as result of the siege imposed on Gaza by the occupation forces, especially the deliberate introduction of drugs, medical supplies and the needs of the health sector for more than four years.

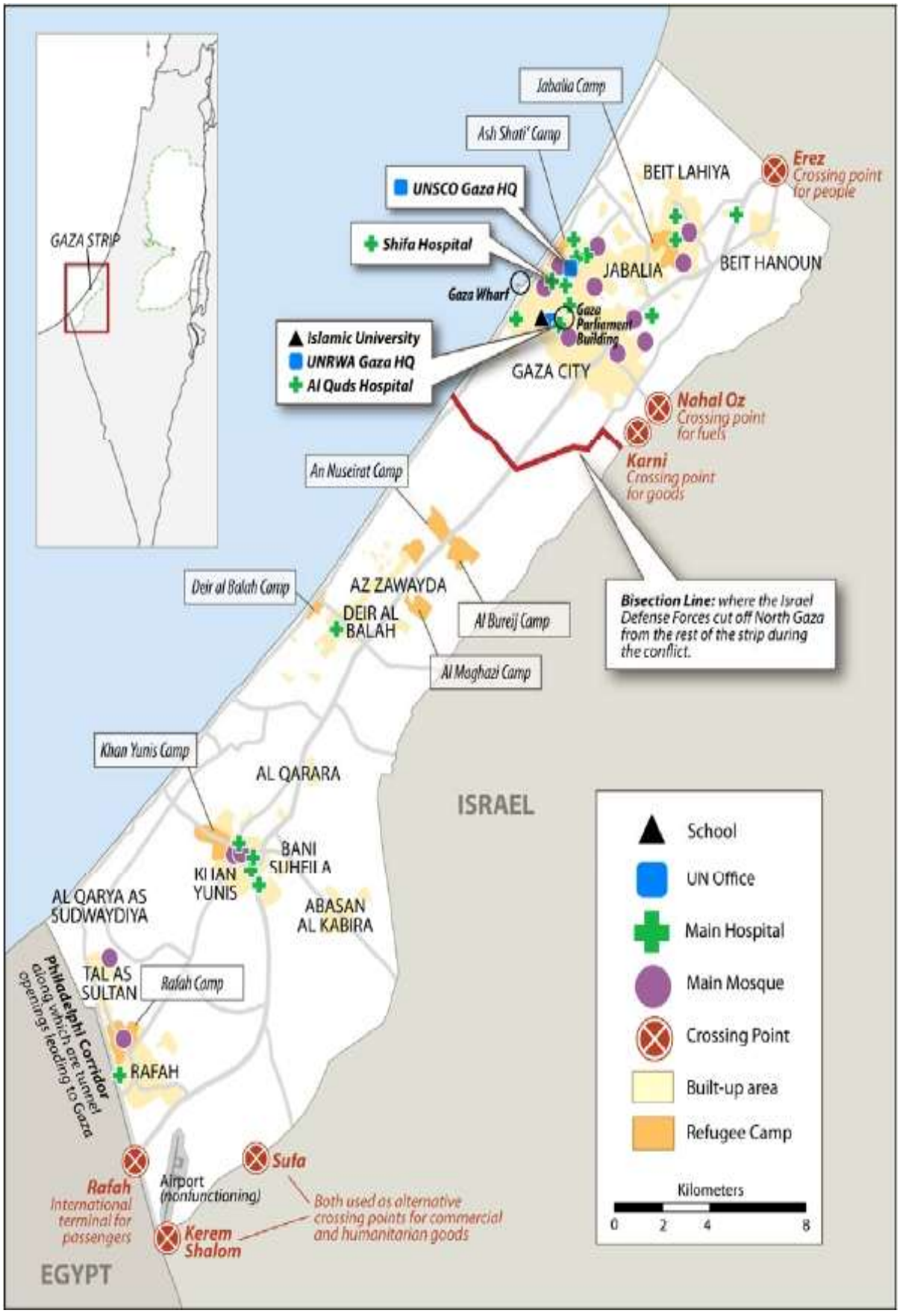
With the above-mentioned problems in buildings, hospitals, primary care centers and family of patients and their accessories, equipment and devices medical and unfortunately there isn't an alternative; due to lack of financial support to cover the expenses of the rehabilitation of those places , repair work , maintenance required , also the costs of purchasing equipment and new equipment, replacement of

old and unserviceable, or to expand the volume of services provided to patients and the needs for health services in the sector.

Last War on Gaza:

On December 27, 2008, Israel launched a major military campaign dubbed "Operation Cast Lead" against Hamas in Gaza Strip. The Israeli offensive came in response to markedly increased Palestinian rocket fire following the expiration of a six-month cease-fire on December 19. On January 3, 2009, Israel began a ground offensive into Gaza. Despite international pressure to halt the fighting (including the passage of U.N. Security Council Resolution 1860 on January 8), the conflict continued until January 18, when Israel unilaterally ceased fire and Hamas followed suit shortly thereafter. Israel's technological superiority and reliance on heavy armor and firepower contributed to a wide disparity, in casualties approximately 1,440 Palestinians have died (with some organizations estimating that at least half of the dead are civilians), compared with 13 dead (including four civilians) on the Israeli side (Medicine Sans Frontiers "MSF", 2009: 1).

The officially stated Israeli goal of Operation Cast Lead was to diminish the security threat to residents of southern Israel by steeply reducing rocket fire from Gaza Strip, weakening Hamas, and restoring Israel's deterrence. Hamas, however, has "spun" the survival of most of its leaders and fighters, and their control over Gaza, as victory. Nevertheless, by temporarily disabling Hamas's military capacity, Israel might have decreased its vulnerability to future attacks by buying time to deploy new, more sophisticated anti-rocket defense systems. Greater U.S., European, and Egyptian openness to implementing tougher anti-smuggling measures both on land and at sea could hinder the rearmament capacity of Hamas and other Palestinian militants in Gaza. Nevertheless, the practicability of such measures, and whether they will be accompanied by an opening of Gaza border crossings to renewed commerce, remains uncertain. International attention has turned to brokering a sustainable cease-fire arrangement and to addressing the needs of Gaza population—both in terms of continued humanitarian assistance and of reconstruction (Zanotti, 2009: 23-25).



Sources: U.N. Office for the Coordination of Humanitarian Affairs (including for the Bisection Line) and UNOSAT, with additional data from UNRWA; adapted by CRS.

War Crimes

Serious violations of international humanitarian law were committed caused a great damage and suffering among the civilian population in Gaza, as:

• The indiscriminate use of weapons such as heavy artillery in densely populated areas.

• Firing on or otherwise preventing ambulances and emergency medical care from reaching persons in need.

• Firing rockets deliberately or indiscriminately into residential areas.

• Targeting persons seeking to communicate their civilian status with white flags.

• Targeting presumptively civilian structures such as government offices, mosques, and police stations that were not being used for military purposes.

Legal cases for these violations of international law are not realistic though, as Israel has not ratified the treaty of the International Criminal Court, and the Palestinian Territories are not recognized as a state which could ratify this treaty. Other means are not probable for political reasons.

(Palestinian Human Rights Monitoring Group, 2009: 5).

The Use of White Phosphorus:

The indiscriminate use of white phosphorus shells by the Israeli army. White phosphorus is a highly incendiary weapon landing on skin, it burns deeply through muscle and into the bone, until deprived of oxygen. A delegation of Amnesty International found still-burning white phosphorus wedges all around residential buildings when entering Gaza after the ceasefire. White phosphorus is supposed to provide a smokescreen for troop movements. The IDF used it in attacks against the vicinity of the UNRWA compound and against al-Quds hospital in Gaza City.

(The Amnesty Organization, 2009: 2).

Psychiatric casualties:

Psychiatric casualties are recognized as an important and inevitable feature of modern warfare. At the beginning of the 20th century they were scarcely acknowledged and still less treated. Today, as a result of lessons learned in the First and Second World Wars, numbers can be predicted on the basis of battle intensity and effective clinical interventions applied (Kristy Muir, 2007: 7).

Early in the First World War, battle conditions were accepted as the cause of psychiatric casualties. Most psychiatrists and psychologists believed that the stimuli experienced in active service triggered a physiological change in some soldiers' central nervous systems (O'Keefe, 1994: 30).

Psychiatrists and psychologists coined the term 'shell shock' to refer to the servicemen who developed a psychological reaction to battle conditions.

(Kristy Muir, 2007).

The large percentage of psychiatric casualties the Armed Forces is a matter of common knowledge. It is apparent that they serve the enemy's ends as effectively as do the casualties resulting from physical injury or infection. (George Pegge, 1990).

In civilian life psychiatric casualties occur both as the result of direct enemy action and in the absence of an emergency, but related to war-time conditions.

(Pearl s. Pouppirt, 1995).

The recognition and treatment of the latter casualties constitute a valuable contribution that civilian psychiatrists can make to the war effort today. This would be a contribution not only towards military victory, but towards minimizing the detrimental effects of war conditions upon the population as a whole (Kristy Muir, 2007).

Civilian psychiatric casualties are of great value to the enemy. As the panic plays a major role in the defeat of the nation. To avoid such mass reactions each civilian should be informed of the danger of attack, the anticipated nature of the attack, the defense plans that have been made, and the duties he will be asked to perform. All people should be given a brief summary of the problem of psychiatric casualties. This should be an

informative outline describing in easily understood terms the causes of such casualties, the types expected, their prophylaxis and first aid treatment. It should be emphasized that emotional manifestations are normal when an individual is exposed to danger. Such reactions are only considered abnormal when they are out of proportion to the situation and exhibit, for the person, a departure from his habitual (adequately adaptive) reaction pattern. They may render him inadequate to perform his duties, to care for himself and others, or result in him being a nuisance or actual danger to himself and others. If incapacity cannot be accounted for on physical grounds, the patient should be labeled, tentatively, a psychiatric casualty and detained at a first aid station until transportation facilities are available to a hospital where a psychiatric clearance can be obtained before the patient is dismissed (Pearl s. Pouppirt, 1995).

In addition, psychiatric casualties should be isolated because of their infectious nature, and the detrimental effect they have on the morale and efficiency of associates. Since it is unlikely that a sufficient number of specialists in psychiatry will be available to treat all psychiatric casualties, each physician should be prepared to care for them. The first question he should ask himself is: "Is this patient a psychiatric casualty, and, if so, why did he become one?" (George Pegge, 1990).

Treatment of psychiatric casualties:

During the First and Second World Wars, psychiatric casualties were treated in field hospitals and specialist clinics. Therefore, these casualties were 'cared for medically', as the Geneva Convention specifies. Psychiatrists treated casualties with methods that they believed were in the patients' best interest for recovery. This included treating patients close to the frontline so they could quickly be returned to active service. However, psychiatrists were also working for the military, where there was an emphasis to maintain military strength (O'Keefe, 1994).

The role of physician in Treatment of psychiatric casualties:

The physician must know that if the reaction is out of proportion to the situation, it is so because of unconscious processes, of which the patient is unaware. A tactful physician often can obtain a sufficient understanding of these processes to enable him to remove the symptoms in a short period of time. These symptoms should be observed

carefully, and thought of as the language by means of which the patient expresses his reaction to insecurity; either by flight from it and/or denial of its existence shown by inhibition of activity (apathy, disabling symptoms, amnesia, etc., to coma), or by excessive action due to anxiety or a failure to repress his aroused aggressions (officiousness, belligerency, etc., to mania) (PM Shyangwa, 2009).

A complete physical examination is necessary in order to discover any physical injury or illness which may be masked by the psychiatric manifestations. Frequently the presenting symptoms of some conditions, such as cerebral concussion, are psychiatric in nature. Much of history taking, psychiatric examination and treatment will be done in conjunction with this physical examination. (Etta Kavanagh, 2010).

Physician cannot approach a psychiatric case with the idea that he can separate his examination, diagnosis, formulation of his plan of therapy and prescription of his treatment. He must be aware that all these factors progress simultaneously from the moment of his first contact with his patient. (Pearl s. Pouppirt, 1995).

The manner of the examiner and the emphasis he places upon questions and parts of the physical examination amount to profound suggestion in the psychotherapy of the patient. Observation of the patient's reactions during the examination, while he recounts his past and family history, and answers questions regarding his family, friends, co-workers, religious affiliations, occupation and damage done to his home or self will enable the physician to determine what constitutes security for this individual. The physician with his manner of calm realistic acceptance of the fact that danger exists, that it is being met, and that the patient is in a place of relative safety (because the physician himself and his assistants exhibit no tension), will supply all the assurance that is necessary in a large percentage of cases to obtain a satisfactory history.

(George Pegge, 1990).

If the patient senses the physician's haste (because he has a long list of patients yet to see) the examination might as well be omitted, and certainly should be postponed. One must accept the fact that in psychiatric casualties' time must be spent on each patient, and the physician must exhibit an unhurried atmosphere of confidence and courage. It is of value to be the first person to interview the patient. The exhibition of an interested

sympathetic willingness to listen and try to help by giving the patient a sense of security, forming the basis of a confidence which often enables the patient to talk freely. (Pearl s. Pouppirt, 1995).

The Health Situation in Gaza during the war:

- 16 health personnel were killed and 22 injured during duty.
- Al-Quds Palestinian Red Crescent Society (PRCS) Hospital in south Gaza City was attacked on January 15. The hospital's pharmacy, administrative buildings, emergency and ambulance station were destroyed. Forty patients who were evacuated were brought to Shifa Hospital. About 200 people who had been seeking refuge in Al-Quds Hospital were evacuated to an UNRWA shelter.
- At Al Wafa Rehabilitation Hospital in Gaza City, staff continued to provide health care despite the facility (the Geriatric building) being damaged on January 15. The hospital's 52 beds were all occupied, eight by patients on life-support machines.
- All Gaza City hospitals were functioning solely on generators since January 16 due to the damaged power lines and electricity outage.
- Al Shifa Hospital ICU remained overwhelmed. Some patients were evacuated but the ICU was functioning at virtually full capacity due to the low evacuation rate of patients through Rafah Crossing and extra patients presenting to the ICU from Al-Quds Hospital.
- 15 of Gaza's 27 hospitals suffered damage, 9 belong to the Ministry of Health and 6 NGO hospitals, among them Al-Wafa rehabilitation hospital, which is Gaza's only rehabilitation hospital.
- Injured patients referrals outside Gaza for specialized care were evacuated exclusively through Rafah crossing: 608 between December 29 and January 22 (of whom 512 to Egyptian hospitals, 61 to Saudi Arabian hospitals. Only 30 patients were able to exit through Erez crossing.
- UNRWA’s Gaza City warehouse with all its supplies was completely destroyed in an attack on January 15 (affecting 70% of Gaza's population).

- UNRWA has established at least 50 emergency shelters for displaced people (around 100.000), in order to provide water, bread and some tinned meat.
- As of January 14, approximately 500 000 people had no access to running water, and the rest of the population only received water for a few hours two to three times per week. (WHO, 2009).

Casualties during the War:

Israelis: 13 dead

Civilians: 3 civilians were killed in Israel by rocket and mortar attacks

Soldiers: 1 soldier was killed in Israel by rocket and mortar attacks

5 soldiers were killed fighting in Gaza

4 soldiers were killed by errant IDF tank shell in Gaza.

Palestinians:

The Martyrs: 1,324 (437 children under 16, 110 women)

Wounded: 5,400. (Palestinian Human Rights Monitoring Group, 2009).

Prominent members of Hamas who were killed during the war:

- Interior Minister, Said Seyam
- Chief of Gaza Police, Tawfiq Jabber
- Head of General Security Service, Salah Abu Shrakh
- Religious Cleric, Nizar Rayyan

The number of Hamas fighters killed and wounded during the were difficult to know as they were brought to separate medical centers, and not to public hospitals.

(The Amnesty Organization, 2009).

Impact of war on Gaza Strip:

1) The health care system:

The health care system's ability to function properly has been weakened considerably. Most medical equipment is unreliable and the embargo makes it impossible to obtain certain spare parts. Similarly, medical units also face drug shortages. More than 5,000 people were wounded during January war. Many are disabled and the only rehabilitation center in Gaza Strip also finds it is difficult to import raw materials and the components required to manufacture artificial limbs. The waiting time for a prosthetic now extends to mid-2010. Even as the 150 disabled patients wait their unexploded munitions continue to kill and wound. Individuals who were disfigured and/or burned should be able to obtain plastic surgery and post-operative care. However, Gaza's only plastic surgeon struggles to treat them all, even as domestic accidents – such as exploding gas bottles. It is estimated that 40 percent of patients with a chronic illness could not obtain their medical treatment during January offensive (life-threatening emergencies received priority at that time). This has had a long-term impact on their health. Patients who cannot be treated in Gaza Strip should be cared for outside the Occupied Territory, but requests for authorization to travel are so complicated to obtain – on both the Israeli and Palestinian sides that some cannot leave Gaza in time to arrive for their appointment.

(Palestinian Human Rights Monitoring Group, 2009)

2) The psychological impact:

The psychological impact of Operation Cast Lead is difficult to assess. Psychologists must respond to a surge of requests. The waiting list is long. "Children are particularly affected (school absenteeism and failure, aggression and bedwetting). Domestic violence has become a major social problem. "During the war, the lack of safe shelter providing protection against almost non-stop bombing and the continued sealing of the borders have trapped the civilian population, placing people in a very vulnerable position. They have lost all sense of security, which is fundamental to general psychological well-being." The World Health Organization estimates that between 20,000 and 50,000 people will have long-term illness following the offensive.

(Medicine Sans Frontiers (MSF), 2009).

3) An economic Effect:

Livelihoods were systematically destroyed, particularly in January. Many small companies, both factories and shops, and private homes were razed or seriously damaged. The United Nations estimates the total cost of this destruction at $139 million. Today, 140,000 of Gaza people are unemployed, bringing the unemployment level to 50 percent, compared to 32 percent in 2007. These figures are among the highest in the world. The blockade has caused the loss of 120,000 jobs in the private sector. On average, every worker must support six or seven family members. Seventy percent of families live on less than $1/day. Today, 75 percent of the Gaza population – more than 1.1 million people – relies on food aid. The restrictions related to heightened security, the last military offensive and the increasingly drastic limitations on fishing and farming areas affect food supplies and produce major price fluctuations. In January 2007, more than 600 trucks entered Gaza every day, compared to fewer than 100 today, 70% of which carry foodstuffs. (Hakeem Eltalla and Luc Hens, 2010).

4) Electricity, water and sanitation shortages**:**

During the last war on Gaza, crucial electricity and water infrastructure and the sanitation system, were targeted and partially destroyed. There's just one power plant left in Gaza. Sixty percent of energy needs are met by buying electricity from Israel and Egypt. Power outages which last from four to eight hours occur every day and 10 percent of the population has no electricity at all. The water system is also extremely fragile and 90 percent of water provided to Gaza residents fails to meet WHO safe drinking water standards. Every day, approximately 80 million liters of wastewater go untreated and are discharged into the Mediterranean, posing risks to health and the environment particularly fishery products. Water-related illnesses, such as acute diarrhea, are increasing. No major reconstruction or repair of this public infrastructure has been performed to date. (Medicine Sans Frontiers "MSF", 2009).

After the previous view of the war on Gaza, the researcher believes that the phenomena of serious and non-normal in Gaza Strip appeared a year after the Israeli war on Gaza, such as high number of birth defects, abortion rates and incidence of diseases such as cancer, because of the Israeli army's use of weapons containing toxic

and radioactive materials through the aggression on Gaza Strip which further deteriorated the situation of the population in Gaza Strip.

The researcher believes that the health and environmental conditions in Gaza Strip is getting worse day after day, as a result of the recent Israeli war and the continued closure of the Israeli occupation authorities to Gaza's border crossings and for the fourth year in a row.

The Concept of Handicap:

Disability:

Is a condition or function judged to be significantly impaired relative to the usual standard of an individual ability of their age group. The term is often used to refer to individual functioning, including physical impairment, sensory impairment, cognitive impairment, intellectual impairment, mental illness, and various types of chronic disease. This usage has been described by some disabled people as being associated with a medical model of disability. (http://www.disabilityaccessinfo.ca.gov)

The human rights or social model by contrast is presented as focusing on the interaction between a person and their environment, highlighting the role of a society in labeling, causing or maintaining disability within that society, including attitudes or accessibility and favoring the majority. Disabilities may come to people during their life or people may be born disabled. On December 13, 2006, the United Nations formally agreed on the Convention on the Rights of People with disabilities, the first human rights treaty of the 21st century, to protect and enhance the rights and opportunities of the world's estimated 650 million disabled people. Countries that sign up to the convention will be required to adopt national laws, and remove old ones, so that persons with disabilities would, for example, have equal rights of education, employment, and cultural life; the right to own and inherit property; not be discriminated all over the life cycle such as; marriage, childhood, etc.; not to be unwilling subjects in medical experiments. (Ahmady, 2005:76).

Disability, Impairment and Handicap:

The terms “Impairment”, “Disability”, and “Handicap” are used in place of each other or can be interchanged. They all have different meanings. The different meanings have different impact for understanding the effects of injury. The most common definition is provided by the WHO (World Health Organization) which distinguishes between the three terms i.e. disability, impairment and handicap. (http://www.disabilityhelper.com)

Impairment– It is defined as any damage or weakening of physiological, psychological and anatomical function or structure. A child unable to bear weight on the feet and inability to move the legs is impairment. If this condition increases then it can lead to deformed bone growth and hip dislocation due to imbalanced muscle contraction. Till now, no treatment is available to reduce his impairment.

(National Dissemination Center for Children with Disabilities, 2011).

Disability – Disability is defined as any limitation or inability to perform an activity due to mental or physical disability. A child cannot walk is defined as disability. Special equipment and physical therapy can be used to improve his disability. If he uses a walker with braces then his disability will surely improved . Another example of disability is a four years old child suffers from cerebral palsy which results into tight and stiff legs and he is unable to stand, move and walk, disability is linked with the social restrictions imposed on the individual because of the society.

(The Equality Commission For Northern Ireland, 1995).

Handicap – A handicap is a drawback for an individual which results from a disability or impairment and precludes an individual from being normal. A child has cerebral palsy, this is called handicap which became an obstacle for him to perform a normal role in school, home and society. He was able to play with another children and interact with the family members and actively participate in the activities as his level of handicap is very mild. But as he grows old, his handicap also increases and he is unable to walk properly. Appropriate equipment's and services reduce the cerebral palsy of the child to some extent. (Ewemar S. 2008).

There was negative connotation between all the terms defined by the World Health Organization. According to the United Nations Standard Rules: these terms are defined as:-

Disability means that a person can become disabled due to mental illness or medical conditions and intellectual, physical and sensory impairment, such conditions may be transitory or permanent in nature.

Handicap means that person cannot take an active part in the activities of community like others. This term emphasizes on the organized activities of disabled people like communication, and limitations in the environment. These limitations prevent the disabled people to take part with other people. It is clear that handicap has many (personal, social and economic) consequences on the person, his family and the society. The following are the most common effects on the related parties.

(http://www.who.int).

Researcher concludes from the foregoing that there are differences over the definition of motor or physical disability, they gathered on the following:

- A defect in all the member responsible for the occurrence of such disability, whether bone or nerve or muscle or Aerha.

-The individual with disabilities lose their ability to perform the functions must be performed by the body and its activities relating to physical life.

- That this situation needs to get medical, psychological, social and professional.
- That may be caused by congenital or acquired.

Consequences of Disability:

There are several consequences of disability on the individuals, the families and communities, as follows. (http://www.saifscotland.org).

1) Consequences on individuals:-

- Decrease in dependence
- Inadequate socialization

- Lack of schooling
- Lack of jobs and income
- Being isolated and segregated

2) Consequences on Family:-

- Need for care
- Economic burden
- Social stigma
- Disturbed relationship
- Members who cannot participate

3) Consequences on society:-

- Discrimination within society
- Disturbed social relationships
- Losing productivity and increase in cost of service

Disability Rights:

The primary goal in the disability rights movement is to improve the quality of life of the people suffering from disabilities. This disability right movement started in 1970s which had taken various steps for the disabled people in the fields such as employment and education. These movements have made the disabled people taking an active part in the mainstream society. The most popular disability rights legislation were formulated in the U.S were the Rehabilitation Act and Americans with Disabilities Act. The Disability Rights of Education and Defense Fund was founded in 1979, which is a policy center formulated to protect and advance the various civil rights of disabled people through technical assistance, advocates, legislation, education and training of attorneys etc. There are various rights of a disabled person which one can avail in different areas of life. (http://www .Disability helper.com)

Rights in Employment:

The employment rights are the same for every employee including the disabled person but there are special provisions formulated for the disabled person under the Disability Discrimination Act. According to this Act, the employers cannot discriminate the disabled people in respect of employment unless it is mentioned in the act. This Act includes job offers, interview arrangements, application forms, and terms of employment, dismissal or redundancy and transfer, promotion or training opportunities. According to the Special Educational Needs and Disability Act 2001, the employers cannot discriminate the disabled students, pupils and adult learners from seeking education. It becomes the legal duty of the education providers to give equal status to the disabled people in schools, colleges and universities.

The education providers should provide them the necessary aid and make necessary adjustments for the disabled people.

Rights in Health care:

Disabled people should also get the same rights to access the social and health services such as dental surgeries, doctor surgeries and hospital services as other people. Doctor cannot stop the treatment of the person due to disability. Under the Act, the disabled people will get every facility to avail the health services.

(http://www.disabilityadjusted.com)

Mental Health Rights:

If the person is not able to carry out the normal day to day activities due to mental health and has an adverse and long term effect on their ability then they can avail the mental facilities under the Act. The person can suffer from different mental impairment which can be the result of disability such as depression, manic depression, learning disabilities and dementia...etc. (http://www .Disability helper.com)

Rights for Physical Disabilities:

The disabled person should have access to the private and public buildings and general accommodation under Discrimination Act. They can advocate the use of wide

doors, wheelchair ramps, corridors, automatic doors and eliminate the steps where elevators and ramps are not available. The disabled person can access any of these rights as stated under Disability Discrimination Act.

Types of Disability:

Under Disability Discrimination Act 1995 (DDA), a disability is a physical or mental impairment that has a long-term or substantial effect on person's ability to carry out day-to-day tasks. This ranges from people with physical and sensory impairments to people with diabetes, disfigurements, heart disease and epilepsy. Not all of these affect how an individual may access the internet however.

(The Equality Commission For Northern Ireland, 1995)

Eyesight:

This includes people with no vision, or some functional vision.... For example, the blind to read web pages use screen readers, and someone with poor vision may use screen magnification or adjust their browser settings to make reading more comfortable. This group also includes people with color blindness and those with eyesight problems related to ageing. (http://www.Disabilityhelper.com)

Hearing:

This includes people who are completely deaf or have partial hearing in one or both ears and require the use of a hearing aid. (http://www.disabilityaccessinfo.ca.gov)

Mobility:

This refers to a wide range of people with varying types of physical disabilities. With regards to the web which refers largely to people with upper limb mobility, manual dexterity and co-ordination problems. This can be caused though a disability that an individual is born with or one that develops due to illness such as Multiple Sclerosis (MS), Parkinson's or a stroke. People with a broken bone would also temporarily fall into the category. (http://public_typesofdisability.hcsp).

Cognitive:

Cognitive impairment refers to people with dyslexia and learning difficulties. Dyslexia is a condition where people have difficulties with reading, writing or spelling. Learning problems can range from someone who has a serious mental impairment, or may be due to more common factors as poor literacy, a low level of skill using a computer, having to use the web in a second language, or problems understanding information. (http://www.Disabilityhelper.com).

Physical handicapped:

Physical handicapped refers to a broad range of disabilities which include orthopedic, neuromuscular, cardiovascular and pulmonary disorders. People with these disabilities often rely upon assertive devices such as wheelchairs, crutches, canes, and artificial limbs to obtain mobility. The physical disability may either be congenital or a result of injury, muscular dystrophy, multiple sclerosis, cerebral palsy, amputation, heart disease, pulmonary disease or more. Some persons may have hidden disabilities which include pulmonary disease, respiratory disorders, epilepsy and other limiting conditions. (Akram & Naseem 2010:76).

Erickson & Lee defined physical handicapped by saying: A person with a disability which has any of the long-lasting conditions that substantially limit one or more physical activities such as walking, climbing stairs, reaching, lifting, or carrying.(Erickson & Lee, 2008:46)

Although the cause of the disability may vary persons with physical handicapped may face the following difficulties. (Terri Goldstein, etc. al, 1995: 47)

- Inability to gain access to inaccessible building or room.
- Decreased eye-hand coordination.
- Impaired verbal communication.
- Decreased physical stamina and endurance.

Types of physical handicapped

There are many different types of physical handicapped.

Some of the main ones include:

1) Muscular dystrophies:

When a child has muscular dystrophy, this means that the muscle fibers in the body gradually weaken over time. Children can have different types of muscular dystrophy. The most common type is Duchene Muscular Dystrophy which occurs only for males. All types of muscular dystrophy are genetic even though other family members may not have the condition. (Ahmady, 2005:76).

2) Acquired brain and spinal injuries:

Acquired brain injury refers to any type of brain damage that happens after birth. Causes include disease, substance abuse, oxygen deprivation, infection or a blow to the head.(http://www.betterhealth.vic.gov.au).

Physical disabilities may result from permanent injuries to the brain, spinal cord or limbs that prevent proper movement in parts of the body.

3) Spinal bifida:

Sometimes, a baby's spinal cords (the nerves that run down the spine) do not develop normally during pregnancy. When this happens, the child can have a physical disability called spinal bifida. The type and amount of disability caused by spinal bifida will depend upon the level of the abnormality of the spinal cord. Children with spinal bifida may have:

- Partial or full paralysis of the legs.
- Difficulties with bowel and bladder control.

They may also have:

- Hydrocephalus (high pressure on the brain because of fluid not being drained away as normal).
- Bone and joint deformities (they may not grow normally).
- Curvature (bending) of the spine.

4) Cerebral palsy:

Cerebral palsy is caused by damage to the parts of the brain which control movement during the early stages of development. In most cases this damage occurs during pregnancy. However, damage can sometimes occur during birth and from brain injuries in early infancy (such as lack of oxygen from near drowning, meningitis, head injury or being shaken).

Children with cerebral palsy may have difficulties with:

- Posture (the ability to put the body in a chosen position and keep it there).
- Movement of body parts or the whole body.
- Muscle weakness or tightness.
- Involuntary muscle movements (spasms).
- Balance and coordination.
- Talking and eating. (Caring together raising them strong 2012)

Causes of physical handicapped:

There are many different causes for physical handicapped. These include:

- Inherited or genetic disorders, such as muscular dystrophy.
- Conditions present at birth (congenital), such as spinal bifida.
- Serious illness affecting the brain, nerves or muscles, such as meningitis.
- Spinal cord injury.
- Brain injury.

Psychiatric symptoms:

Two particularly noteworthy developments have taken place in psychiatry in the last three decades. The classification of psychiatric disorders has become descriptive and the use of standardized assessment methods has grown rapidly (Myers & Winters, 2002:61). The reason behind both of these advances is the need for reliability.

Doctors can agree on what symptoms certain patient has, thus making the descriptive classification reliable. Standardized methods as rating scales allow reliable comparison and communication of findings in psychiatric research. Self-report questionnaires are rating scales that have unique properties, as they rely on the judgment

of the respondent. Because they are sensitive to administrative, environmental, cultural, and linguistic factors, they must be validated in each new patient population, language, or culture in which they are used. (Corcoran & Fischer, 2000:42).

Psychiatry is concerned with phenomenology and the study of mental phenomena. Signs and symptoms play a central role in the current conceptualization of psychiatry and communication within the field. Psychiatric signs are objective findings observed by the clinician, such as obvious motor restlessness, whereas symptoms are subjective experiences, such as a person's complaint of feeling depressed or anxious. Thus, with symptoms, a doctor must rely on the patient's self-report, often with no objective tests being available to confirm or disconfirm these symptoms. (Kessler et.al, 2000:41).

Classification of symptoms:

Most psychiatric textbooks provide an exhaustive list of psychiatric symptoms and signs classified in different ways. Psychiatric lexicons list over 200 psychiatric symptoms and signs (e.g. WHO, 1994: 12, Ayd, 1995)**.** Kaplan and Sadock's synopsis of psychiatry (Kaplan et.al, 1994) classifies them in the following way:

I. Consciousness: *A. Disturbances of consciousness*

B. Disturbances of attention

C. Disturbances in suggestibility

II. Emotion: *Affect*

Mood

Other emotions such as anxiety, fear, or apathy.

Physiological disturbances associated with mood

III. Motor behavior: for example, catatonia, stereotypy, and psychomotor agitation

IV. Thinking: *Disturbances in form or process of thinking*

Specific disturbances in form of thought

Specific disturbances in content of thought

V. Speech: *Disturbances in speech*

Aphasic disturbances

VI. Perception: *Disturbances of perception*

Disturbances associated with cognitive disorder

Disturbances associated with conversion and dissociation

VII. Memory: *Disturbances of memory*

VIII. Intelligence: *Mental retardation*

Dementia

Pseudodementia

Concrete thinking

Abstract thinking

IX. Insight

X. Judgment

This grouping of symptoms is only one of many ways to classify symptoms. Most psychiatric signs and symptoms have their roots in normal behavior and represents points along a continuum of behavior from normal to pathological.

(Kaplan et.al 1994:44).

Psychiatric rating scales:

A rating scale is a measuring instrument where the rated object is assigned to categories or continua that have numerals assigned to them. (Kerlinger & Lee, 2000:63).

The term rating scale includes self-reported rating scales (questionnaires) and observer rating scales. Psychiatric rating scales provide a means of quantifying aspects of a patient's psyche, behavior, and relationships with individuals and society.

(Myers & Winters, 2002:16).

Many psychiatric rating scales are able to measure carefully chosen features of well formulated concepts. They facilitate reliable comparison and communication of findings. The adequacy of rating scales can be judged in terms of their variability, reliability, validity, sensitivity, practicality, and interpretability. Good variability means that the scores on a particular sample are spread over the full range of the scale, not limited to one end of it. Reliability and validity are discussed in the following section. Sensitivity here does not mean case detection but rather the ability to detect changes in the measured construct. Practicality refers to how easy or difficult the use of a scale is in practice. Good interpretability refers to the meaning of particular scores and differences in score values over time or between individuals. (Stewart, 1990:72).

Summary:

Briefly, we will cover the following titles in the beginning; a comprehensive introduction, a review of healthcare history in Islam, the health services situation in Gaza Strip, the process of mental health development, the last war on Gaza, disability, the psychiatric symptoms recorded as a result of those injuries, and the role of doctors and nurses in finding treatments and reducing risks associated with such disabilities.

Chapter Three

Literature Review

Introduction:

In this chapter the researcher addresses some literature review that talked about disability as a result of wars, and the legacy of the psychological effects on the on the residents of these areas. In addition to studies that addressed the issue of psychiatric symptoms have disabled persons. Add to that some studies that talked about the last war on Gaza.

Literature Review

1- Richard F. Mollica (2001): Longitudinal Study of Psychiatric Symptoms, Disability, Mortality, and Emigration among Bosnian Refugees.

The study objective: The Objective of this study was investigated whether previously observed associations continue over time and are associated with mortality emigration to another region.

Target group of the study: Three-year follow-up study conducted in 1999 among 534 adult Bosnian refugees originally living in a refugee camp in Croatia. At follow-up, 376 (70.4%) remained living in the region, 39 (7.3%) were deceased, 114 (21.3%) had emigrated, and 5 (1%) were lost to follow-up. Those still living in the region and the families of the deceased were reinter viewed (77.7% of the original participants).

The study result: Results of this study in 1999 showed that, 45% of the original respondents who met the DSM-IV criteria for depression, PTSD, or both continued to have these disorders and 16% of respondents who were asymptomatic in 1996 developed 1 or both disorders. Forty-six percent of those who initially met disability criteria remained disabled. Log-linear analysis revealed that disability and psychiatric disorder were related at both times. Male sex, isolation from family, and older age were associated with increased mortality after adjusting for demographic characteristics, trauma history, and health status (for male sex, adjusted odds ratio [OR], 2.63; 95% confidence interval [CI], 1.17-5.92; living alone, OR, 2.40; 95% CI, 1.07-5.38; and each 10-year increase in age, OR, 1.91; 95% CI, 1.34-2.71). Depression was associated with higher mortality in unadjusted analysis but it was not after statistical adjustment (unadjusted OR, 3.12; 95% CI, 1.55-6.26; adjusted OR, 1.85; 95% CI, 0.82-4.16). Posttraumatic stress disorder was

not associated with mortality or emigration. Spending less than 12 months in the refugee camp (OR, 11.30; 95% CI, 6.55-19.50), experiencing 6 or more trauma events (OR, 3.34; 95% CI, 1.89-5.91), having higher education (OR, 1.90; 95% CI, 1.10-3.29), and not having an observed handicap (OR, 0.11; 95% CI, 0.02-0.52) were associated with higher likelihood of emigration. Depression was not associated with emigration status.

2- Rita Rosner et.al (2003): Posttraumatic Stress Disorder Three Years after the Siege of Sarajevo.

The study objective: The goals of this study were to estimate the lifetime prevalence of traumatic events, the current prevalence of Posttraumatic Stress Disorder (PTSD), and the connection between kinds of traumatic events experienced and the probability of developing PTSD in three study samples in Sarajevo, Bosnia-Herzegovina, three years after the end of the war.

Target group of the study: A total of 311 people surviving the siege of Sarajevo were assessed with the Checklist for War Related Experiences (CWE) and an adapted version of the Posttraumatic Diagnostic Scale (PDS). The study groups consisted of a randomly selected residents sample (n = 98), a group of individuals in psychological treatment (n = 114), and a group in medical treatment (n =99). Each individual survived an average of 24 traumatic events.

Results of the study: According to the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV; American Psychiatric Association, 1994) criteria, 18.6% of individuals in the resident's sample, 32.7% of those in medical treatment, and 38.6% of those in psychological treatment developed PTSD.

3- Vincent Dubois (2004): Household Survey of Psychiatric Morbidity in Cambodia.

The study objective: The Aims of this study was estimated the prevalence of psychiatric symptoms in the Kampong Cham province and to determine the association between these symptoms and an impaired social functioning

Target group of the study: Cross-sectional cluster sample survey conducted among adults randomly selected within 50 clusters distributed over the province.

Results of the study : The result of the study showed that of the respondents, 42.4% reported symptoms that met the Diagnostic and Statistical Manual of Mental Disorders, 4th edition criteria for depression, 53% displayed high anxiety symptoms and 7.3% met posttraumatic stress disorder (PTSD) criteria. Posttraumatic symptoms of intrusion and avoidance were present in 47.8% and 45.4% respectively. When reviewing comorbidities, 29.2% had depression and anxiety symptoms, 16.5% anxiety symptoms, 6.1% depression and 7.1% had triple comorbidity (PTSD, depression and anxiety). Regarding social functioning, 25.3% reported being socially impaired. Respondents with comorbid symptoms for depression, anxiety and PTSD were associated with an increased risk for social impairment compared with others. Being over 65 years and having experienced violent events were other factors associated with social impairment.

4- Barbara Lopes Cardozo (2004): mental health, social functioning, and Disability in Postwar Afghanistan.

The study objective: The Objective of this study was to provide national estimates of mental health status of the disabled (any restriction or lack of ability to perform an activity in the manner considered normal for a human being) and nondisabled Afghan population aged at least 15 years.

Target group of the study: A national multistage, cluster, population-based mental health survey of 799 adult household members (699 nondisabled and 100 disabled respondents) aged 15 years or older conducted from July to September 2002. Fifty district-level clusters were selected based on probability proportional to size sampling. One village was randomly selected in each cluster and 15 households were randomly selected in each village, yielding 750 households.

Results of the study: Results of the study showed that a total of 407 respondents (62.0%) reported experiencing at least 4 trauma events during the previous 10 years. The most common trauma events experienced by the respondents were lack of food and water (56.1%) for nondisabled persons and lack of shelter (69.7%) for disabled persons. The

prevalence of respondents with symptoms of depression was 67.7% (95% confidence interval [CI], 54.6%-80.7%) and 71.7% (95% CI, 65.0%-78.4%), and symptoms of anxiety 72.2% (95% CI, 63.8%-80.7%) and 84.6% (95% CI, 74.1%-95.0%) for nondisabled and disabled respondents, respectively. The prevalence of symptoms of PTSD was similar for both groups (nondisabled, 42.1%; 95% CI, 34.2%-50.1%; and disabled, 42.2%; 95% CI, 29.2%-55.2%). Women had significantly poorer mental health status than men did. Respondents who were disabled had significantly lower social functioning and poorer mental health status than those who were nondisabled. Feelings of hatred were high (84% of nondisabled and 81% of disabled respondents). Coping mechanisms included religious and spiritual practices; focusing on basic needs, such as higher income, better housing, and more food; and seeking medical assistance.

5- Abdel Aziz Mousa Thabet and Panos Vostanis (2005): Child Mental Health Problems in Gaza Strip.

The study objective: This study described the mental health characteristics of 150 children of 6-13 years of age, who had been referred to different types of services in Gaza Strip: a community mental health center, five primary health centers and a pediatric hospital.

Results of the study: There was a high rate of somatizing disorders among children referred to the mental health center (42%). Parent-reported rates of significant mental health problems were high for all groups, i.e., 70% in the mental health center group, 30% in the pediatric group, and 18% among children referred to primary health centers.

6- Mohammad Ahmadi (2005): handicapped in regular schools in Medina, reality and expectations.

The study objective: The study aims to conduct a field study to find out problems faced by physically disabled students as a result of joining the public schools from their point of view, and the appropriateness of the regular school environment for the integration and assimilation.

The study also aimed to identify the actual reality and hoped for the integration of this category of groups with special needs in regular schools in the light of the extrapolation of the theoretical heritage in research and previous studies.

The study tools: This study used the questionnaire to find out problems of integration faced by the physically disabled students in general education schools.

Questionnaire consisted of four areas: special problems of buildings and school equipment, the problems of a private room classroom, the problems of teachers and administrators, also special problems with colleagues.

Results of the study : The study found that the most important problems of integration faced by physically disabled students in general education schools has been narrowed down in two areas only: the problems of private buildings and school equipment, and the problems of a classroom.

Recommendation of the study: In light of the results of the study researcher proposed a model of educational services and environmental equipment that will help to build a regular public schools to be an educational environment appropriate to accommodate the physically disabled students.

7- Mustafa N. Al-Qamsh (2006): Problems of Mentally Handicapped Children at Home as Seen by Parents and Their Relationship with Some Variables.

The study objective: This study investigated the common problems among mentally handicapped children at home as seen by parents. The study also aimed to investigate the relationship between behavior problems and age, level of retardation, and sex.

Target people of the study: The study sample consisted of 240 parents of handicapped children (males and females). Their ages ranged from birth to 18 years. They were randomly chosen.

The researcher developed an instrument which consisted of 5 common problems: aggression, stereotypic behaviors, hyperactivity, self-injury, and social withdrawal. These dimensions are distributed on (47) items. Acceptable significant validity and reliability have been calculated and approved using the instrument in this study. Parents were asked

to respond to each problem according to its degree on a scale which starts from: the problem doesn't exist to it happens frequently.

The study results: Results indicated that the most common problems among mentally handicapped children at home from the parent's point of view successional: hyperactivity, social withdrawal, stereotypic behavior, aggression and self-injury. The age factor produced significant differences for some problems. Highly significant differences due to level of retardation were found for most problems studied. No significant sex differences were associated with behavior problems.

8- Kristy Muir (2007): The predisposition theory, human rights and Australian psychiatric casualties of war.

This research examined the history of psychological casualties of war from a human rights perspective. It questions whether the human rights of Australian service personnel and veterans have been upheld throughout Australia's military history and argues that the preoccupation with the belief that psychiatric casualties were not a result of war service, but were predisposed in individuals, meant that the human rights of these casualties were at times contravened. And this research explored the scale of psychological problems among Australian veterans and their families between the First World War and the Vietnam War; the changing understanding of what caused psychiatric casualties; how Australian governments and society responded; and whether the rights of soldiers or veterans with poor mental health were upheld. Understanding the history of how Australian service personnel and veterans with mental illness have been treated and perceived is important because of the lingering implications for current veterans and defense personnel.

9- Murphy H, Lloyd K. (2007): Civil conflict in Northern Ireland and the prevalence of psychiatric disturbance across the United Kingdom.

The study objective: The purpose of this study was compared rates of psychiatric morbidity across the United Kingdom, given that one region in particular, Northern Ireland, has experienced political conflict and civil strife for more than 35 years.

Target group of the study: The aims of this study were to assess the impact of low-intensity warfare on rates of psychiatric morbidity in Northern Ireland and to compare these with psychiatric morbidity rates across England, Scotland and Wales.

The sample consisted of 17,343 respondents completing the GHQ-12 across the United Kingdom. In England, 8286 respondents completed the GHQ-12 while 2729, 3165 and 3163 respondents from Wales, Scotland and Northern Ireland completed the GHQ-12 respectively. Results were then weighted according to population size.

Results of the study: The results of the study showed that Rates of psychiatric morbidity varied across each UK region. Wales had the highest mean GHQ-12 score (11.54), followed by Northern Ireland (11.41). English respondents had the lowest mean score (11.02). The difference in mean scores across the four regions in the UK was statistically significant ($F= 5.04$, $df = 3$, $p < 0.001$). Post-hoc analyses indicated that the mean scores for England differed significantly from those for Wales and Northern Ireland but not for Scotland. Region accounted for less than 1% of the variation in GHQ-12 scores.

10- A. Fernandez et.al (2007): Treatment adequacy for anxiety and depressive disorders in six European countries.

The study objective: The aims of this study were described the adequacy of treatment for anxiety and depressive disorders in Europe and how it differs between providers. The overall proportion of adequate treatment was 45.8% (57.4% in the specialized sector and 23.3% in the general medical care sector). Between-country differences were found in treatment adequacy in the specialized setting. Organizational and political aspects may explain these findings

Target group of the study: This study is based on a European epidemiological study of the prevalence and treatment of mental disorders.

Data for the project were provided by 21 425 respondents. A description of the ESEMeD methodology has been provided by Alonso et al (2004). Response rates ranged from 45.9% in France to 78.6% in Spain.

Data were weighted to adjust for the multistage probability sampling. Population projection weights were used to restore the representativeness of the sample regarding age and gender distribution in each country. A logistic model was used to analyses factors associated with treatment adequacy. Since the same individual could have received treatment in both the specialized and general medical sectors, a generalized estimating equation model was used, including two observations for those treated in both sectors

Results of the study: Results of this study showed an average of 29.5% (429 individuals) of those with a diagnosis of major depressive episode or anxiety disorder in the past 12 months had consulted any health service during that period. Of these individuals, 59 lived in Belgium, 89 in France, 49 in Germany, 36 in Italy, 62 in The Netherlands and 134 in Spain. The overall proportion of treatment adequacy for any disorder was 45.8% (95% CI 39.2–52.4), ranging between 45.8% (95% CI 38.47–53.05) for major depressive episode and 54.5% (95% CI 44.78–64.19) for anxiety disorder. By setting, rate of treatment adequacy for any disorder was 57.4% (95% CI 49.7–65.1) in the specialized care category and 23.3% (95% CI 16.7–29.8) in the general medical care category (specialized care as reference, OR=0.25, 95% CI 0.16–0.38). The same pattern was observed for both types of disorder.

11- Abdel Aziz Mousa Thabet et.al (2008): The relationship between Siege of Gaza Strip, anger, and psychological symptoms.

The study objective: The aim of the study was to investigate the impact of siege of the Gaza Strip on Palestinians feelings of anger and anger state in relation psychological symptoms in relation to other socioeconomic variables.

Target group of the study: A random sample of 386 adults ' age range (18-64 years) selected from a community base. The subjects were interviewed using the following tools: Sociodemographic scale, Gaza Siege Checklist, Symptom Checklist (BSI-53), and State–Trait Anger Expression Inventory.

Results of the study: The results showed that the most common impact of siege of Gaza items was: prices are sharply increased (97.67%), I feel I am in a big prison (92.23%), I cannot find things I need in the market (91.70%), I quitted some purchased daily needs (88.30%), and social visits are less than before (85.23%). The main

psychopathology showed that 75.91 % feel worthlessness, 56.5% blaming themselves for things, 55.7% feel that everything in life is difficult, 54.4% had nervousness, 41.8% feel tense or keyed up, and 41.1% feel easily annoyed or irritated.

The results showed that females reported more Somatization, obsessive compulsive disorder, and phobic anxiety. Palestinians live in camps reported more general psychological problems, Somatization, obsessive compulsive problems, interpersonal sensitivity, depression symptoms, anxiety, hostility, phobic anxiety, paranoid ideation than those in cities and village. However, psychosis symptoms were more common in people living in villages than in camps and cities. The results showed that there were statistically significant positive correlation between total siege scores and BSI in which people who scored more in siege items had more psychopathology, Somatization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, panic (phobic anxiety), paranoid ideation, and psychosis.

The results showed that the psychological problems were predicted by suffering of not being able to receive proper medical care, feeling of being in a big prison, sold some of furniture and gold, was not able to get specific medicine for themselves or for one of the family member, and quitted purchasing daily needs.

In this study, impact of siege on the Palestinians feelings of anger and inability to ventilate their anger, beside other socioeconomic adversities due to closure of the borders and unemployment due to siege lead to more psychological problems. This highlight the need to break down the siege on Gaza by supporting of the international organizations and this could be by lobbying with local and international human rights and civil society organizations to break the siege.

12- Kaoruko Seino et.al (2008): Prevalence of and factors influencing posttraumatic stress disorder among mothers of children under five in Kabul, Afghanistan, after decades of armed conflicts.

The study objective: The present study was performed to examine the impact of exposure to events related to armed conflicts on post-traumatic stress disorder (PTSD)

among women raising children, and to identify factors that alleviate the negative consequences of exposure to traumatic events.

Target group of the study: A structured interview survey was conducted in Kabul Province, Afghanistan, in 2006. The subjects were mothers of children less than 5 years old randomly selected from 1400 households in Kabul Province, Afghanistan. Symptoms of PTSD were assessed according to the criteria of Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). Exposure to traumatic events related to armed conflict, experience of hardship with regard to basic needs, resources that the subjects seek for mental health support, and socioeconomic variables were evaluated. Logistic regression analysis was performed to determine the association between PTSD symptoms and predictor variables.

Results of the study: Results of this study showed that prevalence rate of PTSD among 1172 women participated in this study was 29.8%. The most prevalent symptom was arousal (74.8%), followed by re-experiencing (54.9%) and avoidance (33.7%). The prevalence rate of PTSD symptoms among subjects who reported having experienced at least one event related to armed conflict (52.7%) was significantly higher than that among those who reported no such experiences (9.6%). Experience of food shortage was independently associated with PTSD. Seeking support for mental health was related to lower prevalence of PTSD symptoms among those who reported no direct experience of events related to armed conflict. However, no such relationship was observed with PTSD symptoms among those who reported having direct experience of events related to armed conflict.

13- Sigurjon B Stefansson, Elias Olafsson, Allen Hauser (2008): Psychiatric morbidity in epilepsy: a case controlled study of adults receiving disability benefits.

The study objective: The Objective of this study is to compare the prevalence of non-organic psychiatric disorders among disabled patients of normal intelligence with epilepsy with the prevalence of similar psychiatric disorders among age and sex matched disabled patients with other somatic diseases.

Results of the study: The results suggest that there is not a difference in the prevalence of non-organic psychiatric disorders among disabled patients of normal intelligence with epilepsy compared with patients with other disabling somatic diseases. However, the data indicate that when psychopathology is present disabled patients with epilepsy are more likely to have psychotic illness than the other disabled patients.

14- Altawil M., etc.al (2008): The Effects of Chronic War Trauma among Palestinian Children.

The study objective: to explore the long-term effects of war and occupation on the Palestinian children in Gaza Strip. 1,137 children aged between 10 and 18 years were randomly selected from all parts of Gaza Strip to participate in the study. The participants completed a Checklist of Traumatic Experiences (CTE), a Symptoms of Post-Traumatic Stress Disorder Scale (SPTSDS) and Personality Assessment Questionnaire (PAQ).

Results of the study: The research found that every child in Palestine had been exposed to at least three traumatic events. The most prevalent types of trauma exposure for Palestinian children were as follows: 99% of children had suffered humiliation (either to themselves or a family member); 97% had been exposed to the sound of explosions/bombs; 85% had witnessed a martyr's funeral and 84% had witnessed shelling by tanks, artillery, or military planes.

15- PM Shyangwa et.al (2009): Psychiatric morbidity among physically ill persons in eastern Nepal.

The study objective: The objective of this study is to estimate the prevalence of psychiatric morbidity among admitted physically ill patients. And to describe demographic characteristics, referral sources, pattern of referral and other relevant variables.

Target group of the study: This study investigated the prevalence and pattern of psychiatric morbidity among 151 physically ill psychiatric-referred cases admitted various departments in BPKIHS. Consecutive referral cases were initially worked up by junior residents and diagnosis/differential diagnosis were made by consultant according to ICD-10 diagnostic guidelines.

Results of the study: Of total 151; M: 77 (50.9%) and F: 74 (49.1); Majority 38 (25.1%) of subjects were young with age 15-24 years and 95 (62.9%) were from plains. About 21.8% referrals came from internal medicine followed by emergency department, 9 (5.9%). The highest number of cases 48 (31.7%) had neuropsychiatric illnesses and 17.0% had some medical complications resulted from suicide act.

Among psychiatric co morbidity, dissociative/conversion disorders were the commonest 26 (17.2%) followed by alcohol use-related disorders 25 (16.5%) and depressive disorder 20 (13.2%). The conclusion of this study was: the co-occurrence of medical and psychological/psychiatric conditions is common, which demands timely identification and early interventions in order to reduce morbidity and mortality.

16- Abu-Sakran A. (2009) The handicapped Psychological and social adjustment its relation with their center of control (internal - external) in Gaza Strip.

The study objective: This study tries to explain the relationship between the psychological and social alignment and the internal and external control for handicaps moreover this study tries to know more about the level between them in Gaza strip.

Study sample: The study sample consists of (360) handicaps from different varieties like (cerebral palsy CP, quadriplegia, flat foot and bowing of the leg….etc) in Gaza strip.

Study tools: The assessment of psychological and social alignment (by layla wait: 2006 and some improvement by searcher). The assessment of internal & external control (By alaa' kanafani: 1982 and some improvement to be suitable in Palestinian environment).

The study result: The results revealed that there is a difference statistically in the handicaps control as related to sex difference (male, female) in the study sample. There is no statistic difference in the handicap control related to marital state (single, married and widow, divorced). There is no statistic difference in the handicaps control related to the degree of impaired. There are statistic differences in the handicap social and psychological alignment related to the cause of handicap and more for the injured one and also related to congenital cause, injury cause.

17- Ananya Ray Laskar et.al (2010): Psychosocial Disorders among Disabled Children and Some Epidemiological Correlates.

The study objective: This Study aimed to assess the psychosocial changes and its determinants in disabled children in comparison with apparently healthy children so that

necessary modifications can be designed and implemented accordingly. A cross-sectional study was conducted from April 2005 to March 2006 in the Institute for Physically Handicapped, New Delhi.

Target group of the study: Parents of 100 children with physical disability of age group 6-15 years were interviewed using semi-structured questionnaire and Childhood Psychopathology Measurement.

Results of the study: Scale (CPMS). 37% of disabled children had psychosocial problems according to the CPMS scale, while among children without disability it was 17%. Presence of high proportion of psychosocial problem indicates a need for screening and early detection of psychosocial problems in developing rehabilitation programmes for children with physical disabilities.

18- Veronese A, Ayuso-Mateos JL & et.al (2012): The Impact of work disability and depressive disorders on the European population.

The study objective: The aim was to study the impact of depressive disorders on work disability to discover the determinants of depression for work disability in the European countries.

Target group of the study: The sample was composed of 31,126 individuals from 29 countries included in the 2002 World Health Survey of the World Health Organization. National representative samples of countries from all regions of Europe and with different levels of economic development and health coverage were selected.

Results of the study: Estimates of people not working because of ill health did not differ among European countries in relation to levels of economic development or health coverage. Significant determinants of people with diagnosis of depression not working because of ill health (reference category) versus working were age (odds ratio = 0.97), female sex (odds ratio = 1.71), education (odds ratio = 1.11), marital status (being unmarried indicating less probability), lowest income level, and comorbidity with angina pectoris (odds ratio = 0.51). Moreover, according to previous studies, we found some determinants (comorbidity with other diseases, young age, and unemployment) impacting on health status.

Conclusions: Depression is a substantial cause of work disability and it is a complex phenomenon that involves many variables. Investigation into this relationship should improve, focusing on the role of determinants.

19- Abeyasinghe NL, de Zoysa P & et.al (2012): The prevalence of symptoms of Post-Traumatic Stress Disorder among soldiers with amputation of a limb or spinal injury a report from a rehabilitation centre in Sri Lanka.

The study objective: This study was conducted to determine the prevalence of Post-Traumatic Stress Disorder among soldiers who had undergone amputation of a lower or an upper limb or sustained a spinal cord injury in the battlefield, and to compare the prevalence among these categories. The research presented seeks to increase the awareness of this condition among those treating war casualties so that appropriate treatment choices could be made to address them.

Target group of the study: The study was carried out in 2009 at a rehabilitation centre for combatants of war. Data were collected from 96 male army veterans between the ages of 18-49 years using a pre-tested self-administered questionnaire based on the Diagnostic and Statistical Manual of Mental Disorders, the Impact of Event Scale and the PTSD symptom scale. Soldiers with injuries sustained at least four weeks prior to the study were selected by a convenience sampling technique. Soldiers with multiple injuries, head injuries or those diagnosed with psychiatric disorders were excluded.

Results of the study: The results revealed that 41.7% of the study population was compatible with the diagnosis of Post-Traumatic Stress Disorder. Within the three groups, 42.5% of the lower limb amputees, 33.3% of the upper limb amputees and 45.7% of the participants with spinal cord injury had symptoms compatible with Post-Traumatic Stress Disorder. There was no difference between the prevalence among the different injury categories considered. This study highlights the need to pay more attention in providing psychological care as a part of the overall health management of injured combatants. Early preparation of soldiers for stressors of war and screening for and proper management of Post-Traumatic Stress Disorder will improve the overall outcome of rehabilitation.

20- Perkins ZB, De'Ath HD & et.al (2012): Factors affecting outcome after traumatic limb amputation.

The study objective: The aim of this review was to describe common causes of disability and highlight therapeutic interventions that may optimize outcome after traumatic leg amputation. A comprehensive search of medline, Embase and Cumulative Index to Nursing and Allied Health Literature databases was performed, using the terms 'leg injury', 'amputation' and 'outcome'. Articles reporting outcomes following traumatic leg amputation were included. Traumatic leg amputation commonly affects young, active people and leads to poor long-term outcomes.

Results: Studies demonstrated that pain; psychological illness, decreased physical and vocational function, and increased cardiovascular morbidity and mortality were common causes of disability after traumatic leg amputation. The evidence highlights that appropriate preoperative management and operative techniques, in conjunction with suitable rehabilitation and postoperative follow-up, can lead to improved treatment outcome and patient satisfaction.

Conclusions: Patients who undergo leg amputation after trauma are at risk of poor long-term physical and mental health. Clinicians involved in their care have many opportunities to improve their outcome using a variety of therapeutic variables.

Critique of previous studies

Previous studies have agreed as follows:

1. It focused on persons with physical disability, and estimated psychological symptoms that people suffer it. Such as **Thabet et.al (2008)** study, and **A. Fernandez et.al (2007)** study, and **Richard F. Mollica (2001),** and **Vincent Dubois (2004)** study, and **Murphy H, Lloyd K. (2007).**
2. Most of it depended on previous studies to explain or to investigate the relationships between physical disability and other variables. Such as **A. Fernandez et.al (2007) study** based on a European epidemiological study of the prevalence and treatment of mental disorders. And **Richard F. Mollica (2001) study,** three-year follow-up study conducted in 1999 among 534 adult Bosnian refugees originally living in a refugee camp in Croatia. And **Kristy Muir (2007)** examined the history of psychological casualties of war from a human rights perspective.

Previous studies have disagreed as follows:

1. It deals with impact of different factors on people such as **Thabet et. al (2008)** study investigated the impact of siege of Gaza Strip on Palestinians feelings of anger and anger state in relation psychological symptoms in relation to other socioeconomic variables. And **Sigurjon B Stefansson, and etc. al. (2008)** study compared the prevalence of non-organic psychiatric disorders among disabled patients of normal intelligence with epilepsy with the prevalence of similar psychiatric disorders among age and sex matched disabled patients with other somatic diseases. Generally speaking, the media experts act as a guardian of people's rights, especially the personnel of public relations.
2. It used different methods (questioners, a multidimensional model, etc.) to collect data and to highlight results. Such as **Mustafa N. Al-Qamsh (2006) study** developed an instrument which consisted of 5 common problems: aggression, stereotypic behaviors, hyperactivity, self-injury, and social withdrawal. And **Ananya Ray Laskar etc al (2010) study** used semi-structured questionnaire and Childhood Psychopathology Measurement Scale (CPMS).

3. It applied on different societies and on different samples, such as **A. Fernandez et.al (2007) study** described the adequacy of treatment for anxiety and depressive disorders in Europe and how it differs between providers, and **Richard F. Mollica (2001) study** investigated whether previously observed associations continue over time and are associated with mortality emigration to another region among Bosnian Refugees, and **Barbara Lopes Cardozo (2004)** study provided national estimates of mental health status of the disabled (any restriction or lack of ability to perform an activity in the manner considered normal for a human being) and nondisabled Afghan population aged at least 15 years. And **Rita Rosner et al (2003) study** estimated the lifetime prevalence of traumatic events, the current prevalence of Posttraumatic Stress Disorder (PTSD), and the connection between the kinds of traumatic events experienced and the probability of developing PTSD in three study samples in Sarajevo, Bosnia-Herzegovina, three years after the end of the war. And **Kaoruko Seino et al (2008)** study conducted in Kabul Province, Afghanistan, to examine the impact of exposure to events related to armed conflicts on post-traumatic stress disorder (PTSD) among women raising children, and to identify factors that alleviate the negative consequences of exposure to traumatic events. And **Vincent Dubois (2004)** study estimated the prevalence of psychiatric symptoms in the Kampong Cham province and to determine the association between these symptoms and an impaired social functioning.

Contributions of the study:

This study will investigate the prevalence of Psychiatric symptoms among physical handicapped persons who are victims of the last war on Gaza. The researcher found a lack of the previous studies that deal immediately with the same subject matter. This research is considered as one of the most important studies as an Analytical Approach to investigate the level of Psychiatric symptoms among physical handicapped persons who are victims of the last war on Gaza.

This study will contribute to the understanding of the reality of physically disabled people in Gaza Strip and suffer from it. Also shedding light on the most important mental symptoms from which they suffer, especially after the last war on Gaza Strip.

Chapter Four

Methodology and Procedures of study

Introduction:

In this chapter, the researcher presents the procedures and steps that were used in the study, also explains and clarifies methodology of the study, population of the study, selecting the sample of the study, tools and statistical methods that are used in the data analysis to get the results and the findings.

Methodology:

The researchers used the analytical descriptive approach that tries to answer the basic question and analyze the phenomenon, its nature and environment, explains the relationship between components; the description is about the units, conditions, relationships, categories, ratings, or patterns that already exist. This may include the views and attitudes, as well as the processes included, the effects and directions that emerged, it means that the descriptive approach study how the phenomenon works.

(Abuhatab & Sadeq, 1991: 104).

The Population of Study:

The study population consists of all physical handicapped persons who are victims of the last war on Gaza Strip (380 persons).

The Study tools:

Tools were used in this study:

1- The checklist symptoms SCL90. (L.R. Derogatis, R.S. Lipman, L.Covi).

2- Questionnaire to measure the other variable like gender, age, marital status, area of living, qualification, work status, monthly income, type of physical handicap.

The checklist symptoms SCL90:

Symptom-Checklist-90 (SCL-90) Designed by (Derogatis, Lipman & Covi, 1976), and have been issued a revised edition in 1986.It lists and widespread use in many global studies and list contains SCL-90 modified-like its predecessor (90) items measure a wide range of symptoms of mental disorders and measure existing nine sub-areas (Somatization - Obsessive compulsive - Interpersonal sensitivity – Anxiety - Depression-

Hostility-Phobic anxiety-Paranoia and Psychotic).In 1984 issued Abed AL-Raqib EL-Beheiri Arabic translation of the list from the original text exhibitors to explain the forms of the disturbances measured by the list of items and how to correct.

The Pilot sample of study:

A pilot sample was chosen that equals (50) of physical handicapped persons who are victims of the last war on Gaza Strip. This sample includes both gender (males and females) and the researcher conducting the validity and reliability analysis using appropriate statistical techniques.

The Overall sample of study:

The study sample was chosen to be totally (125) of physical handicapped persons who are victims of the last war on Gaza Strip, Note that the study population of 380 people and the researcher used systematic random sample and are intended to sample selection from among the original members of the community in a systematic manner. Continued researcher in the application of questionnaires on the study sample approximately 5 months has mobilized questionnaires by conducting interviews with people who have chosen· Noticed that varieties of age and qualification. The demographic characteristics of the sample are shown as follows:

Demographic characteristics of the study sample:

In order to figure out the features of the sample, frequencies and percentages were calculated for each of the demographic characteristics, related results are shown as follows:

Table (1): Demographic characteristics of the study sample (N=125)

The variable	Category	N	%
Gender	Male	96	76.8
	Female	29	23.2
Age (years)	18-25	46	36.8
	26-35	55	44.0
	36-45	20	16.0
	46 or more	4	3.2
Qualification	not educated/illiterate	3	2.4
	high school or less	74	59.2
	Diploma	27	21.6
	Bachelor	20	16.0
	post Graduate	1	0.8
Social Status	Married	58	46.4
	Single	46	36.8
	Divorced	14	11.2
	Widow	7	5.6
Area of living	Rafah	14	11.2
	Khanyounis	17	13.6
	Middle Zone	15	12.0
	Gaza	40	32.0
	North Gaza	39	31.2
Working status	Working	39	31.2
	not working	83	66.4
	Temporary unemployment	3	2.4
Month income (NIS)	1000 or less	79	63.2
	1001-2000	31	24.8
	2001-3000	15	12.0
Type of handicap	finger amputation	10	8.0
	hand amputation	24	19.2
	feet amputation	10	8.0
	leg amputation	11	8.8
	Other	70	56.0

From the previous table:

- For the Gender, most of the sample was males (76.8%), and the left (23.2%) were females.

- Age of the sample: majority of the sample were in between 26-35 years (44%), (36.8%) were having ages between 18-25 years, the least were aged more than 46 years (3.2%).

- Qualification: (59.2%) of the sample having "high school or less", and (21.6%) of the sample having "Diploma", and (0.8%) of the sample having "post Graduate".

- Social Status: majority of the sample were in between 26-35 years (44%), (36.8%) were having ages between 18-25 years, the least were aged more than 46 years (3.2%).

- Area of living: most of the sample lives in Gaza (32.0%), then those who are living the North Gaza (31.2%), and the least part of the sample live in Rafah (11.2%).

- Working status: most of the sample does not work (66.4%), while (31.2%) are working; finally (2.4%) are working as Temporary unemployment.

- Month Income: most of the sample have month income that is less than or equals1000 NIS (63.2%), then (24.8%) have monthly income between 1001 up to 2000 NIS, and the least amount of the sample have monthly income from 2001 up to 3000 NIS (12%)

- Type of Handicap: (19.2%) of the total sample are hand amputated, (8.8%) are leg amputated, (8.0%) are finger amputated, also (8.0%) are feet amputated, finally, (56%) are having other types of handicap.

Factors of the Study:

The researcher used a measure to study a list of symptoms (SCL-90), which measures 9 dimensions of psychiatric symptoms, the table below shows the nine dimensions of the SCL-90 measure and questions that are related to each dimension:

Table (2)

Shows the questions that related to each factor of the study

Nu.	Dimension	Item	Items
1	Somatization dimension	12	42-52-58-56-12-49-27-48-4-53-1-40
2	Obsessive Compulsive dimension	10	45-38-51-9-46-55-10-28-65-3
3	Interpersonal Sensitivity dimension	9	6-21-34-36-37-41-61-69-73
4	depression dimension	13	5-14-15-20-22-26-29-30-31-32-54-71-79
5	anxiety dimension	10	2-17-23-33-39-57-72-78-80-86
6	hostility dimension	6	11-24-63-67-74-81
7	Phobic Anxiety dimension	7	13-25-47-70-75-82-50
8	paranoid ideation dimension	6	8-18-43-68-76-83
9	psychotic dimension	10	7-16-35-62-77-84-85-87-81-90
10	Additional items	7	19-60-44-64-66-59-89
	Total	90	

Questionnaire Scaling:

The researchers have used a questionnaire to measure the response to the questionnaire's items as in the following table:

Table (3): Questionnaire scale

Response	Never	Rarely	Some times	Usually	Always
Degree	0	1	2	3	4

Pilot Study:

The researcher applied the measure of Psychiatric symptoms with the related items on a random sample (Pilot Study Sample) that was 50 of physically handicapped from the total population of the study. He selected the pilot sample and applied the measure on them to know how it is applicable in the Palestinian environment, also for calculating the validity and reliability coefficients of the measure using appropriate statistical methods.

Reliability and Validity of the Measure:

1- Validity of the Measure

The Validity of the measure of Psychiatric symptoms was calculated shown as follows:

Internal Consistency

The internal consistency is the second statistical test that used to test the validity of the test. The internal consistency indicates the correlation of the total of each item/ statement with the total degree of the method. It also indicates the correlation of the total of each method with the total of the measure

(Al Agha, 1997: p110).

To figure out the internal consistency, the researcher calculated the correlation coefficients between the degree of each dimension and the total degree of the measure, as well as the Pearson's correlation coefficient between the degree of each question (statement) and the total score of its related dimention, all of these are illustrated through the tables in the following:

Table (4)

Correlation coefficients betweenSCL-90 items of the domains and the total degree of the SCL-90 Scale

Nu.	Dimension	Pearson correlation	p-value
1	somatization dimension	0.79	0.001**
2	Obsessive Compulsive dimension	0.78	0.001**
3	Interpersonal Sensitivity dimension	0.88	0.001**
4	depression dimension	0.74	0.001**
5	anxiety dimension	0.76	0.001**
6	hostility dimension	0.60	0.001**
7	Phobic Anxiety dimension	0.75	0.001**
8	paranoid ideation dimension	0.75	0.001**
9	psychotic dimension	0.80	0.001**

** P-value<0.01 * P-value<0.05 // P-value>0.05

The results in the previous table showed that the correlation coefficients for the total of the measure of SCL-90 and all its related factors are to be statistically significant correlated at a level of significance (p-value < 0.01), the correlation coefficients of the total measure and the factors are ranging between (0.60 - 0.88), this gives a clear evidence that the researcher can be sure how appropriate is the measure to be applied onto the total sample of the study.

As the scale of SCL-90 has nine factors, correlation coefficients have been computed between the statements of each of the nine factors and the total score for each factor separately, this can be seen in the following tables:

Table (5)

Shows the Correlation coefficients between items of the somatization Symptom of the dimension and the total degree of the domain

Nu.	Symptoms of the Somatization dimension	Pearson correlation	p-value
1	Headaches	0.512	0.001**
4	Faintness or dizziness	0.618	0.001**
12	Pains in heart or chest	0.514	0.001**
27	Pains in lower back	0.631	0.001**
40	Nausea or upset stomach	0.585	0.001**
42	Soreness of muscles	0.545	0.001**
48	Trouble getting your breath	0.584	0.001**
49	Hot or cold spells	0.438	0.001**
52	Numbness or tingling in part of the body	0.615	0.001**
53	Lump in your throat	0.602	0.001**
56	Feeling weak in parts of your body	0.550	0.001**
58	Heavy feeling in your arms or legs	0.366	0.001**

** P-value<0.01 * P-value<0.05 // P-value>0.05

The results of the previous table showed that the total dimensions (Somatization) have very high correlation coefficients with each of its related statements, the significance was within a level less than 0.01, Pearson's correlation coefficients were ranging between (0.36 -0.61), and this indicates that the Symptom of Somatization and its related questions have a very high amount of validity.

Table(6)

Shows the Correlation coefficients between the items of the Obsessive Compulsive Symptom and the total degree of the factor

Nu.	Obsessive Compulsive dimension	Pearson correlation	p-value
3	Repeated unpleasant thoughts	0.363	0.001**
9	Trouble remembering things	0.651	0.001**
10	Worried about sloppiness or carelessness	0.419	0.001**
28	Feeling blocked in getting things done	0.670	0.001**
38	Having to do things very slowly to ensure correctness	0.580	0.001**
45	Having to check and double-check what you do	0.657	0.001**
46	Difficulty making decisions	0.674	0.001**
51	Your mind going blank	0.651	0.001**
55	Difficulty in concentration	0.733	0.001**
65	Having to repeat the same actions, such as touching, counting, washing	0.262	0.066//

** P-value<0.01 * P-value<0.05 // P-value>0.05

The results of the previous table showed that the total dimensions (Obsessive Compulsive) have very high correlation coefficients with each of its related statements, the significance was within a level less than 0.01, Pearson's correlation coefficients were ranging between (0.36 -0.73), and this indicates that the Symptom of Obsessive Compulsive and its related questions have a very high amount of validity.

Except statement (65) which appeared to be not statistically significant (p-value>0.05), and therefore it should be deleted from the dimensions and the whole measure.

Table (7)

Shows the Correlation coefficients between items of the Interpersonal Sensitivity Symptoms and the total degree of the factor

Item	Symptom of the Interpersonal Sensitivity dimension	Person correlation	p-value
6	Feeling critical of others Feeling uncomfortable about eating or drinking in public	0.767	0.001**
21	Feeling shy or uneasy with the opposite sex	0.700	0.001**
34	Your feelings being easily hurt	0.797	0.001**
36	Feeling others do not understand you or are unsympathetic	0.810	0.001**
37	Feeling that people are unfriendly or dislike you	0.846	0.001**
41	Feeling inferior to others	0.662	0.001**
61	Feeling uneasy when people are watching or talking about you	0.709	0.001**
69	Feeling very self-conscious with others	0.763	0.001**
73	Feeling uncomfortable about eating or drinking in public	-0.039	0.787//

** P-value<0.01 * P-value<0.05 // P-value>0.05

The results of the previous table showed that the total dimensions (Interpersonal Sensitivity) have very high correlation coefficients with each of its related statements, the significance was within a level less than 0.01, Pearson's correlation coefficients were ranging between (0.66 -0.84), and this indicates that the Symptom of Interpersonal Sensitivity and its related questions have a very high amount of validity.

Except statement (73) which appeared to be not statistically significant (p-value>0.05), and therefore it should be deleted from the dimensions and the whole measure.

Table(8)

Shows the Correlation coefficients between items of Symptoms of the depression dimension and the total degree of the domain

Item	Symptoms of the depression dimension	Person correlation	p-value
5	Loss of sexual interest or pleasure	0.581	0.001**
14	Feeling low in energy or slowed down	0.433	0.001**
15	Thoughts of ending your life	0.568	0.001**
20	Crying easily	0.662	0.001**
22	Feelings of being trapped or caught	0.210	0.143//
26	Blaming yourself for things	0.457	0.001**
29	Feeling lonely	0.441	0.001**
30	Feeling blue	0.647	0.001**
31	Worrying too much about things	0.625	0.001**
32	Feeling no interest in things	0.822	0.001**
54	Feeling hopeless about the future	0.429	0.001**
71	Feeling everything is an effort	0.449	0.001**
79	Feelings of worthlessness	0.623	0.001**

** P-value<0.01 * P-value<0.05 // P-value>0.05

The results of the previous table showed that the total dimensions (depression) have very high correlation coefficients with each of its related statements, the significance was within a level less than 0.01, Pearson's correlation coefficients were ranging between (0.42-0.82), and this indicates that the Symptom of depression and its related questions have a very high amount of validity.

Except statement (22) which appeared to be not statistically significant (p-value>0.05), and therefore it should be deleted from the dimensions and the whole measure.

Table (9)

Shows the Correlation coefficients between items of Symptoms of the anxiety dimension and the total degree of the domain

Item	Symptoms of the anxiety dimension	Person correlation	p-value
2	Nervousness or shaking inside	0.507	0.001**
17	Trembling	0.544	0.001**
23	Suddenly scared for no reason	0.457	0.001**
33	Feeling fearful	0.657	0.001**
39	Heart pounding or racing	0.628	0.001**
57	Feeling tense or keyed up	0.573	0.001**
72	Spells of terror or panic	0.497	0.001**
78	Feeling so restless you couldn't sit still	0.801	0.001**
80	The feeling that something bad is going to happen to you	0.554	0.001**
86	Thoughts or images of a frightening nature	0.580	0.001**

** P-value<0.01 * P-value<0.05 // P-value>0.05

The results of the previous table showed that the total dimensions (anxiety) have very high correlation coefficients with each of its related statements, the significance was within a level less than 0.01, Pearson's correlation coefficients were ranging between (0.45-0.80), and this indicates that the Symptom of anxiety and its related questions have a very high amount of validity.

Table (10)

Shows the Correlation coefficients between items of Symptoms of the hostility dimension and the total degree of the domain

Item	Symptoms of the hostility dimension	Person correlation	p-value
11	Feeling easily annoyed or irritated	0.45	0.001**
24	Temper outbursts that you could not control	0.84	0.001**
63	Having urges to beat, injure or harm someone	0.67	0.001**
67	Having urges to break or smash things	0.87	0.001**
74	Getting into frequent arguments	0.024//	0.86//
81	Shouting or throwing things	0.76	0.001**

** P-value<0.01 * P-value<0.05 // P-value>0.05

The results of the previous table showed that the total dimensions (hostility) have very high correlation coefficients with each of its related statements, the significance was within a level less than 0.01, Pearson's correlation coefficients were ranging between (0.45-0.87), and this indicates that the Symptom of hostility and its related questions have a very high amount of validity.

Except statement (74) which appeared to be not statistically significant (p-value>0.05), and therefore it should be deleted from the dimensions and the whole measure.

Table (11)

Show the Correlation coefficients between items of Symptoms of the Phobic Anxiety dimension and the total degree of the domain

Item	Symptoms of the Phobic Anxiety dimension	Person correlation	p-value
3	Feeling afraid in open spaces or on the street	0.66	0.001**
25	Feeling afraid to get out of your house alone	0.26	0.06//
47	Feeling away to travel on buses, subways or trains	0.47	0.001**
50	Having to avoid certain things, places or activities because they frighten you	0.80	0.001**
70	Feeling uneasy in crowds, such as shopping or at a movie	0.72	0.001**
75	Feeling nervous when you are left alone	0.68	0.001**
82	Feeling afraid you will faint in public	0.73	0.001**

** P-value<0.01 * P-value<0.05 // P-value>0.05

The results of the previous table showed that the total dimensions (Phobic Anxiety) have very high correlation coefficients with each of its related statements, the significance was within a level less than 0.01, Pearson's correlation coefficients were ranging between (0.47-0.80), and this indicates that the Symptom of Phobic Anxiety and its related questions have a very high amount of validity.

Except statement (25) which appeared to be not statistically significant (p-value>0.05), and therefore it should be deleted from the dimensions and the whole measure.

Table (12)

Show the Correlation coefficients between items of Symptoms of the paranoid ideation dimension and the total degree of the domain

Item	Symptoms of the paranoid ideation dimension	Person correlation	p-value
8	Feeling others are to blame for most of your troubles	0.57	0.001**
18	Feeling that most people cannot be trusted	0.63	0.001**
43	Feeling you are watched or talked about by others	0.89	0.001**
68	Having ideas or beliefs that others do not share	0.73	0.001**
76	Others not giving you proper credit for your achievements	0.74	0.001**
83	Feeling that people will take advantage of you if you let them	0.71	0.001**

** P-value<0.01 * P-value<0.05 // P-value>0.05

The results of the previous table showed that the total dimensions (paranoid ideation) have very high correlation coefficients with each of its related statements, the significance was within a level less than 0.01, Pearson's correlation coefficients were ranging between (0.57-0.89), and this indicates that the Symptom of paranoid ideation and its related questions have a very high amount of validity.

Table (13)

Shows the Correlation coefficients between items of Symptoms of the psychotic dimension and the total degree of the domain

Item	Symptoms of the psychotic dimension	Person correlation	p-value
7	The idea that someone else can control your thoughts	0.75	0.001**
16	Hearing voices that other people do not hear	0.78	0.001**
35	Other people being aware of your private thoughts	0.70	0.001**
62	Having thoughts that are not your own	0.30	0.03*
77	Feeling lonely when you are with people	0.78	0.001**
84	Having thoughts about sex that bother you a lot	0.53	0.001**
85	The idea that you should be punished for your sins	0.57	0.001**
87	The idea that something serious is wrong with your body	0.02	0.87//
88	Never feeling close to another person	0.78	0.001**
90	The idea that something is wrong with your mind	0.35	0.02*

** P-value<0.01 * P-value<0.05 // P-value>0.05

The results of the previous table showed that the total dimensions (psychotic) have very high correlation coefficients with each of its related statements, the significance was within a level less than 0.01, Pearson's correlation coefficients were ranging between (0.30-0.78), and this indicates that the Symptom of psychotics and its related questions have a very high amount of validity.

Except statement (87) which appeared to be not statistically significant (p-value>0.05), and therefore it should be deleted from the dimensions and the whole measure.

Note: The researcher delete 6 statements which correlation coefficient less than 0.3 by the test of Kaiser . This statements is (65-73-22-74-25-87).

Reliability of the SCL-90 Scale:

The measure is said to be reliable when it gives the same results if it is reapplied in the same conditions on the same sample. (Richard, 2004).

The reliability can be measured by both ways: Alpha Cronbach's and the Spilt- half techniques.

Cronbach's alpha:

To calculate the reliability of the test, the researcher used the following two methods:

Cronbach's Coefficient Alpha: $$\alpha = \frac{K}{K-1}\left(1 - \frac{\sum_{i=1}^{K}\sigma_{Y_i}^2}{\sigma_X^2}\right)$$

The researcher calculated the reliability of the test by using Alpha Cronbach's formula, (K) is the number of items of the test, (σ^2_{χ}) is the variance of the total test marks where (σ^2_{Yi}) is the component of the test and (i) is sample questions of the test (Cronbach's and Richard, 2004). 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 researcher found the reliability of the overall measure (SCL-90) by calculating the Cronbach's alpha coefficient (Nu. of items = 84); where the value of alpha = (0.95), and this indicates strongly that the measure has a high reliability amount, While the Cronbach's alpha coefficient coefficients for the nine dimensions of the measure were ranging in between (0.70 - 0.85), and this implies that both the whole measure and the related dimensions have a high reliability, which meets the requirements of applying the measure on the sample of the study. The following table shows the related details:

Table (14)

Cronbach's alpha values for the domains SCL-90 Scale

Nu.	Diemontion	Item	Cronbach's alpha
1	somatization dimension	12	0.77
2	Obsessive Compulsive dimension	9	0.75
3	Interpersonal Sensitivity dimension	8	0.85
4	depression dimension	12	0.77
5	anxiety dimension	10	0.78
6	hostility dimension	5	0.70
7	Phobic Anxiety dimension	6	0.74
8	paranoid ideation dimension	6	0.80
9	psychotic dimension	9	0.79
10	Additional items	7	0.46
Total		84	0.95

Split half method:

The researcher calculated the reliability of the SCL-90 measure by using split half method as another way to test the reliability, this method works by dividing the whole test items into two parts, then the correlation coefficients between the sum of items for the first part and the sum of items for the second part were calculated, Pearson's correlation coefficient for the whole measure was (0.88), and the Spearman-Brown formula was (0.93), this indicates that the test has a high degree of reliability, the following table shows the correlation coefficient and Spearman-Brown values of the whole questionnaire and its dimensions.

Table (15)
Constancy coefficient using half-split for the Scale -90 and its domains

Nu.	Diemontion	Person Correlation	Spilt- half
1	somatization dimension	0.66	0.79
2	Obsessive Compulsive dimension	0.59	0.74
3	Interpersonal Sensitivity dimension	0.77	0.87
4	depression dimension	0.62	0.76
5	anxiety dimension	0.63	0.77
6	hostility dimension	0.73	0.84
7	Phobic Anxiety dimension	0.60	0.75
8	paranoid ideation dimension	0.71	0.82
9	psychotic dimension	0.56	0.72
10	Additional items	0.31	0.47
Total		0.88	0.93

Statistical Methods:

To answer the study questions and hypotheses, the researchers used the following statistical methods:

- Frequencies and Percentages: used to help the researcher to describe the study sample.
- Mean, Standard deviation and percentage mean for describing the dimensions.
- Pearson's Correlation Coefficients to measure the degree of correlation as well to study the relation between variables.
- Cronbach's alpha coefficient and Split-half coefficient to determine the constancy of questionnaires' items.
- T-Test to determine the difference between the categories of the categorical variables (two categories).
- One-Way ANOVA to study the difference between the categories of the categorical variables (three or more categories).

Difficulties faced the researcher:

1- The difficulty of obtaining full statistical numbers specifically physically disabled.
2- Difficulties in sharing and completing the questionnaires from the sample.
3- Difficulty in choosing the sample away from bias.
4- The financial heaviness of preparing the tools and the copies.
5- The psychological issue of the researcher plays a role in the difficulties.
6- Instability of the situation where the problem of power outages for hours him great harm and burden on researcher.

Summary:

In the chapter, the researcher specified the main methodological parts. Including: the study design, study sample (study population, sample size, sampling process), study location, the measuring tools that were used in collection data, (description of the questionnaire of psychiatric symptoms), reliability and validity calculations, data collection procedures and data analysis procedures.

Chapter 5

Results & Discussion

Questions of the study:

-What are the Psychiatric symptoms among physical handicapped persons who are victims of the last war against Gaza?

The following question is illustrated from the above major one:

- What is the level of each of the Psychiatric symptoms: Somatization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobia, paranoia, psychotics among physical handicapped persons who are victims of the last war against Gaza Strip?

To figure out the Psychiatric symptoms among physical handicapped persons who were victims of the last war on Gaza, the followings were computed: the percentages, the percentage weights, means and STD dev for each single dimension, and the total Psychiatric symptoms. Related results are shown at the table below:

Table (16)

Shows the results of descriptive, percentages, and presented weight for (Psychiatric symptoms) and the related sub-factors

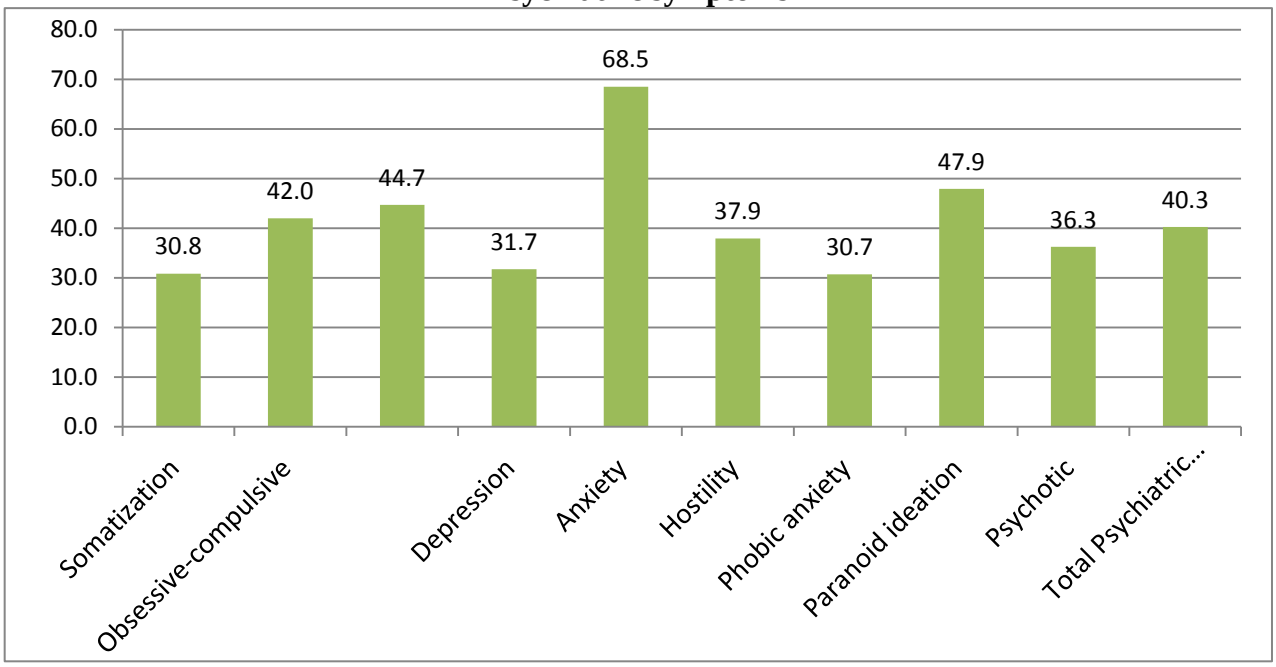
The Dimension	Nu. Qs	Total degree	Mean	Std. Dev	Percentage Weight	Order
Somatization	12	48	14.8	3.5	30.83	8
Obsessive Compulsive	10	40	16.8	4.7	42.00	4
Interpersonal Sensitivity	9	36	16.1	4.8	44.72	3
Depression	13	52	16.5	3.0	31.73	7
Anxiety	10	40	27.4	4.3	68.50	1
Hostility	6	24	9.1	2.5	37.92	5
Phobic Anxiety	7	28	8.6	2.6	30.71	9
Paranoid ideation	6	24	11.5	3.6	47.92	2
Psychotic	10	40	14.5	4.8	36.25	6
Total Psychiatric symptoms	84	336	135.3	23.5	40.27	-

From the previous table:

For the level of each of the Psychiatric symptoms among physical handicapped for persons who were victims of the last war on Gaza, the results showed that the most common dimension was the Anxiety with percentage weight equals 68.5%, and this implies how high degrees of Anxiety the sample have, then comes the dimension of Paranoid ideation percentage weight equals 47.9%, then the Interpersonal Sensitivity with percentage weight equals 44.7%, the least common dimension was the Phobic Anxiety with percentage weight equals 30.7%, and this shows that the sample have low degrees of that dimension for physical handicapped persons who were victims of the last war against Gaza.

For the Total Psychiatric symptoms among physical handicapped persons who were victims of the last war on Gaza, the percentage weight was 40.27%, that shows that the sample of handicapped persons have slightly moderated amount of the overall Psychiatric symptoms.

Figure (1)
Shows the orders, percentages, for all sub-factors and the total factor of Psychiatric symptoms



Hypotheses of the Study:

- There are no statistical significant differences at ($\alpha \leq 0.05$) in Psychiatric symptoms due to demographic characteristics of the sample?

And this hypothesis sub-divided into the following hypotheses:

1. There are no statistical significant differences at ($\alpha \leq 0.05$) in Psychiatric symptoms due to gender?

To figure out that, the researcher used two independent samples T-Test to figure out the differences between the **Psychiatric symptoms** of handicapped persons who are victims of the last war on Gaza towards the gender (male, female) of the sample.

Table (17)

Shows the results of t-test for the differences of the Psychiatric symptoms in terms of gender

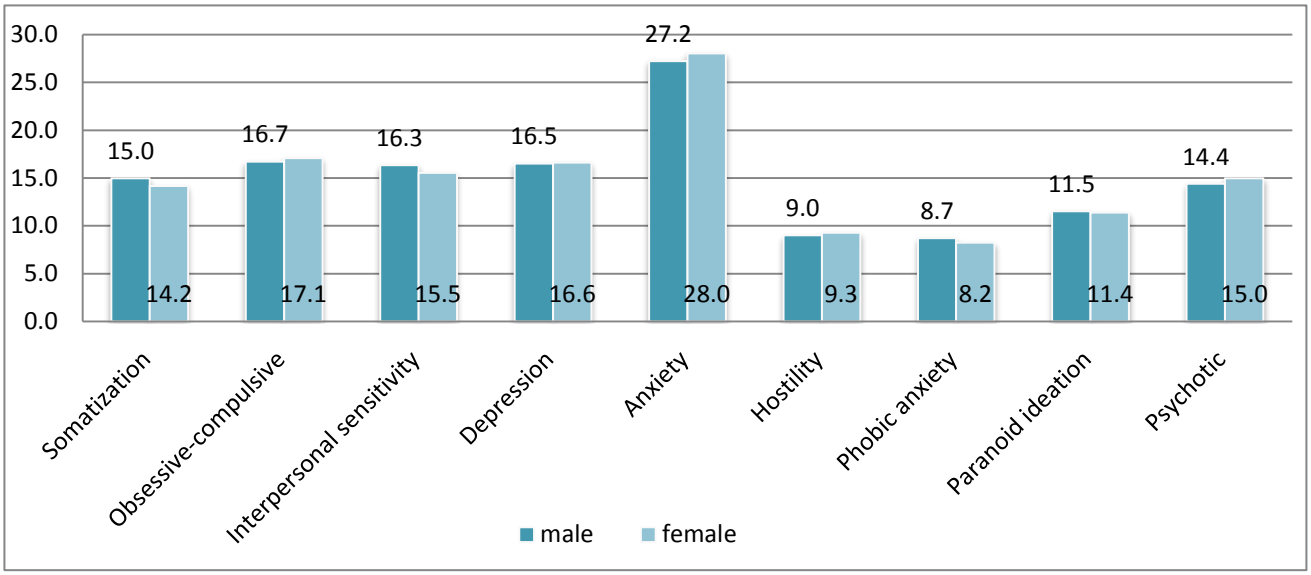
The Dimension	Male (N=95)		Female (N=29)		T-test	p-value
	Mean	Std. Dev.	Mean	Std. Dev.		
Somatization	14.97	3.55	14.17	3.49	1.06	0.29\\
Obsessive Compulsive	16.72	3.85	17.07	7.00	-0.35	0.73\\
Interpersonal Sensitivity	16.33	4.45	15.52	5.72	0.80	0.43\\
Depression	16.50	3.11	16.61	2.38	-0.17	0.87\\
Anxiety	27.22	4.50	28.03	3.37	-0.89	0.37\\
Hostility	9.00	2.52	9.28	2.53	-0.52	0.61\\
Phobic Anxiety	8.72	2.56	8.24	2.61	0.87	0.39\\
Paranoid ideation	11.52	3.57	11.38	3.70	0.18	0.86\\
Psychotic	14.40	4.63	14.97	5.36	-0.56	0.58\\
Total Psychiatric symptoms	135.35	23.87	135.14	22.63	0.04	0.97\\

** P-value<0.01 * P-value<0.05 \\ P-value>0.05

- There were no statistical significant differences (P-value>0.05) between the means of the following Psychiatric symptoms dimensions (Somatization, Obsessive-compulsive, Interpersonal sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation, Psychotic, Total Psychiatric symptoms) for handicapped persons who are victims of the last war on Gaza, toward the gender. Which means that the handicapped males and females have the same degrees **Psychiatric symptoms.**

Figure (2)

Shows the means for the Psychiatric symptoms for males and females



2. There are no statistical significant differences at (α≤0.05) in Psychiatric symptoms due to the age of the sample?

To figure out that, the researcher used One-way ANOVA test to figure out the differences between the Psychiatric symptoms of handicapped persons who are victims of the last war on Gaza towards the age Categories (18-25 years, 26-35 years, 36-45 years, 46 years or more), as shown at the following table:

Table (18)
Shows the results of One-way ANOVA for the differences of the Psychiatric symptoms in terms of age

The Dimension	Category	Sum of Squares	d.f.	Mean Square	F test	p-value
Somatization	Between Groups	8.1	3	2.7	0.21	0.887\\
	Within Groups	1528.9	120	12.7		
	Total	1537.1	123			
Obsessive Compulsive	Between Groups	33.2	3	11.1	0.48	0.691\\
	Within Groups	2748.7	121	22.7		
	Total	2782.0	124			
Interpersonal Sensitivity	Between Groups	63.4	3	21.1	0.92	0.429\\
	Within Groups	2731.2	120	22.7		
	Total	2794.6	123			
Depression	Between Groups	10.6	3	3.5	0.40	0.752\\
	Within Groups	1062.2	120	8.8		
	Total	1072.9	123			
Anxiety	Between Groups	37.4	3	12.4	0.68	0.565\\
	Within Groups	2180.3	119	18.3		
	Total	2217.8	122			
Hostility	Between Groups	17.3	3	5.7	0.91	0.438\\
	Within Groups	768.1	121	6.3		
	Total	785.4	124			
Phobic Anxiety	Between Groups	8.0	3	2.6	0.40	0.753\\
	Within Groups	803.5	120	6.6		
	Total	811.6	123			
Paranoid Ideation	Between Groups	28.2	3	9.4	0.72	0.536\\
	Within Groups	1550.6	120	12.9		
	Total	1578.9	123			
Psychotic	Between Groups	78.2	3	26.0	1.14	0.335\\
	Within Groups	2764.8	121	22.8		
	Total	2843.1	124			
Total Psychiatric Symptoms	Between Groups	899.8	3	299.9	0.53	0.658\\
	Within Groups	64193.2	115	558.2		
	Total	65093.1	118			

** P-value<0.01 * P-value<0.05 \\ P-value>0.05

The previous table shows that there were no significant differences (P-value>0.05) between the means of the following Psychiatric symptoms: (Somatization, Obsessive-compulsive, Interpersonal sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid Ideation, Psychotic, Total Psychiatric Symptoms), of handicapped persons who are victims of the last war on Gaza toward the age Categories, which means that persons with all ages have the same degrees of the dimensions of Psychiatric symptoms that mentioned above.

3. There are no statistical significant differences at ($\alpha \leq 0.05$) in Psychiatric symptoms due to Qualification?

To figure out that, the researcher used One-way ANOVA test to figure out the differences between the Psychiatric symptoms of handicapped persons who are victims of the last war on Gaza towards the qualification Categories (not educated, high school or less, Diploma, post graduate).

Table (19)
Shows the results of One-way ANOVA for the differences of the Psychiatric symptoms in terms of Qualification

The Dimension	Category	Sum of Squares	d. f.	Mean Square	F test	p-value
Somatization	Between Groups	73.1	4	18.3	1.48	0.156\\
	Within Groups	1464.1	119	12.3		
	Total	1537.1	123			
Obsessive Compulsive	Between Groups	118.9	4	29.7	1.34	0.562\\
	Within Groups	2663.1	120	22.2		
	Total	2782.0	124			
Interpersonal Sensitivity	Between Groups	159.6	4	39.9	1.80	0.108\\
	Within Groups	2635.0	119	22.1		
	Total	2794.7	123			
Depression	Between Groups	21.8	4	5.4	0.62	0.747\\
	Within Groups	1051.1	119	8.8		
	Total	1072.9	123			
Anxiety	Between Groups	22.8	4	5.7	0.31	0.937\\
	Within Groups	2195.0	118	18.6		
	Total	2217.9	122			
Hostility	Between Groups	46.1	4	11.5	0.87	0.201\\
	Within Groups	739.4	120	6.2		
	Total	785.5	124			
Phobic Anxiety	Between Groups	57.5	4	14.4	2.27	0.132\\
	Within Groups	754.1	119	6.3		
	Total	811.6	123			
Paranoid Ideation	Between Groups	55.3	4	13.8	1.08	0.27\\
	Within Groups	1523.6	119	12.8		
	Total	1579.0	123			
Psychotic	Between Groups	131.3	4	32.8	1.45	0.217\\
	Within Groups	2711.8	120	22.6		
	Total	2843.2	124			
Total Psychiatric Symptoms	Between Groups	3147.0	4	786.8	1.45	0.094\\
	Within Groups	61946.1	114	543.4		
	Total	65093.1	118			

** P-value<0.01 * P-value<0.05 \\ P-value>0.05

The previous table shows that there were no significant differences (P-value>0.05) between the means of the following Psychiatric symptoms: (Somatization, Obsessive-compulsive, Interpersonal sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid Ideation, Psychotic, Total Psychiatric Symptoms), of handicapped persons who are victims of the last war on Gaza towards the qualification Categories, which means that persons with all educational levels have the same degrees of the dimensions of Psychiatric symptoms that mentioned.

4. There are no statistical significant differences at ($\alpha \leq 0.05$) in Psychiatric symptoms due to social Status?

To figure out that, the researcher used One-way ANOVA test to figure out the differences between the Psychiatric symptoms of handicapped persons who are victims of the last war on Gaza towards the social status Categories: (single, married, divorced, widow).

Table (20)
Shows the results of One-way ANOVA for the differences of the Psychiatric symptoms in terms of the marital status

The Dimension	Category	Sum of Squares	d. f.	Mean Square	F test	p-value
Somatization	Between Groups	39.6	3	13.2	1.05	0.370\\
	Within Groups	1497.5	120	12.4		
	Total	1537.1	123			
Obsessive Compulsive	Between Groups	13.2	3	4.4	0.19	0.901\\
	Within Groups	2768.7	121	22.8		
	Total	2782.0	124			
Interpersonal Sensitivity	Between Groups	203.9	3	67.9	3.14	0.028*
	Within Groups	2590.6	120	21.5		
	Total	2794.6	123			
Depression	Between Groups	4.9	3	1.6	0.18	0.905\\
	Within Groups	1067.9	120	8.8		
	Total	1072.9	123			
Anxiety	Between Groups	16.8	3	5.6	0.30	0.823\\
	Within Groups	2201.0	119	18.4		
	Total	2217.8	122			
Hostility	Between Groups	6.5	3	2.1	0.34	0.796\\
	Within Groups	778.9	121	6.4		
	Total	785.4	124			
Phobic Anxiety	Between Groups	46.8	3	15.6	2.45	0.067\\
	Within Groups	764.7	120	6.3		
	Total	811.6	123			
Paranoid Ideation	Between Groups	91.3	3	30.4	2.45	0.066\\
	Within Groups	1487.6	120	12.3		
	Total	1578.9	123			
Psychotic	Between Groups	172.7	3	57.5	2.61	0.055\\
	Within Groups	2670.3	121	22.0		
	Total	2843.1	124			
Total Psychiatric Symptoms	Between Groups	1314.3	3	438.1	0.79	0.502\\
	Within Groups	63778.7	115	554.5		
	Total	65093.1	118			

** P-value<0.01 * P-value<0.05 \\ P-value>0.05

The previous table shows that there were no significant differences (P-value>0.05) between the means of the following Psychiatric symptoms: (Somatization, Obsessive-compulsive, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid Ideation ,Psychotic, Total Psychiatric Symptoms), of handicapped persons who are victims of the last war on Gaza towards the social status Categories, which means that persons with all social status have the same degrees of the Psychiatric symptoms dimensions that mentioned.

There were statistical significant differences (F-test = 3.14, P-value<0.01) between the degrees of Interpersonal sensitivity of handicapped persons who are victims of the last war on Gaza towards the social status Categories, the test of LSD (Least Square Differences) was used to figure out the differences in between the categories of social status. The test showed that the significant differences were toward those handicapped who are divorced; this means that they have less degrees of Interpersonal sensitivity than the handicapped that have the following social statuses (single, married, widow) in terms of handicapped persons who are victims of the last war on Gaza.

Table (21)
Shows the results of LSD for the differences of Psychiatric symptoms in terms of the marital status

The Dimension	Social Status	N	Means	Widow	divorced	single	married
Interpersonal sensitivity	married	58	16.59	1.99\\	3.73**	0.39\\	1
	single	45	16.20	2.37\\	3.34*	1	-
	divorced	14	12.86	5.71**	1	-	-
	widow	7	18.57	1	-	-	-

5. There are no statistical significant differences at ($\alpha \leq 0.05$) in Psychiatric symptoms due to Area of Living?

To figure out that, the researcher used One-way ANOVA test to figure out the differences between the Psychiatric symptoms of handicapped persons who are victims of the last war on Gaza towards the Area of living Categories: (Rafah, Khanyounis, Middle Zone, Gaza, and North Gaza).

Table (22)
Shows the results of One-way ANOVA for the differences of the Psychiatric symptoms in terms of the Area of living

The Dimension	Category	Sum of Squares	d. f.	Mean Square	F test	p-value
Somatization	Between Groups	89.2	4	22.3	1.83	0.127\\
	Within Groups	1447.9	119	12.2		
	Total	1537.1	123			
Obsessive Compulsive	Between Groups	482.6	4	120.6	6.30	0.000**
	Within Groups	2299.4	120	19.2		
	Total	2782.0	124			
Interpersonal Sensitivity	Between Groups	245.3	4	61.3	2.86	0.026*
	Within Groups	2549.3	119	21.4		
	Total	2794.7	123			
Depression	Between Groups	41.0	4	10.3	1.18	0.322\\
	Within Groups	1031.9	119	8.7		
	Total	1072.9	123			
Anxiety	Between Groups	171.3	4	42.8	2.47	0.048*
	Within Groups	2046.5	118	17.3		
	Total	2217.9	122			
Hostility	Between Groups	131.2	4	32.8	6.02	0.000**
	Within Groups	654.3	120	5.5		
	Total	785.5	124			
Phobic Anxiety	Between Groups	36.1	4	9.0	1.39	0.243\\
	Within Groups	775.5	119	6.5		
	Total	811.6	123			
Paranoid Ideation	Between Groups	103.3	4	25.8	2.08	0.087\\
	Within Groups	1475.7	119	12.4		
	Total	1579.0	123			
Psychotic	Between Groups	158.7	4	39.7	1.77	0.139\\
	Within Groups	2684.4	120	22.4		
	Total	2843.2	124			
Total Psychiatric Symptoms	Between Groups	7742.7	4	1935.7	3.85	0.006**
	Within Groups	57350.4	114	503.1		
	Total	65093.1	118			

** P-value<0.01 * P-value<0.05 \\ P-value>0.05

The previous table shows that there were no significant differences (P-value>0.05) between the means of the following Psychiatric symptoms: (Somatization, Depression, Phobic anxiety, Paranoid Ideation, Psychotic), of handicapped persons who are victims of the last war on Gaza towards the area of living Categories, which means that persons that live in all areas have the same degrees of the Psychiatric symptoms dimensions that mentioned previously.

- There were statistical significant differences (F-test = 6.30, P-value<0.01) between the degrees of Obsessive Compulsive of handicapped persons who are victims of the last war on Gaza towards the area of living Categories, the test of LSD (Least Square Differences) was used to figure out the differences in between the categories of living area. The test showed that the significant differences were toward those handicapped that live in Gaza; this means that they have more degrees of Obsessive Compulsive than the handicapped that live in North Gaza in terms of handicapped persons who are victims of the last war on Gaza.

- There were statistical significant differences (F-test = 2.86, P-value<0.05) between the degrees of Interpersonal Sensitivity of handicapped persons who are victims of the last war on Gaza towards the area of living Categories, the test of LSD (Least Square Differences) was used to figure out the differences in between the categories of living area. The test showed that the significant differences were toward those handicapped that live in Gaza; this means that they have more degrees of Interpersonal Sensitivity than the handicapped that live in the following areas (Khanyounis, Middle Zone, and North Gaza) in terms of handicapped persons who are victims of the last war on Gaza. Other significant differences were toward the area Gaza, which means that handicapped who live in Gaza have less degrees of Interpersonal Sensitivity than the handicapped that live in Rafah in terms of handicapped persons who are victims of the last war on Gaza.

- There were statistical significant differences (F-test = 2.47, P-value<0.05) between the degrees of Anxiety of handicapped persons who are victims of the last war on Gaza towards the area of living Categories, the test of LSD (Least Square Differences) was used to figure out the differences in between the categories of living area. The test showed that the significant differences were toward those handicapped that live in

North Gaza; this means that they have less degrees of Anxiety than the handicapped that live in Gaza in terms of handicapped persons who are victims of the last war on Gaza.

- There were statistical significant differences (F-test = 6.02, P-value<0.01) between the degrees of Hostility of handicapped persons who are victims of the last war on Gaza towards the area of living Categories, the test of LSD (Least Square Differences) was used to figure out the differences in between the categories of living area. The test showed that the significant differences were toward those handicapped that live in North Gaza; this means that they have less degrees of Hostility than the handicapped that live in the following areas (Khanyounis, Middle Zone, and Gaza), in terms of handicapped persons who are victims of the last war on Gaza.

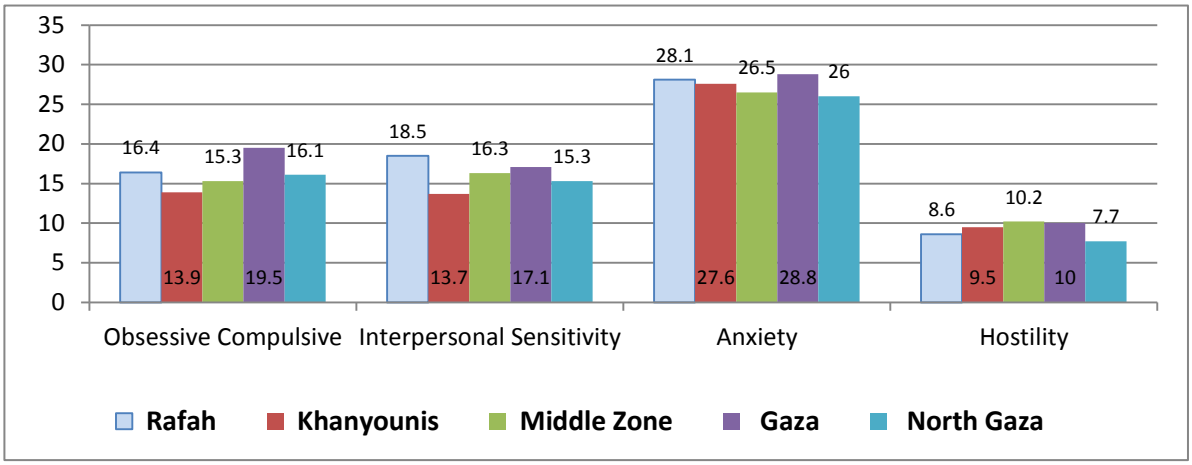
- There were statistical significant differences (F-test = 3.85, P-value<0.01) between the degrees of Total Psychiatric Symptoms of handicapped persons who are victims of the last war on Gaza towards the area of living Categories, the test of LSD (Least Square Differences) was used to figure out the differences in between the categories of living area. The test showed that the significant differences were toward those handicapped that live in North Gaza; this means that they have fewer degrees of Total Psychiatric Symptoms than the handicapped that live in the following areas (Gaza and Rafah) in terms of handicapped persons who are victims of the last war on Gaza. Other significant differences were toward the area Gaza, which means that handicapped that live in Gaza have more degrees of Total Psychiatric Symptoms than the handicapped that live in Khanyounis in terms of handicapped persons who are victims of the last war on Gaza.

Table (23)
Shows the results of LSD for the differences of Psychiatric symptoms in terms of the area of living

The Dimension	Area	N	Means	North Gaza	Gaza	Middle Zone	Khanyounis	Rafah
Obsessive Compulsive	Rafah	14	16.4	0.151//	0.793//	0.865//	0.432//	1
	Khanyounis	17	13.9	0.554//	0.198//	0.318//	1	-
	Middle Zone	15	15.3	0.085//	0.950//	1	-	-
	Gaza	40	19.5	0.017*	1	-	-	-
	North Gaza	39	16.1	1	-	-	-	-
Interpersonal Sensitivity	Rafah	14	18.5	0.852//	0.025*	0.504//	0.120//	1
	Khanyounis	17	13.7	0.084//	0.000**	0.374//	1	-
	Middle Zone	15	16.3	0.531//	0.002**	1	-	-
	Gaza	40	17.1	0.001**	1	-	-	-
	North Gaza	38	15.3	1	-	-	-	-
Anxiety	Rafah	14	28.1	0.114//	0.565//	0.322//	0.748//	1
	Khanyounis	17	27.6	0.194//	0.311//	0.476//	1	-
	Middle Zone	15	26.5	0.675//	0.073//	1	-	-
	Gaza	39	28.8	0.004**	1	-	-	-
	North Gaza	38	26.0	1	-	-	-	-
Hostility	Rafah	14	8.6	0.229//	0.060//	0.063//	0.258//	1
	Khanyounis	17	9.5	0.008**	0.535//	0.419//	1	-
	Middle Zone	15	10.2	0.001**	0.724//	1	-	-
	Gaza	40	10.0	0.000**	1	-	-	-
	North Gaza	39	7.7	1	-	-	-	-
Total Psychiatric Symptoms	Rafah	13	142.9	0.030*	0.788//	0.236//	0.075//	1
	Khanyounis	16	127.9	0.900//	0.012*	0.542//	1	-
	Middle Zone	15	132.8	0.402//	0.080//	1	-	-
	Gaza	38	144.9	0.001**	1	-	-	-
	North Gaza	37	127.0	1	-	-	-	-

** P-value<0.01 * P-value<0.05 \\ P-value>0.05

Figure (3): Shows the differences of the Psychiatric symptoms in terms of the Area of living



6. There are no statistical significant differences at ($\alpha \leq 0.05$) in Psychiatric symptoms due to Working Status?

To figure out that, the researcher used One-way ANOVA test to figure out the differences between the Psychiatric symptoms of handicapped persons who are victims of the last war on Gaza towards the working status Categories: (Working, not working, temporary unemployment).

Table (24)

Shows the results of One-way ANOVA for the differences of the Psychiatric symptoms in terms of the working status

The Dimension	Category	Sum of Squares	d. f.	Mean Square	F test	p-value
Somatization	Between Groups	131.2	2	65.6	5.64	0.005**
	Within Groups	1405.8	121	11.6		
	Total	1537.1	123			
Obsessive Compulsive	Between Groups	76.8	2	38.4	1.73	0.181\\
	Within Groups	2705.1	122	22.1		
	Total	2782.0	124			
Interpersonal Sensitivity	Between Groups	169.7	2	84.8	3.91	0.023*
	Within Groups	2624.9	121	21.6		
	Total	2794.6	123			
Depression	Between Groups	45.4	2	22.7	2.67	0.073\\
	Within Groups	1027.4	121	8.4		
	Total	1072.9	123			
Anxiety	Between Groups	50.8	2	25.4	1.40	0.249\\
	Within Groups	2167.0	120	18.0		
	Total	2217.8	122			
Hostility	Between Groups	9.3	2	4.6	0.73	0.480\\
	Within Groups	776.1	122	6.3		
	Total	785.4	124			
Phobic Anxiety	Between Groups	63.9	2	31.9	5.17	0.007**
	Within Groups	747.6	121	6.1		
	Total	811.6	123			
Paranoid Ideation	Between Groups	97.2	2	48.6	3.97	0.021*
	Within Groups	1481.6	121	12.2		
	Total	1578.9	123			
Psychotic	Between Groups	244.7	2	122.3	5.74	0.004**
	Within Groups	2598.3	122	21.2		
	Total	2843.1	124			
Total Psychiatric Symptoms	Between Groups	5817.6	2	2908.8	5.69	0.004**
	Within Groups	59275.4	116	510.9		
	Total	65093.1	118			

** P-value<0.01 * P-value<0.05 \\ P-value>0.05

The previous table shows that there were no significant differences (P-value>0.05) between the means of the following Psychiatric symptoms: (Obsessive Compulsive, Depression, Anxiety, Hostility), of handicapped persons who are victims of the last war on Gaza towards the working status Categories, which means that persons that the handicapped persons with different working statuses all have the same degrees of the Psychiatric symptoms dimensions that mentioned previously.

- There were statistical significant differences (F-test=5.6, P-value<0.01) between the degrees of Somatization of handicapped persons who are victims of the last war on Gaza towards the working status Categories, the test of LSD (Least Square Differences) was used to figure out the differences in between the categories of working status. The test showed that the significant differences were toward those handicapped that are not working; this means that they have more degrees of Somatization than these handicapped that have job (either permanent or temporary jobs) in terms of handicapped persons who are victims of the last war on Gaza.

- There were statistical significant differences (F-test=3.9, P-value<0.05) between the degrees of Interpersonal Sensitivity of handicapped persons who are victims of the last war on Gaza towards the working status Categories, the test of LSD (Least Square Differences) was used to figure out the differences in between the categories of working status. The test showed that the significant differences were toward those handicapped that are working as temporary unemployment; this means that they have less degrees of Interpersonal Sensitivity than these handicapped that have the following working statuses (working, not working) in terms of handicapped persons who are victims of the last war on Gaza.

- There were statistical significant differences (F-test=5.17, P-value<0.01) between the degrees of Phobic Anxiety of handicapped persons who are victims of the last war on Gaza towards the working status Categories, the test of LSD (Least Square Differences) was used to figure out the differences in between the categories of working status. The test showed that the significant differences were toward those handicapped that are working as temporary unemployment; this means that they have less degrees of Phobic Anxiety than these handicapped that have the following working statuses (working, not working) in terms of handicapped persons who are victims of the last war on Gaza.

- There were statistical significant differences (F-test=5.69, P-value<0.01) between the degrees of Paranoid Ideation of handicapped persons who are victims of the last war on Gaza towards the working status Categories, the test of LSD (Least Square Differences) was used to figure out the differences in between the categories of working status. The test showed that the significant differences were toward those handicapped that are working as temporary unemployment; this means that they have less degrees of Paranoid Ideation than these handicapped that have the following working statuses (working, not working) in terms of handicapped persons who are victims of the last war on Gaza.

- There were statistical significant differences (F-test=5.7, P-value<0.01) between the degrees of Psychotic of handicapped persons who are victims of the last war on Gaza towards the working status Categories, the test of LSD (Least Square Differences) was used to figure out the differences in between the categories of working status. The test showed that the significant differences were toward those handicapped that are working as temporary unemployment; this means that they have less degrees of Psychotic than these handicapped that have the following working statuses (working, not working) in terms of handicapped persons who are victims of the last war on Gaza.

- There were statistical significant differences (F-test=5.7, P-value<0.01) between the degrees of Total Psychiatric Symptoms of handicapped persons who are victims of the last war on Gaza towards the working status Categories, the test of LSD (Least Square Differences) was used to figure out the differences in between the categories of working status. The test showed that the significant differences were toward those handicapped that are working as temporary unemployment; this means that they have fewer degrees of Total Psychiatric Symptoms than these handicapped that have the following working statuses. Other significant differences were toward those handicapped that are not working; this means that they have more degrees of Total Psychiatric Symptoms than these handicapped that working statuses (either permanent or temporary jobs) in terms of handicapped persons who are victims of the last war on Gaza.

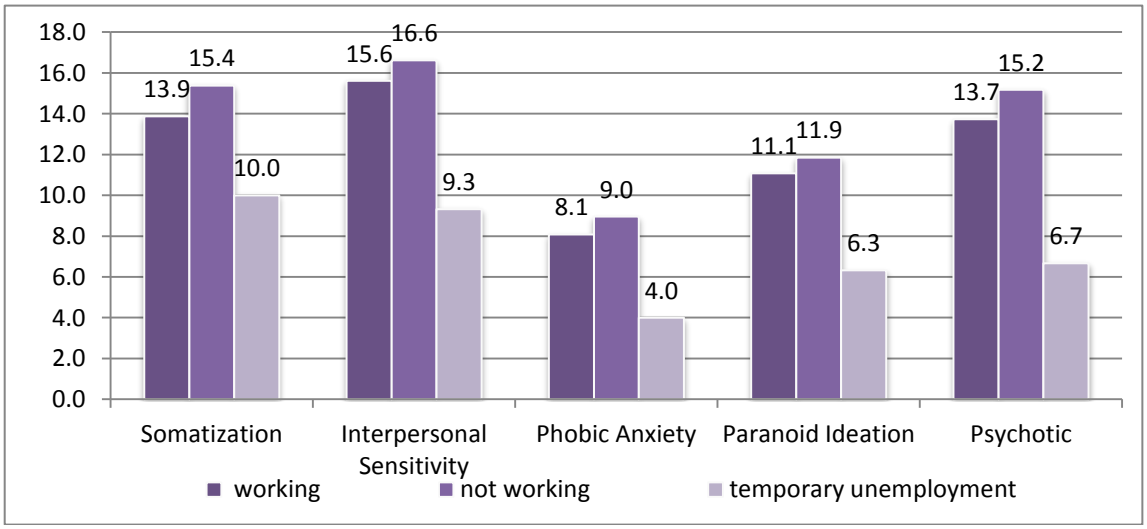
Table (25)
Shows the results of LSD for the differences of Psychiatric symptoms in terms of the working status

The Dimension	working status	N	Means	temporary unemployment	not working	working
Somatization	working	39	13.87	3.87\\	1.52*	1
	not working	82	15.39	5.39**	1	-
	temporary unemployment	3	10.00	1	-	-
Interpersonal Sensitivity	working	39	15.62	6.28*	1.02\\	1
	not working	82	16.63	7.30**	1	-
	temporary unemployment	3	9.33	1	-	-
Phobic Anxiety	working	39	8.08	4.08*	0.89\\	1
	not working	83	8.96	4.96**	1	-
	temporary unemployment	2	4.00	1	-	-
Paranoid Ideation	working	38	11.08	4.75*	0.78\\	1
	not working	83	11.86	5.52**	1	-
	temporary unemployment	3	6.33	1	-	-
Psychotic	working	39	13.74	7.08*	1.44\\	1
	not working	83	15.18	8.51**	1	-
	temporary unemployment	3	6.67	1	-	-
Total Psychiatric Symptoms	working	37	129.30	34.80*	9.80*	1
	not working	80	139.10	44.60**	1	-
	temporary unemployment	2	94.50	1	-	-

** P-value<0.01 * P-value<0.05 \\ P-value>0.05

Figure (4)

Shows the differences of the Psychiatric symptoms in terms of the working status



7. There are no statistical significant differences at ($\alpha \leq 0.05$) in Psychiatric symptoms due to monthly income?

To figure out that, the researcher used One-way ANOVA test to figure out the differences between the Psychiatric symptoms of handicapped persons who are victims of the last war on Gaza towards the monthly income Categories: (1000 NIS or less, 1001-2000 NIS, 2001-3000 NIS, 3001 NIS or more).

Table (26)

Shows the results of One-way ANOVA for the differences of the Psychiatric symptoms in terms of the monthly income

The Dimension	Category	Sum of Squares	d. f.	Mean Square	**F test**	**p-value**
Somatization	Between Groups	53.4	2	26.7	2.18	0.117\\
	Within Groups	1483.6	121	12.2		
	Total	1537.1	123			
Obsessive Compulsive	Between Groups	18.6	2	9.3	0.41	0.663\\
	Within Groups	2763.3	122	22.6		
	Total	2782.0	124			
Interpersonal Sensitivity	Between Groups	65.7	2	32.8	1.45	0.237\\
	Within Groups	2728.9	121	22.5		
	Total	2794.6	123			
Depression	Between Groups	17.0	2	8.5	0.97	0.380\\
	Within Groups	1055.9	121	8.7		
	Total	1072.9	123			
Anxiety	Between Groups	10.9	2	5.4	0.29	0.744\\
	Within Groups	2206.9	120	18.3		
	Total	2217.8	122			
Hostility	Between Groups	4.4	2	2.2	0.34	0.708\\
	Within Groups	781.0	122	6.4		
	Total	785.4	124			
Phobic Anxiety	Between Groups	11.0	2	5.5	0.83	0.436\\
	Within Groups	800.5	121	6.6		
	Total	811.6	123			
Paranoid Ideation	Between Groups	30.7	2	15.3	1.20	0.305\\
	Within Groups	1548.2	121	12.7		
	Total	1578.9	123			
Psychotic	Between Groups	18.2	2	9.1	0.39	0.674\\
	Within Groups	2824.8	122	23.1		
	Total	2843.1	124			
Total Psychiatric Symptoms	Between Groups	1639.0	2	819.5	1.49	0.228\\
	Within Groups	63454.0	116	547.0		
	Total	65093.1	118			

** P-value<0.01 * P-value<0.05 \\ P-value>0.05

The previous table shows that there were no significant differences (P-value>0.05) between the means of all dimensions of Psychiatric symptoms of handicapped persons who are victims of the last war on Gaza towards the monthly income Categories, which means that persons that the handicapped that have any monthly income also seem to have the same degrees of the Psychiatric symptoms that mentioned previously.

8. There are no statistical significant differences at ($\alpha \leq 0.05$) in Psychiatric symptoms due to the type of physical handicap?

   To figure out that, the researcher used One-way ANOVA test to figure out the differences between the Psychiatric symptoms of handicapped persons who are victims of the last war on Gaza towards the type of handicap Categories: (finger amputation, hand amputation, feet amputation, leg amputation, others).

Table (27)
Shows the results of One-way ANOVA for the differences of the Psychiatric symptoms in terms of the type of physical handicap

The Dimension	Category	Sum of Squares	d. f.	Mean Square	**F test**	**p-value**
Somatization	Between Groups	36.1	4	9.0	0.71	0.583\\
	Within Groups	1501.0	119	12.6		
	Total	1537.1	123			
Obsessive Compulsive	Between Groups	95.5	4	23.8	1.06	0.376\\
	Within Groups	2686.4	120	22.3		
	Total	2782.0	124			
Interpersonal Sensitivity	Between Groups	301.6	4	75.4	3.60	0.008**
	Within Groups	2492.9	119	20.9		
	Total	2794.6	123			
Depression	Between Groups	11.3	4	2.8	0.31	0.866\\
	Within Groups	1061.5	119	8.9		
	Total	1072.9	123			
Anxiety	Between Groups	59.7	4	14.9	0.81	0.517\\
	Within Groups	2158.0	118	18.2		
	Total	2217.8	122			
Hostility	Between Groups	8.7	4	2.1	0.33	0.853\\
	Within Groups	776.7	120	6.4		
	Total	785.4	124			
Phobic Anxiety	Between Groups	106.7	4	26.6	4.50	0.002**
	Within Groups	704.9	119	5.9		
	Total	811.6	123			
Paranoid Ideation	Between Groups	206.7	4	51.6	4.48	0.002**
	Within Groups	1372.2	119	11.5		
	Total	1578.9	123			
Psychotic	Between Groups	309.0	4	77.2	3.65	0.008**
	Within Groups	2534.0	120	21.1		
	Total	2843.1	124			
Total Psychiatric Symptoms	Between Groups	5849.8	4	1462.4	2.81	0.029*
	Within Groups	59243.2	114	519.6		
	Total	65093.1	118			

** P-value<0.01 * P-value<0.05 \\ P-value>0.05

The previous table shows that there were no significant differences (P-value>0.05) between the means of the following Psychiatric symptoms: (Somatization, Obsessive Compulsive, Depression, Anxiety, Hostility), of handicapped persons who are victims of the last war on Gaza towards the type of handicap Categories, which means that persons that have any type of handicap, have the same degrees of the Psychiatric symptoms dimensions that mentioned previously.

- There were statistical significant differences (F-test=3.6, P-value<0.01) between the degrees of Interpersonal Sensitivity of handicapped persons who are victims of the last war on Gaza towards the types of handicaps, the test of LSD (Least Square Differences) was used to figure out the differences in between the categories of handicap. The test showed that the significant differences were toward those persons that have other types of handicaps; this means that they have more degrees of Interpersonal Sensitivity than these that have the types (finger amputation, leg amputation) in terms of handicapped persons who are victims of the last war on Gaza.

- There were statistical significant differences (F-test=4.5, P-value<0.01) between the degrees of Phobic Anxiety of handicapped persons who are victims of the last war on Gaza towards the types of handicaps, the test of LSD (Least Square Differences) was used to figure out the differences in between the categories of handicap. The test showed that the significant differences were toward those persons that have finger amputation; this means that they have less degrees of Phobic Anxiety than these that have the types (hand amputation, other) in terms of handicapped persons who are victims of the last war on Gaza.

- There were statistical significant differences (F-test=4.48, P-value<0.01) between the degrees of Paranoid Ideation of handicapped persons who are victims of the last war on Gaza towards the types of handicaps, the test of LSD (Least Square Differences) was used to figure out the differences in between the categories of handicap. The test showed that the significant differences were toward those persons that have finger amputation; this means that they have less degrees of Paranoid Ideation than these that have the types (hand amputation, other). Other significant differences were toward those persons that have feet amputation and other handicaps; this means that the

people that have feet amputation have less degrees of Paranoid Ideation than these other types in terms of handicapped persons who are victims of the last war on Gaza.

- There were statistical significant differences (F-test=3.65, P-value<0.01) between the degrees of Psychotic of handicapped persons who are victims of the last war on Gaza towards the types of handicaps, the test of LSD (Least Square Differences) was used to figure out the differences in between the categories of handicap. The test showed that the significant differences were toward those persons that have finger amputation; this means that they have less degrees of Psychotic than these that have the types (hand amputation, other) in terms of handicapped persons who are victims of the last war on Gaza.

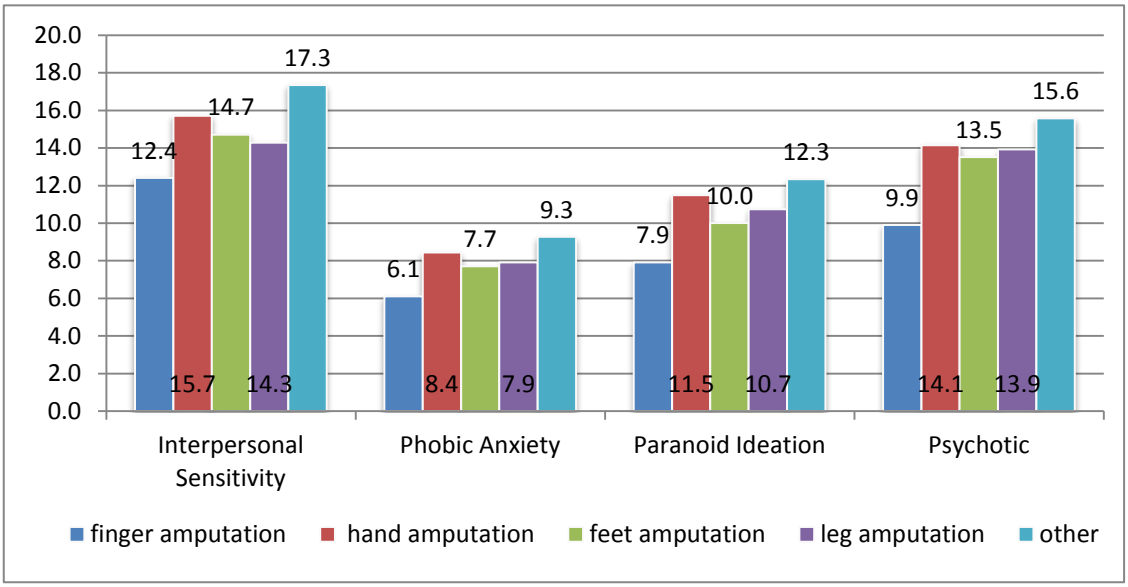
- There were statistical significant differences (F-test=2.81, P-value<0.01) between the degrees of Total Psychiatric Symptoms of handicapped persons who are victims of the last war on Gaza towards the types of handicaps, the test of LSD (Least Square Differences) was used to figure out the differences in between the categories of handicap. The test showed that the significant differences were toward those persons that have finger amputation; this means that they have less degrees of Total Psychiatric Symptoms than these that have the types (hand amputation, other) in terms of handicapped persons who are victims of the last war on Gaza.

Table (28)
Shows the results of LSD for the differences of Psychiatric symptoms in terms of the type of physical handicap

The Dimension	Type of handicap	N	Means	Other	leg amputation	feet amputation	hand amputation	finger amputation
Interpersonal Sensitivity	finger amputation	10	12.40	4.93**	1.87\\	2.30\\	3.31\\	1
	hand amputation	24	15.71	1.62\\	1.44\\	1.01\\	1	-
	feet amputation	10	14.70	2.63\\	0.43\\	1	-	-
	leg amputation	11	14.27	3.06*	1	-	-	-
	other	69	17.33	1	-	-	-	-
Phobic Anxiety	finger amputation	10	6.10	3.16**	1.81\\	1.60\\	2.33*	1
	hand amputation	23	8.43	0.82\\	0.53\\	0.73\\	1	-
	feet amputation	10	7.70	1.56\\	0.21\\	1	-	-
	leg amputation	11	7.91	1.35\\	1	-	-	-
	other	70	9.26	1	-	-	-	-
Paranoid Ideation	finger amputation	10	7.90	4.43**	2.83\\	3.60\\	3.58**	1
	hand amputation	23	11.48	0.85\\	0.75\\	0.63\\	1	-
	feet amputation	10	10.00	2.33*	0.73\\	1	-	-
	leg amputation	11	10.73	1.60\\	1	-	-	-
	other	70	12.33	1	-	-	-	-
Psychotic	finger amputation	10	9.90	5.67**	4.01*	3.60\\	4.22*	1
	hand amputation	24	14.13	1.45\\	0.22\\	0.63\\	1	-
	feet amputation	10	13.50	2.07\\	0.41\\	1	-	-
	leg amputation	11	13.91	1.66\\	1	-	-	-
	other	70	15.57	1	-	-	-	-
Total Psychiatric Symptoms	finger amputation	10	116.30	23.58**	12.25\\	13.14\\	19.27*	1
	hand amputation	21	135.57	4.31\\	7.03\\	6.13\\	1	-
	feet amputation	9	129.44	10.44\\	0.90\\	1	-	-
	leg amputation	11	128.55	11.34\\	1	-	-	-
	other	68	139.88	1	-	-	-	-

** P-value<0.01 * P-value<0.05 \\ P-value>0.05

Figure (5)
Shows the differences of the Psychiatric symptoms in terms of the type of physical handicap



Discussions:

There is no significant difference at (α≤0.05) in Psychiatric symptoms due to demographic factors.

And it is sub-categorized into the following hypotheses

1. **There is no significant difference at (α≤0.05) in Psychiatric symptoms due to gender.**

The result showed that there were no statistical significant differences in the mean of the psychiatric symptoms (Somatization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychotic, total psychiatric symptoms) in terms of gender.

The researcher can be explained this result ;that the handicapped people both genders (male or female)were facing the same circumstances of the being handicapped due to the war, they suffers from the same problems and both received the same level of care so gender is not impact .

On the other hand the study of (**Mustafa N. Al-Qamsh ,2006**) was agree with this study. it said that no significant sex differences were associated with behavior problems.

2. **There is no significant difference at (α≤0.05) in Psychiatric symptoms due to the age.**

The result showed that there were no statistical significant differences in the mean of the psychiatric symptoms (Somatization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychotic, total psychiatric symptoms) in terms of age categories.

This can be explained as follows, the Palestinian people, especially the people of the Gaza strip, are known for their intimate social bonds and interactions. Therefore, we have been used to the fact that the Gazans people are extremely emotional in times of war and disaster. Social support is more focused on vulnerable groups in crises, wars and disasters, while adolescents, youth, young and old people receive the same social support accordingly.

3. **There is no significant difference at ($\alpha \leq 0.05$) in Psychiatric symptoms due to Qualification.**

The result showed that there were no statistical significant differences in the mean of the psychiatric symptoms (Somatization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychotic, total psychiatric symptoms) in terms of qualification categories.

The researcher can be explained this result that the Palestinian people are very much into Therefore, the researcher believes this factor made the disabled people class, because of their disability, more versed in general knowledge through making use of their leisure time. We do believe that both disabled and highly educated people are both on the same footing in terms of knowledge – which balanced off all differences in terms of the academic qualification factor politics and possess the mechanisms and strategies to cope with the ongoing incidents and difficulties.

4. **There is no significant difference at ($\alpha \leq 0.05$) in Psychiatric symptoms due to Social Status.**

The result showed that there were no statistical significant differences in the mean of the psychiatric symptoms (Somatization, obsessive compulsive, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychotic, total psychiatric symptoms) in terms of social status.

The researcher can be explained this result that the disabled person, due to his disability, need to constantly carry out routine daily activities by himself, therefore, he is accustomed to the fact that he needs to do things by his own. The researcher points out that the social status factor, whether the disabled person is single, divorced or widow, had no impact on developing psychological symptoms.

It's widely known that the Palestinian community has a patriarchal structure. The set of common norms and traditions urge community members to be self-dependent. It’s also obvious that the never-ending wars and the Israeli occupation, which has been ongoing for 60 years now, have cultivated a sense of relentlessness and non-surrender in the minds and hearts of the people, including non-surrender to disability.

This study agree with (Abu Sakran, 2009) study's that says that there is no statistical difference in the handicap control related to marital state (single, married, widow, divorced).

And the result showed there were significant differences between the degrees of interpersonal sensitivity of handicapped persons who are victims of the last war on Gaza towards the social status .the test showed that the significant differences were toward those handicapped who are divorced ; this means that they have less degree of interpersonal sensitivity than the handicapped that have the following social statuses (single,married,widow)in terms of handicapped persons who are victims of the last war on Gaza.

The researcher can be explained this result that in principle, divorce, in and of itself, is a trauma. Therefore , divorced females with special needs resort to psychological defensive maneuvers " compensation " to prove to themselves and others that their disability has not impaired them from advancing and accomplishing success in their lives their interpersonal sensitivity was less than their widowed and single counterparts.

5. There is no significant difference at ($\alpha \leq 0.05$) in psychiatric symptoms due to Area of living.

The result showed that there were no significant differences (P-value>0.05) between the means of the following Psychiatric symptoms: (Somatization, Depression, Phobic anxiety, Paranoid Ideation, Psychotic, Additional Items), of handicapped persons who are victims of the last war on Gaza towards the area of living Categories.

The researcher believes that all the Gazans people are invariably subject to continuous psychological pressure. These pressures are caused as a result of occupation, closure, blockade, unemployment and hunger conditions. Given the fact that the disabled people make up a large portion of the Gazans community – then what's so different in the psychological symptoms among the disabled people , if the disabled person lives in the south , middle , or north of the Gaza Strip. Additionally, we still recall what the Israeli defense minister said during the war "there's no safe place in the Gaza Strip".

And the result showed there were significant differences between the degrees of Obsessive Compulsive, Interpersonal Sensitivity, Hostility, and Total Psychiatric Symptoms of handicapped persons who are victims of the last war on Gaza towards the area of living Categories.

The result mean the people who live in Gaza have high degree of Obsessive Compulsive, Anxiety, Hostility. So the researcher can explained this result the majority of the Gaza Strip's civilians are refugees who live in camps , and as reported (**Abdel Aziz Thabet et.al,2008**) study's says that Palestinians live in camps reported more general psychological problems, Somatization, Obsessive compulsive problems, interpersonal sensitivity, depression symptoms, anxiety, hostility, phobic anxiety, paranoid ideation than those in cities and village.

This result agree with that result related to **(Murphy H, Lloyd K, 2007)** that says that Rates of psychiatric morbidity varied across each UK region. And (**Abdel Aziz Thabet et.al, 2008**).

The study showed that persons with disabilities who live in Rafah town to have a high degree of interpersonal sensitivity residents of other regions.
There is no doubt that the Rafah area in particular have distinct features different from other regions, is no secret to anyone years ago that the vast majority of the population of Rafah area live in the area adjacent to the border and no secret that the Rafah area which is characterized by being located on the border where Israeli troops day and night with the thread owner of constant psychological pressure and tank shells voice and explosions that are not interrupted.. Perhaps that's about residents of the Rafah area to people who are better quickly emotion and excess interpersonal sensitivity.

6. **There is no significant difference at ($\alpha \leq 0.05$) in psychiatric symptoms due to Working status**.

The result showed that there were no significant differences (P-value>0.05) between the means of the following Psychiatric symptoms: (Obsessive Compulsive, Depression, Anxiety, Hostility, and the Additional Items), of handicapped persons who are victims of the last war on Gaza towards the working status Categories.

The researcher can be explained this result that work is what generates confidence and self-dependency. Knowing that the Palestinian people already have high ambitions and unrelenting, will which have been further fostered by the ongoing incidents and circumstances; the researcher tends to believe that work had no evident impact on developing psychological symptoms. The working disabled people pass their times at the workplace, while those unemployed people with different disabilities resort to organizations and societies (Friends of people with Special Needs Society) (Physically Handicapped Society) which I myself paid a visit to more than once. When I surveyed their opinions, I found out that they feel entertained in the company of their peers who share their burdens and distresses. Additionally, the researcher , through his own observations , found that ex-PA employees who still receive monthly salaries experience psychological distresses which clearly indicate that work has no impact whatsoever on developing psychological distresses.

The result showed that there were significant differences (F-test=5.6, P-value<0.01) between the degrees of Somatization, Interpersonal Sensitivity, Anxiety, Paranoid Ideation, Total Psychiatric Symptoms of handicapped persons who are victims of the last war on Gaza towards the working status Categories.

The result showed that Non-working people developed a higher degree of Somatization than did working and temporarily employed people has.

The researcher contends that such outcomes are expected according to Freud's psychoanalysis theory; somatic symptoms reflect suppressed desires and repressed emotions. If we hypothesize that unemployment yields anxiety and psychological stress as the disabled person is left to his negativistic thoughts which are reflected negatively on his body, behavior and emotions, then it would be natural for the jobless disabled people to develop somatic symptoms.

This result agree with that result related to **(Abu Sakran, A 2009)** that says that there are statistic difference psychological and social alignment and their control related to economic state, whose working or not and it's more for those working in many study.

The result showed that People who work on a temporary basis are less prone to symptoms (interactive sensitivity, phobia, paranoia and psychosis)

The researcher can be explained this result that the non-working disabled people have been used to a certain lifestyle since they don't work. As a result, they became more moderate and less demanding … the working ones have also adapted their lifestyles to their monthly wages. It's noteworthy that the growing life requirements and increased prices have contributed to creating anxieties about the future and increased interpersonal sensitivity. The temporarily employed people have developed growing feelings about being helpless, weakened, and vulnerable to their anxiety, disability, fear from the unknown, insecure and uncertain about themselves and others. This could be due to feelings of insecurity and ambiguity in terms of salaries.

7. **There is no significant difference at ($\alpha \leq 0.05$) in Psychiatric symptoms due to Monthly income.**

The result showed that there were no significant differences (P-value>0.05) between the means of all dimensions of Psychiatric symptoms of handicapped persons who are victims of the last war on Gaza towards the monthly income Categories.

The researcher believes that low paid disabled people can make up the difference in their salaries by receiving additional assistance from disabled and wounded people organizations, e.g. The Palestinian Wounded Organization. Therefore, the difference in salaries starts to fade off. As far as the researcher's knowledge is concerned, the disabled person receives 1000 NIS on a monthly basis, thus, the monthly salary factor had no impact on the differences among disability classes.

There are several consequences of disability on the individual, family and community, as follows **(Scottish Accessible Information Forum, http://www.saifscotland.org.uk, 17/10/2011)** Consequences on individuals are (Decrease in dependence, Inadequate socialization, Isolated and segregated. Consequences on Family (Need for care, Disturbed relationship, Social stigma. Consequences on society (Discrimination within society, Disturbed social relationship, Loss of productivity and increase cost of service)

So the researcher can be explained this result that the handicapped people suffer from many thing such as isolation, Social stigma, need for care so, the income was not affected by Psychiatric symptoms.

8. There is no significant difference at ($\alpha \leq 0.05$) in psychiatric symptoms due to the Type of physical handicap.

The result showed that there were significant differences (F-test=3.6, P-value<0.01) between the degrees of Interpersonal Sensitivity of handicapped persons who are victims of the last war on Gaza towards the types of handicaps.The test showed that the significant differences were toward those persons that have other types of handicaps; this means that they have more degrees of Interpersonal Sensitivity than these that have the types (finger amputation, leg amputation) in terms of handicapped persons who are victims of the last war on Gaza**.**

The researcher can be explained this result that Some disabled people suffer from personality damage, e.g. inferiority, low self-esteem, irritability, excessive shyness, aggressiveness and denial etc. Other forms of symptoms may appear as well, e.g. prevalent defensive behavior such as compensating and projecting ambivalent behavior and justifications, which produce self-resentment, blaming their biased community and protesting against unfair treatment. Consequently, they avoid social contact contesting with others, and remain self-centered. They also develop perceptions of inferiority about themselves as a result of being treated as outcast and unequal by the physically sound people. The disabled people with hand and leg amputations or paralysis, hitherto, have high interpersonal sensitivity if compared to those who suffer from finger or foot amputations**.**

The result showed that there were significant differences (F-test=4.5, P-value<0.01) between the degrees of Phobic Anxiety, Paranoid Ideation, Psychosis of handicapped persons who are victims of the last war on Gaza towards the types of handicaps.The test showed that the significant differences were toward those persons that have finger amputation; this means that they have less degrees of Phobic Anxiety, Paranoid Ideation, Psychosis than these that have the types (hand amputation, other) in terms of handicapped persons who are victims of the last war on Gaza.

The researcher can be explained these results that hand and foot are basic parts and resources which no human can function without. If someone lost his foot, leg, hand or if he became paralyzed, this is likely to throw him into several predicaments, such as

feeling stigmatized, and other social, family and work problems start to arise. So size of disability has great significance.

Freud, a pioneer in the psychoanalysis school, states that psychological problems stem from unconsciousness, as the human keeps suppressing the undesired feelings inside. Once these feelings start to surface, then problems arise. This gives us an indication that a disabled person who lost his finger suffers less than that who lost his feet and became paralyzed. Traumas also create profound shakes of a person's self-perception such as feelings of despair and defensiveness. The greater the size of despair , failure and psychological conflict , the more complicated the psychological dysfunctions and vice versa. Paranoia is merely resorting to defensive compensation maneuvers.

This study agree with (**Abeyasinghe, NL et.al 2012**) study's that says that The results revealed that 41.7% of the study population was compatible with the diagnosis of Post-Traumatic Stress Disorder. Within the three groups, 42.5% of the lower limb amputees, 33.3% of the upper limb amputees and 45.7% of the participants with spinal cord injury had symptoms compatible with Post-Traumatic Stress Disorder. There was no difference between the prevalence among the different injury categories considered. This study highlights the need to pay more attention in providing psychological care as a part of the overall health management of injured combatants. Early preparation of soldiers for stressors of war and screening for and proper management of Post-Traumatic Stress Disorder will improve the overall outcome of rehabilitation. And the (**Perkins ZB, et.al 2012**) study's that says that vocational function, and increased cardiovascular morbidity and mortality were common causes of disability after traumatic leg amputation.

General discussion:

Researcher sees that the results showed the absence of statistically significant differences between the variables used by the researcher studying due to several reasons for example not limited to ... Beginning to say that the Palestinian people and moments first to suffer from the scourge of injustice and aggression since the British mandate through expulsion Palestinians from their homes in 1948 and then the 1967 war and then what he suffered from massacres and genocides as happened in the Sabra and Shatila massacre in 1982 and then the outbreak of the first intifada in 1987 down to the

Al-Aqsa Intifada in 2000 and after that the problem of the blockade for more than 5 years, while Hamas took the reins of government in Gaza and ending the war recent Gaza at the end of 2008 and beginning of 2009 used the Israeli army ugliest ways and means lethal weapons internationally banned where they used of white phosphorus and cluster bombs and rockets blazing all this was to suppress the will of the Palestinian people, Add to that the problems of unemployment, hunger and poverty all these reasons were not to affect individuals and spectra of this people and this was clear from the findings of the results and here ask the following question .. .

Why did the reasons which listed don't affected on the citizens in Gaza strip?

The answer in short Right back to the following factors:

First: faith in God that he is alone capable of supporting this helpless people what distinguishes this people their patience and religiosity counted only for the pleasure of God Almighty. .

Second: the traditions and customs of the people of Palestine and specifically for the people of Gaza are interdependent and social interaction, which reflected the positive return in force cohesion and psychological support in finding a mental toughness in this segment of the people.

Third: As mentioned that wars and successive disasters, so we find that the Palestinian people accustomed to such a cause and circumstances and so was formatted for what is happening and what may happen in the future.

Fourth: As mentioned in the search, the category disabled in the Gaza Strip received support from government institutions and non-governmental, whether this support financially or morally or socially, perhaps this was a factor that contributed to the emergence of the results is that there is no statistically significant differences between the variables used by the researcher.

Recommendations

1. Ministry of health must be having comprehensive database regarding physically disabled people.
2. Providing hospitals with specialists in mental health and psychotherapy fields to increase the opportunity for early intervention in psychotherapy with those cases.
3. Special centers specialized in dealing with this segment because they have a special status.
4. Activation law of disabled Palestinian, which provides job opportunities for disabled people by 5% of governmental jobs.
5. Establishment of specialized centers with artificial limbs due to a lack of such centers in Gaza Strip, which requires treatment abroad for these cases and this, increases the economic and social burdens on family and community alike.
6. Providing Guidance programs generally for disabled cases and especially for amputation to reduce psychological problems.
7. Development rehabilitation programs for disability and amputation and keep up what is new.
8. Field survey and researches in order to identify the problems facing this segment and solving it.
9. Provision rehabilitation cadres specialized in dealing with disabled people and people with artificial limbs in the aspects that related to psychological and social matters.
10. There are a large number of disabled people increase year after year and must be reintegrated into society according to their abilities.
11. Emphasize the importance of rehabilitation of amputees in the early stages by providing psychological, social, medical and professional services.
12. Activating the role of universities and civil society organizations to promote community awareness.
13. Activating the role of media to promote the culture of integration of disabled people into society.
14. Take advantages from the recent war in Gaza to minimize the number of injured people and the consequent disabilities.

Suggestions:

- Making more surveys and studies continuing the efforts started by the researcher in the light of this study, as he sees that this category of people are in need of more studies and surveys, as the theoretical heritage lacks of attention to this subject, as these studies have to know more of their problems and help minimize them, including:

1- Making studies on age category younger than 18 years.

2- Study (psychological disorders, self-esteem, independence, sickness delusion, feeling of guilt).

3- Making a comparative study between the war-resultant conditions, and sickness-resultant conditions focusing on the scope of effect.

4- Making studies exposing the evolving of the body during various of life times.

5- Making studies to expose the differences of the evolving of the body between two Arabian societies (Palestine and another Arabian country) , focusing on the social, political & demographical nature, that Palestine specialize in than other countries.

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Appendages

Appendix (1): Final Questionnaire

تعليمات

فيما يلي قائمة بالمشاكل والشكاوي التي قد يعاني منها عامة الناس، اقرأ كل عبارة بدقة، وبعد التأكد من انطباق العبارة عليك أرجو أن تضع علامة داخل أحد المربعات الموجودة إلى يسار السؤال والتي تصف معاناتك أحسن وصف، أي إلى أي مدى تنطبق عليك هذه المشكلة خلال الشهر الماضي حتى اليوم، ضع العلامة داخل مربع واحدة فقط بعد كل مشكلة مع عدم اغفال الاجابة عن أي عبارة، إذا غيرت رأيك في الاستجابة، امسح العلامة الأولى تماماً وضعها في المربع المناسب.

ملاحظة : الاجابة علي اسئلة الاستبانة ربما تأخذ من وقتكم 15 دقيقة فالرجاء أن يكون لديكم متسع من الوقت

اقرأ المثال الآتي قبل أن تبدأ:

مثال

ما مقدار معاناتك من الأعراض الآتية:

الرقم	العبارة	مطلقاً	نادراً	أحياناً	كثيراً	دائماً
1-	الإحساس بآلام أسفل الظهر		×			

أولاً: بيـــانات شخصيـــة

الجنس: ☐ذكر ☐ أنثى

العمر: ☐ 18-25 ☐من 26-35 ☐من 36-45 ☐من 46 فأكثر

المؤهل العلمي: ☐أمي ☐ثانوية عامة فما دون ☐ دبلوم ☐ بكالوريوس ☐ دراسات عليا

الحالة الاجتماعية: ☐متزوج ☐أعزب ☐ مطلق ☐ أرمل

منطقة السكن : ☐ رفح ☐ خانيونس ☐الوسطى ☐غزة ☐شمال غزة

الوظيفة : ☐ يعمل ☐ لايعمل ☐ بطالة مؤقتة

إذا كان يعمل الرجاء تحديد المهنة .....

الدخل الشهري: ☐ 1000 شيكل فأقل ☐1001 -2000 شيكل ☐2001- 3000 شيكل ☐3001 شيكل فأكثر

حجم الإعاقة: ☐بتر أصبع ☐بتر يد ☐ بتر قدم ☐ بتر ساق غير ذلك .....

ما مقدار معاناتك من الأعراض الآتية:

الرقم	العرض	مطلقاً	نادراً	أحياناً	كثيراً	دائماً
1-	الصداع					
2-	سرعة الانفعال أو الاضطراب الداخلي					
3-	وجود أفكار أو خواطر أو ألفاظ غير مرغوب فيها لا تفارق بالك					
4-	الشعور بالإعياء أو الإغماء أو الدوخة					
5-	فقدان الاهتمام الجنسي أو اللذة الجنسية					
6-	الشعور بالحساسية تجاه الآخرين					
7-	الاعتقاد بأن شخصا ما يستطيع السيطرة على أفكارك					

الرقم	العرض	مطلقاً	نادراً	أحياناً	كثيراً	دائماً
8-	إلقاء اللوم على الآخرين في معظم متاعبك					
9-	الصعوبة في تذكر الأشياء					
10-	الانشغال الزائد فيما يتعلق بالقذارة والإهمال					
11-	الشعور بسرعة المضايقة والاستثارة					
12-	الإحساس بآلام في القلب أو الصدر					
13-	الشعور بالخوف في الأماكن المفتوحة أو الشوارع					
14-	الشعور بالخمول أو قلة النشاط					
15-	التفكير في إنهاء حياتك					
16-	سماع أصوات لا يسمعها الآخرون					
17-	رعشة بالجسم					
18-	الشعور بعدم الثقة في معظم الناس					
19-	ضعف الشهية للطعام					
20-	البكاء بالسهولة					
21-	الشعور بالخجل أو الاضطراب مع الجنس الآخر					
22-	الشعور بالرعب المفاجئ بدون سبب					
23-	ثورات مزاجية لا يمكنك السيطرة عليها					
24-	لوم نفسك على الأحداث التي تمر بك					
25-	الإحساس بآلام أسفل الظهر					
26-	عدم القدرة على إتمام أعمالك					
27-	الشعور بالوحدة حتى في وجود الآخرين					

الرقم	العرض	مطلقاً	نادراً	أحياناً	كثيراً	دائماً
28-	الاحساس بالانقباض					
29-	القلق على الأشياء بصورة مبالغ فيها					
30-	الشعور بعدم الاهتمام بما حولك					
31-	الشعور بالخوف					
32-	الإحساس بأن مشاعرك يمكن أن تجرح بسهولة					
33-	الاعتقاد بأن الآخرين يطلعون على أفكارك الخاصة					
34-	الشعور بأن الآخرين لا يفهمونك أو لا يتعاطفون معك					
35-	الشعور بعدم صداقة الناس لك أو أنهم لا يحبونك					
36-	الاضطرار إلى أداء أعمالك ببطء شديد حتى تتأكد من دقتها					
37-	الإحساس بضربات القلب وزيادة سرعتها					
38-	الإحساس بالغثيان واضطراب المعدة					
39-	الإحساس بأنك أقل من الآخرين (عقدة النقص)					
40-	الشعور بآلام في العضلات					
41-	الشعور بأن الآخرين يراقبونك أو يتحدثون عنك					
42-	صعوبة الاستغراق في النوم					
43-	الاضطرار إلى إعادة التأكد من أفعالك (تعيد وتزيد)					
44-	صعوبة اتخاذ القرارات					
45-	الشعور بالخوف عند ركوبك للباصات أو السيارات					
46-	الصعوبة في التقاط أنفاسك					
47-	الإحساس بنوبات من السخونة أو البرودة في جسمك					

الرقم	العرض	مطلقاً	نادراً	أحياناً	كثيراً	دائماً
48-	الاضطرار إلى تجنب أشياء أو أفعال أو أماكن معينة لأنها تسبب لك الإحساس بالخوف					
49-	الإحساس بأن ذهنك خالي من الأفكار					
50-	تنميل أو شكشكة في أجزاء من جسمك					
51-	الإحساس بأن شيء يقف في زورك (يسد زورك)					
52-	الإحساس باليأس من المستقبل					
53-	صعوبة في التركيز					
54-	الشعور بضعف في أجزاء من جسمك					
55-	الشعور بالتوتر أو أنك مشدودة داخليا					
56-	الشعور بثقل في ذراعيك ورجليك					
57-	التفكير في الموت					
58-	الافراط في تناول الطعام					
59-	الشعور بالضيق والاضطرابات عندما يتحدث الناس عنك أو يراقبونك					
60-	الشعور بأن أفكارك ليست من صنعك					
61-	الإحساس بدافع ملح لأن تضرب أو تجرح أو تؤذي شخص معين					
62-	الاستيقاظ من النوم في الساعات المبكرة من الصباح					
63-	نوم مضطرب أو غير مريح					
64-	الشعور بدافع ملح لتكسير أو تخريب الأشياء					
65-	وجود أفكار أو معتقدات لديك لا يشاركك فيها الآخرون					
66-	الإحساس بالخجل والهيبة في وجود الآخرين					

الرقم	العرض	مطلقاً	نادراً	أحياناً	كثيراً	دائماً
67-	الشعور بالضيق في الأماكن المزدحمة كالأسواق والسينما.					
68-	الشعور بأن كل شيء عناء في عناء (الدنيا تعب في تعب)					
69-	نوبات من الفزع أو الذعر بدون سبب معقول					
70-	الشعور بالتوتر عندما تكون بمفردك					
71-	الشعور بأن الآخرين لا يعطونك ما تستحق من ثناء وتقدير على أعمالك وانجازاتك					
72-	الشعور بالوحدة حتى في وجود الآخرين					
73-	الشعور بعدم الاستقرار لدرجة لا تمكنك من الجلوس هادئة في مكان					
74-	الشعور بأنك عديم الأهمية					
75-	الشعور بأن الأشياء المألوفة تبدو غريبة أو غير حقيقية					
76-	نوبات من الصراخ وقذف الأشياء					
77-	الشعور بالخوف من الإغماء في الأماكن العامة					
78-	الإحساس بأن الناس سوف يأخذون فرصتك لو مكنتهم من ذلك					
79-	أفكار عن الجنس تسبب لك اضطرابا شديدا					
80-	أفكار تسيطر عليك بأنك لابد وأن تعاقب على ذنوبك					
81-	الاعتقاد بأنك مدفوع لعمل أشياء معينة					
82-	عدم الشعور بأنك قريب من أي إنسان آخر					
83-	الشعور بالذنب					
84-	الاعتقاد بأن هناك تغيراً غريباً قد طرأ على أفكارك					

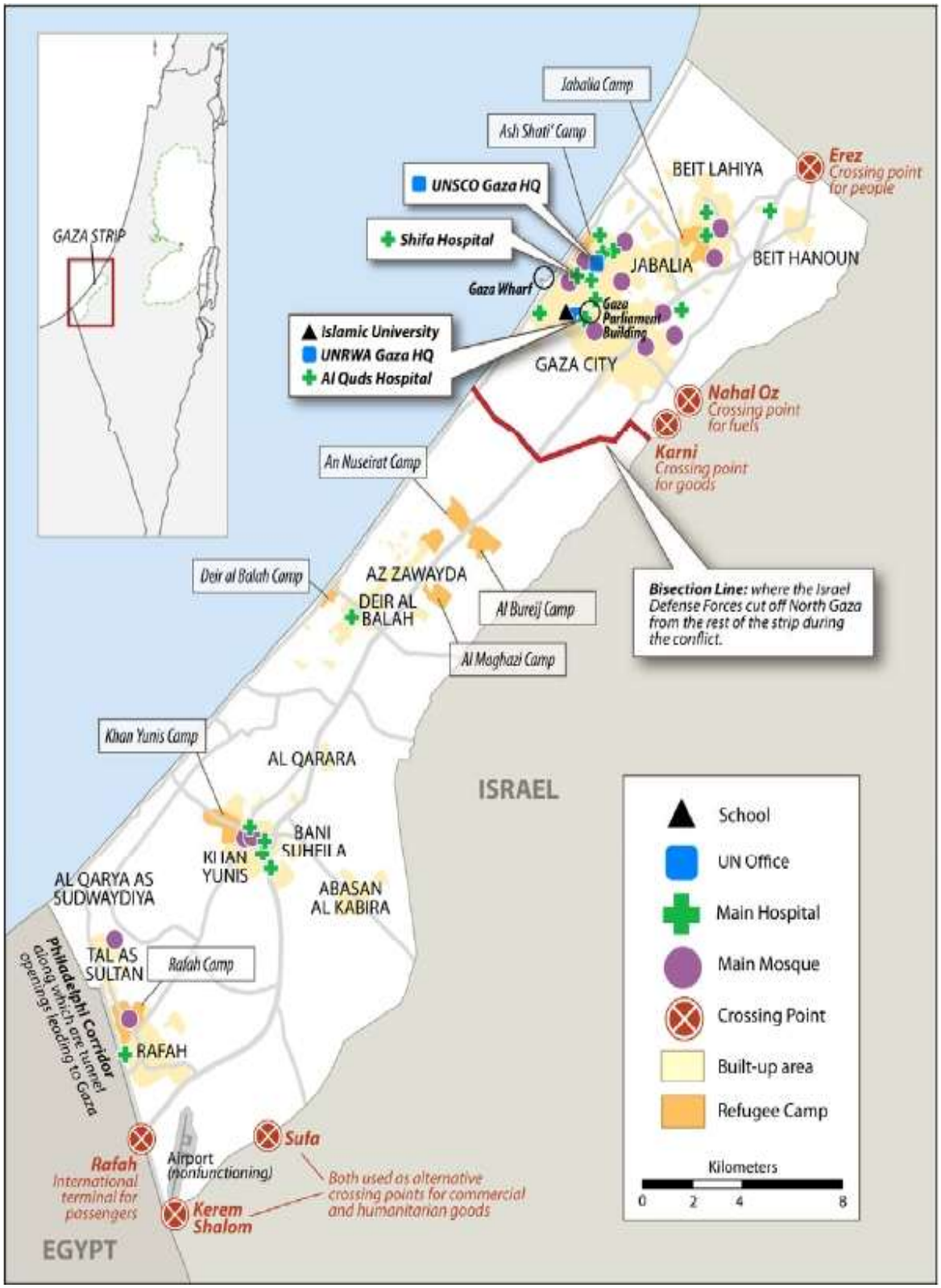
Appendix (2): Supervisors & Auditors

NO	Name	Qualification	Institute
1.	د. عايش سمور	مدير عام الإدارة العامة للصحة النفسية	مستشفي الطب النفسي
2.	د. خضرة العمصي	مدير دائرة التطوير والتدريب	مستشفي الطب النفسي
3.	د. حبيب الحواجري	الأخصائي النفسي الإكلينيكي	مستشفي الطب النفسي
4.	د. يوسف عوض الله	المدير الطبي لعيادة رفح النفسية	عيادة رفح النفسية
5.	د. جميل الطهراوي	أستاذ الصحة النفسية المشارك. قسم الإرشاد النفسي	الجامعة الإسلامية
6.	د.أشرف الجدي	الأستاذ المساعد في التمريض والصحة العامة	الجامعة الإسلامية
7.	أ. عماد حبوب	ماجستير صحة نفسية ومجتمعية	محاضر بالجامعة الإسلامية

Appendix (3): Abbreviations

Shortcut	Meaning
A.D.	Anno Domini
P.B.U.H.	Peace Be Upon Him
UN	United Nation
WHO	World Health Organization
HIV\AIDS	Human Iimmunodeficiency Virus. Acquired Immune Deficiency
PHIC	Palestinian Health Information Center
MOH	Ministry Of Health
UNRWA	United Nations Relief and Works Agency
NGOs	Non Governmental Organizations
IUDs	Intra-Uterine Devices
ILO	International Labor Organization
MSF	Medicine Sans Frontiers
U.S.	United States
PRCS	Palestinian Red Crescent Society
ICU	Intensive Care Unit
IDF	Israel Defense Forces
DDA	Disability Discrimination Act
MS	Multiple Sclerosis
SCL-90	Symptom Checklist 90

Appendix (4): Gaza Strip Map



Sources: U.N. Office for the Coordination of Humanitarian Affairs (including for the Bisection Line) and UNOSAT, with additional data from UNRWA; adapted by CRS

Appendix (5): Facilitate the task of the researcher

الجامعة الإسلامية- غزة
كليـــة التربية – قسم الإرشاد النفسي
ج س غ / 63/
25 محرم 1433 هـ
21 ديسمبر 2011 م

داخلي 2430

السيد / م. مصعب عبد المالك
مدير جمعية السلامة الخيرية
السلام عليكم ورحمة الله وبركاته،،،

حفظه الله..

الموضوع : "تسهيل مهمة باحث"

يهديكم قسم الإرشاد النفسي أطيـب التحيـات، وبالإشـارة للموضـوع أعـلاه، فـإن الطالب/**أيمن محمد الغوطي** يرغب في إجراء دراسة بعنـوان: "**الأعـراض النفـسية لـدى الأشخاص الذين اصيبوا بإعقات حركية من جراء الحرب الأخيرة على قطاع غزة**" ويتطلـب ذلك تطبيق أدوات الدراسة على فئة المعاقين حركياً المسجلين لدى الجمعية، برجـاء التكـرم تسهيل مهمه الباحث.

وتقبلوا فائق التقدير والإحترام،

ودمتـم في خدمة العلـم وطلبته،،،

رئيس قسم الإرشاد النفسي
د. أنور عبد العزيز العبادسة

- صورة للملف.