

**Posttraumatic Stress Disorder, Depression, and Anxiety  
Among Gaza Strip Adolescents in the Wake of the Second  
Uprising (Intifada)**

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229

%69

%95

%40

**ABSTRACT**

**Objective:** Children and adolescents of the Gaza Strip have been subjected to continuous violence since the eruption of the second Intifada (Uprising). Little is known, however, about the psychological effects of this violence on children and adolescents of Gaza. Thus, the purpose of the present investigation was to evaluate and describe the psychological effects of exposure of war-like circumstances on this population.

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**Method:** Participants for this study were 229 Palestinian adolescents living in the Gaza Strip who were administered measures of posttraumatic stress disorder (PTSD), depression, anxiety, and coping.

**Results:** Of the 229 participants, 68.9% were classified as having developed PTSD, 40.0% reported moderate or severe levels of depression, 94.9% were classified as having severe anxiety levels, and 69.9% demonstrated undesirable coping responses. A canonical discriminant analysis revealed that adolescents diagnosed with PTSD tended to be those who reported the highest levels of depression, anxiety, and positive reappraisal coping, and the lowest levels of seeking guidance and support coping.

**Conclusions:** These results indicate that a significant proportion of Palestinian adolescents living in the Gaza Strip are experiencing serious psychological distress.

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The Israeli-Palestinian land has been recognized as a fear- and anxiety-provoking region where large numbers of civilian casualties have been reported (Heraclides, 1989). Specifically, this region has witnessed a dramatic increase in the number of deaths and injuries reported since the outbreak of the second “Al-Aqsa” Intifada or uprising (2000–present).

Many studies have documented the adverse consequences of the first Intifada on the well-being of Palestinian children and adolescents (Elbedour, ten Bensel, & Bastien, 1993; Elbedour, Van Slyck, & Stern, 1998; Garbarino & Kostelny, 1996; Punamaki, 1996; Qouta, Punamaki, & el-Sarraj, 2001; Thabet & Vostanis, 2000). A study by Elbedour (1998) of traumatic reactions to the first Uprising (Intifada) from 1987 to 1993 indicated a Posttraumatic Stress Disorder (PTSD) rate ranging from 12% to 18%. Garbarino and Kostelny (1996) reported a similar rate of PTSD on the same population. In a more recent investigation of the long-term effects of the first Intifada, Thabet and Vostanis (2000) reported an even higher prevalence of PTSD: 41% of the sample showed moderate or severe symptoms. Equally important is that approximately 42% of Palestinian children and adolescents in the West Bank and the Gaza Strip have been found to have witnessed the death of a close family member, and 35% have been found to have witnessed violent clashes with the Israeli army (Qouta, El-Sarraj, & El-Masri, n.d.).

Most of the data pertaining to the effect of the Israel-Palestine conflict on the well-being of Palestinian children and adolescents have come primarily from empirical studies conducted during the first Intifada. Clearly, more research is needed in the domain of rehabilitation, treatment of, and prevention from disorders of PTSD, depression, and behavior problems among Palestinian children and adolescents. Logically, much work also is needed to capture how the political trauma associated with the second Intifada affected the social and psychological adjustment of youth. In sharp contrast to the first Intifada, the Al-Aqsa Intifada (2000-present) is markedly distinguished for its severe, prolonged distress and extraordinary increase in the number of injuries and deaths of children and adolescents. Studies of problems of adjustment and adaptation of Palestinian youth surviving in the shadow of the second Intifada are limited, thereby necessitating more research in this area.

To date, there is strong evidence to suggest the children of the Gaza Strip are one of the most vulnerable populations in the region and are more likely to experience psychological disturbances and report significant traumatic experiences of Al-Aqsa Intifada-related stressful events. Because

of the ongoing political turmoil and the legacy of occupation, the Gaza Strip is considered a socially, economically, and psychologically high-risk community (Fields, Elbedour, & Abu Hein, 2002). According to Thabet and Vostanis (2000), approximately 825,000 Palestinians (78% of the total population) in the Gaza Strip are registered refugees, of whom 63% live in eight refugee camps, compared to 27% of Palestinians who live in 19 camps in the West-Bank--a profile that highlights the unique life of Palestinians in the Gaza Strip. This portion of Palestinian society living in the Gaza Strip, especially those residing in refugee camps, is at the bottom of the socioeconomic ladder. Indeed, more than 70% live on less than \$2.00 per day (Thabet & Vostanis, 2000), they have a very high population density, and their infrastructure is underdeveloped or destroyed in the course of the Intifada. According to Fields et al. (2002), relative to other places in the West Bank, the community of refugee camps in the Gaza Strip and the West Bank are often "invisible," both within the Palestinian community and outside their cultural groups (Yahya, 1991). These camps were established for the impoverished Palestinian who fled to the Gaza Strip (e.g., from Beersheva, Lod) in order to seek out safer living conditions and in an attempt to escape the war that broke out in 1948 between Palestinians and Israeli-Jewish for the control of territory.

It is clear that urgent action must be taken by researchers to examine the mental health status of the population of Gazan Palestinian children and adolescents who experience the political violence of Al-Aqsa' Intifada and social chaos that resulted from the ongoing conflict. Empirical investigations are needed to assess the severity of their traumatic responses and the processes they have used to cope with these traumatic experiences so that appropriate interventions can be developed. Therefore, the intent of this study is to address the mental status of adolescents from the refugee camps of Rafah and Khan-Younis in the southern region of the Gaza Strip. The vast majority of direct confrontations in the course of the second Intifada (2000–present) between the Israeli army and Palestinians occur in these two camps. Because these camps are situated in a remote part of the Gaza Strip, and as a result of the tight travel restrictions to and from these camps, the experiences of these civilians have not been empirically studied. The present study was guided by the following three research questions: (1) What is the mental health status of adolescents from these two camps in Gaza? (2) How have these adolescents coped with the traumatic events of the second Intifada? and (3) What factors best predict their mental status? In the present study, we hypothesized that a significant proportion of the

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adolescents in these camps experience high levels of PTSD and other forms of psychological distress.

### **Method**

#### ***Participants***

The researchers received permission to conduct the study from the education office in the city of Ramallah in the West Bank. A social worker (with a Master's degree) who worked with one of the co-authors of the present study in a community mental health center in Gaza collected the data. This center provides mental health services and psychotherapy to traumatized individuals and families in the Gaza Strip.

A two-stage random sampling scheme was used to select the participants for the current study. In the first stage, three schools were randomly selected from the three high schools serving the refugee camp of Rafah and seven schools serving the refugee camp of Khan-Younis in the southern region of the Gaza Strip. The researchers obtained permission to collect data from the principals of these three schools under the condition that the study would maintain the highest standards of confidentiality and privacy. From these schools, a simple random sample of 300 adolescents (Stage 2) was drawn using the Statistical Package for Social Sciences (SPSS; SPSS Inc., 2001) software from the school rosters provided by the principals of these three schools—100 from each school. Of the 300 selected participants, 229 (76.3%) agreed to participate in the study and were able to obtain their parents' formal consent for taking part via an informed consent form. The response rate was considered to be satisfactory, especially bearing in mind the sensitive and pioneering nature of the study. The use of random sampling and the large response rate suggest that the sample was representative of the population of adolescents in the refugee camps of Rafah and Khan-Younis. The participants were given contact information for the community mental health center in Gaza in case they wished to seek counseling and/or emotional support for any emotional trauma triggered by disclosing their experiences in the study. The children were informed that their participation in the investigation was completely voluntary and anonymous, and they could withdraw from the study at any time. Also, they were informed that no identifying information would be collected, thereby making their responses completely anonymous. Participants did not receive any incentive for their participation, other than the opportunity to share their experiences.

Data were collected in 2002. A slight majority of the 229 adolescents was male (52.8%). Females (47.2) Ages of the participants

ranged from 15 to 19 years ( $M = 17.13$ ,  $SD = 1.51$ ). These adolescents belonged to families with an average of (4.1) members ( $SD = 2.15$ ).

### **Instruments and Procedure**

Participants were administered the following measures: The Posttraumatic Stress Disorder Interview (PTSD-I; Watson, Juba, Manifold, Kucala, & Anderson, 1991) closely matches the *Diagnostic and Statistical Manual of Mental Health Disorders—Fourth Edition* (DSM-IV; American Psychiatric Association, 1994) diagnostic criteria for posttraumatic stress disorder (PTSD). The first item of the PTSD-I represents a modified stressor criterion question (i.e., Section A of the PTSD-I). This question asks respondents whether they have experienced something that is both very uncommon and so horrible that it would be very distressing to almost anyone, and what this event is. If respondents reply affirmatively to the criterion question, they are asked to specify whether this event directly involved them and with whom this incident occurred (e.g., family member, friend). They are then asked to use this incident as the basis for completing the subsequent PTSD-I questionnaire items. Respondents replying negatively to the first question are asked to think of the most horrible or frightening event that they had experienced and to use that experience as a basis for answering the subsequent questionnaire items.

The remainder of the PTSD-I consists of 17 items (i.e., Sections B – D) referring to PTSD diagnostic criteria (rated on a 7-point Likert-type scale that ranges from 1 = “no; never” to 7 = “extremely; always”), plus two questions (i.e., Section E) asking them whether they had experienced these problems at least a few times each week for at least one month sometime after the event, as well as over the past month. (In the current study, the participants were asked whether they believed they could change their psychological state and asking them to specify what they believed was the factor that would best help them change their psychological status.) Thus, Section A of the PTSD-I (3 items) is labeled “History of trauma,” Section B (4 items) is labeled “Trauma Experiencing,” Section C (7 items) is labeled “Avoidance of Stimuli Associated with Trauma,” Section D (6 items) is labeled “Increased Arousal,” and Section E (2 items) is not labeled. Following Watson et al. (1991), participants were given a current PTSD diagnosis if (a) they reported experiencing an event that was both very uncommon and horrible; (b) they indicated a “4” or higher response to at least one of the four “Trauma Re-experiencing” items, (c) they indicated a “4” or higher response to at least three of the seven “Avoidance of Stimuli

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Associated with Trauma” items, (d) they indicated a “4” or higher response to at least two of the six “Increased Arousal” items, and (e) they reported that they had these symptoms at least a few times each week over the past month. Any participant reporting that he/she had not experienced an event that was both very uncommon and horrible would not meet the diagnostic category of PTSD. (For the present investigation, scores from the 17-item PTSD-I scale yielded a reliability coefficient (i.e., KR-20) of .75 (95% confidence interval [CI] = .70, .80).

The Beck Depression Inventory—II (BDI-II; Beck, Steer, & Brown, 1996) is a 21-item instrument designed to assess the severity of depression through self-ratings. This measure also is in line with the depression criteria of the DSM–IV. It is the most widely used instrument for detecting depression, taking only five minutes to complete. The following cut score guidelines for the total scores recommended by Beck et al. were used: 0-13 (minimal), 14-19 (mild), 20-28 (moderate), and 29-63 (severe). For the current study, reliability was .85 (95% CI = .82, .88).

The Beck Anxiety Inventory (BAI; Beck & Steer, 1990) consists of 21 descriptive statements of anxiety symptoms that are rated on a 4-point scale. This scale measures the severity of self-reported anxiety. The following cut score guidelines for the total scores recommended by Beck and Steer were used: 0-7 (minimal), 8-15 (mild), 16-25 (moderate), and 26-63 (severe). For the present study, reliability was .85 (95% CI = .82, .88).

The Coping Responses Inventory (CRI-Youth Form; Moos, 1993) is a 48-item instrument designed to measure eight different types of coping responses to stressful life circumstances. These responses are measured by eight scales: Logical Analysis (LA), Positive Reappraisal (PR), Seeking Guidance and Support (SG), Problem Solving (PS), Cognitive Avoidance (CA), Acceptance or Resignation (AR), Seeking Alternative Rewards (SR), and Emotional Discharge (ED). The first set of four scales assess approach coping, whereas the second set of four scales assess avoidance coping. The first two scales in each set measure cognitive coping strategies, and the third and fourth scales in each set assess behavioral coping strategies. Each of these eight scales consists of six items. According to Moos (1993), “In responding to the CRI-Youth, adolescents select and describe a recent (local) stressor and use a four-point scale (varying from “not at all” to “fairly often”) to rate their reliance on each of 48 coping items” (p. 1). All raw scores were converted to *T*-scores, using conversion tables provided by Moos (1993). Specifically, as recommended by Moos (1993), *T*-scores above 54 were classified as representing above average scores (desirable

response) for the four approach coping scales, and *T*-scores below 46 were categorized as representing below average scores (desirable response) for the four avoidance coping scales. For the present investigation, score reliability for the total scale was .84 (95% CI = .80, .87).

All instruments were translated into Arabic using the translation-back translation method (Herrera, DelCampo, & Ames, 1993).

We started reviewed the instruments and translate it to Arabic version ,then we started standardization of the tools in the Palestinian society.

### **Data Analysis**

The data were analyzed using descriptive and inferential analyses. The inferential analyses included use of chi-square analyses and independent samples *t*-tests to examine relationships among the selected variables. In addition, a canonical discriminant analysis was used to determine whether any of the coping responses or the anxiety or depression scores (i.e., dependent variables) discriminated adolescents diagnosed with PTSD and those not diagnosed with PTSD (i.e., group membership). Canonical discriminant analyses describe the differences on dependent variables that are measured on the interval or ratio scale and/or are dichotomous with respect to a nominally scaled variable, namely group membership (Huberty, 1994; Onwuegbuzie & Daniel, 2003). In the present study, there were 10 predictors (i.e., 8 coping responses, 1 depression score, and 1 anxiety score) and one outcome (group membership) variable (i.e., incidence of PTSD). The number of canonical functions (i.e., factors) that are yielded for a given data set is equal to the number of groups being compared minus one. Because two groups were involved, one canonical function was generated.

### **Results**

Psychological traumatic events reported by the participants, in order of endorsement rate, included the witnessing of a friend being killed (48.5%), a family member being killed (15.7%), home being demolished (7.9%), a friend being injured through confrontation with Israeli soldiers (6.1%), study participant being personally shot (4.4%), family member being shot (3.5%), firing of missiles (7.9%), physical injury (2.6%), and kicking and punching by the army (1.8%). Approximately one-third (34.1%) of participants indicated that the painful event had directly involved them. Of those who indicated that the painful event cited had involved someone else, 31.0% reported that it had involved a friend, 16.6% a known society

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member (e.g., community leader), 11.8% a relative, 8.3% an immediate family member, and 6.1% a combination of family and friend.

## **Post-Traumatic Stress Syndrome**

With respect to scores on the PTSD-I, 68.9% of the sample were classified as having developed PTSD, and there was no statistically significant difference between males (69.0%) and females (68.9%) with respect to this diagnosis. Also, no statistically significant difference with regard to PTSD diagnosis emerged between participants who reported that their painful event directly involved them (67.6%) and those who reported that the event involved someone else (70.6%).

## **Depression**

The BDI scores revealed that 13.5% of the sample was classified as having serious depression, 26.5% as having moderate depression, 22.8% as having mild depression, and 37.2% as having minimal depression. Thus, 40.0% of the participants reported moderate or severe levels of depression. The mean BDI score was 17.7 ( $SD = 10.38$ ). A series of independent  $t$ -tests was conducted to examine differences in gender and locus of painful event with respect to the total BDI scores. After applying the Bonferroni adjustment, the  $t$ -tests revealed no statistically significant difference between female participants ( $M = 17.3$ ,  $SD = 9.65$ ) and male participants ( $M = 18.1$ ,  $SD = 11.03$ ). Similarly, no statistically significant difference emerged between participants who reported that their painful event directly involved them ( $M = 19.4$ ,  $SD = 16.72$ ) and those who reported that the event involved someone else ( $M = 16.7$ ,  $SD = 9.63$ ).

## **Anxiety**

The BAI scores revealed that 94.9% of the sample was classified as having severe anxiety levels, and 5.1% as having moderate anxiety levels. The mean BAI score was 40.0 ( $SD = 9.68$ ). A series of independent  $t$ -tests, after applying the Bonferroni adjustment, revealed no statistically significant difference ( $t = 1.82$ ,  $p > .05$ ) between male ( $M = 38.9$ ,  $SD = 9.37$ ) and female ( $M = 41.3$ ,  $SD = 9.91$ ) participants. However, participants who reported that their painful event directly involved them ( $M = 42.3$ ,  $SD = 8.74$ ) reported statistically significantly higher levels of anxiety than did those who reported that the event involved someone else ( $M = 38.6$ ,  $SD =$

10.00). The effect size ( $d$ ) associated with this gender difference was 0.38, which, using Cohen's (1988) criteria, can be considered small to moderate.

### **Coping**

Moos' (1993) criteria were used to determine coping responses that were below and above average. As noted above,  $T$ -scores above 54 were classified as representing above average scores (desirable response) for the four approach coping scales, and  $T$ -scores below 46 were categorized as representing below average scores (undesirable response) for the four avoidance coping scales. According to Moss (1993, pp. 4-5),  $T$ -scores ranging between 46 and 54 are considered average ( $M = 50$ ,  $SD = 10$ ). With respect to the approach coping scales, the proportion of adolescents whose coping responses were below average (undesirable response) were as follows: Logical Analysis (69.9%), Problem Solving (60.3%), Positive Reappraisal (46.7%), and Seeking Guidance and Support (46.7%). With regard to the avoidance coping scales, the proportion of adolescents whose coping responses were below average (undesirable response) were as follows: Acceptance or Resignation (49.8%), Seeking Alternative Rewards (45.4%), Emotional Discharge (38.0%), and Cognitive Avoidance (28.8%).

### **Predictors of Post-Traumatic Stress Disorder**

The resulting discriminant function was statistically significant,  $F(10) = 17.29$ ,  $p < .05$  (canonical  $R = .29$ ). The group centroids were 0.20 for adolescents diagnosed with PTSD and -0.46 for adolescents not diagnosed with PTSD, indicating that this function discriminated between these two groups. An examination of the within-group standardized coefficients (Table 1) indicated that, using a cutoff loading of 0.3 (Lambert & Durand, 1975; Tabachnick & Fidell, 1996), the following five variables made an important contribution to the discriminant function: depression, anxiety, positive reappraisal, seeking guidance and support, and seeking alternative rewards. Depression and seeking alternative rewards made the biggest contributions. The pooled within-group correlations (i.e., structure coefficients; Table 1) indicated that four of these five variables made an important contribution to the canonical function: depression, anxiety, positive reappraisal, and seeking guidance and support. Depression made the largest contribution, followed by anxiety. Because seeking alternative rewards was characterized by a large standardized coefficient and a small structure coefficient, this variable served as a suppressor (Onwuegbuzie & Daniel, 2003). The positive standardized and structure coefficients indicate that high scores are associated with PTSD diagnosis, whereas negative

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standardized and structure coefficients indicate that high scores are associated with non-PTSD diagnosis

**Table (1)**  
**Standardized and Structure Coefficients Pertaining to Discriminant Analysis: Coping, Anxiety, and/or Depression Scores Discriminating Adolescents Diagnosed With PTSD and Adolescents not Diagnosed With PTSD**

Measure	Standardized Coefficients	Structure Coefficients
<b>Coping Variables:</b>		
Logical Analysis	.13	.19
Positive Reappraisal	.47*	.37*
Seeking Guidance and Support	-.48*	-.34*
Problem Solving	-.16	-.02
Cognitive Avoidance	-.01	.28
Acceptance or Resignation	-.28	-.07
Seeking Alternative Rewards	.54*	.24
Emotional Discharge	-.19	.07
<b>Depression Variable:</b>		
Total Depression Scores	.53*	.63*
<b>Anxiety Variable:</b>		
Total Anxiety Scores	.34*	.51*

- significant loadings (i.e., loadings greater than .3)

### **Discussion:**

The present study indicates that a significant proportion of Palestinian children and adolescents living in the refugee camps of Rafah and Khan-Younis in the southern region of the Gaza Strip are experiencing psychological distress as a result of the violence associated with the second Intifada. In particular, 69% of the adolescents were classified as having developed PTSD. This proportion is larger than that reported by Qouta, Punamaki, et al. (2001) for children and adolescents in selected refugee and non-refugee camps in the Gaza Strip. Thus, the present prevalence rate (i.e., 69%) is extremely disturbing, especially bearing in mind the fact that PTSD has been found to lead to negative outcomes, including depression and suicidal behavior (Grunebaum, Malone, & Mann, 2003). Both within and outside of these refugee camps in Gaza, adolescents continue to be direct and indirect victims of official and unofficial violence, thereby harboring an increasing sense of helplessness and despair. Nearly one-half of the

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Palestinian participants (40.0%) were classified as reporting moderate or severe levels of depression.

Additionally, the results of the anxiety scale demonstrate that Palestinian adolescents are predominantly occupied with an intense experience of uncertainty and anxiety. Disturbingly, all sample members reported moderate or severe levels of anxiety. Further, between 29% (Cognitive Avoidance) and 70% (Logical Analysis) of the sample reported undesirable coping responses. These results suggest that a significant proportion of adolescents in the refugee camps of Rafah and Khan-Younis do not have the necessary coping resources to deal with problems and stressors. Unfortunately, poor coping responses have been found to predict an array of negative outcomes such as alcohol and drug use, conduct disorder, and behavior problems (Moos, 1993).

The canonical discriminant analysis revealed that adolescents diagnosed with PTSD tended to be those who reported the highest levels of depression, anxiety, and positive reappraisal coping and the lowest levels of seeking guidance and support coping. Seeking alternative rewards served as a suppressor variable. Suppressor variables are variables that assist in the prediction of dependent variables due to their correlation with other independent variables (Tabachnick & Fidell, 1996). Consequently, the inclusion of seeking alternative rewards in the canonical correlation model strengthened the multivariate relationship between coping responses, anxiety, and depression as independent variables and the occurrence of PTSD. Thus, adolescents in the refugee camps of Rafah and Khan-Younis in the Gaza Strip are experiencing extremely high rates of psychological maladjustment, with one mental disorder (e.g., anxiety, depression) being associated with an increased likelihood of the adolescent experiencing another mental problem (e.g., PTSD).

The relationship found between coping responses and PTSD is congruent with Kuterovac-Jagodic (2003) who reported that the type of coping strategies is predictive of both short- and long-term PTSD reactions. It is also consistent with Durakovic-Belko, Kulenovic, and Dapic (2003) who observed that coping mechanisms play an important role in determining who will experience the most severe PTSD symptoms. The fact that adolescents diagnosed with PTSD were found in the current study to be those who relied less on coping based on seeking guidance and support is somewhat consistent with Dirkzwager, Bramsen and van der ploeg (2003) who reported that less use of coping strategies involving seeking social support was associated with higher PTSD symptom severity. Also, the

finding that adolescents diagnosed with PTSD were found in the present investigation to be those with the highest levels of coping associated with positive reappraisal is somewhat consistent with Dirkzwager et al. (2003) who noted that more use of coping strategies involving “wishful thinking” was associated with greater PTSD symptoms. Future research, using qualitative techniques, should investigate this link between positive reappraisal and PTSD among Gaza youth.

Common themes that pervade the responses of the participants are the multiple losses they have endured, including personal, family, and community losses. For example, approximately one-half (48.5%) of the participants reported the death of a family member, and 15.7% and 7.91% witnessed the demolition of homes and the injury of a friend, respectively. Also, approximately one-third (34.1%) of participants indicated that the painful event cited had directly involved them. Of those who indicated that the painful event cited had involved someone else, 31.0% reported that it had involved a friend, 16.6% a known society member, 11.8% a relative, 8.3% an immediate family member, and 6.1% a combination of family and friend. The overall findings in the present study indicate that these adolescents experience significant levels of psychological distress as a result of the high frequency of anxiety, depression, and preoccupation with the traumatic situation. Studies of Garbarino, Kostelny, and Dubrow (1991) offer support for these findings. Specifically, these researchers found that the accumulation of traumatic experiences is increasingly becoming a core feature of their lives, rather than an isolated incident of trauma.

Comparing the present results to those examining the rate of PTSD among Palestinian children and adolescents in Gaza during the first Intifada (Uprising) (1987–1993) (e.g., Elbedour, 1998) demonstrates that the psychological damage inflicted by the violence of the past three years remains severe, interfering substantially with the adolescents’ psychological functioning. In fact, the current Al-Aqsa Intifada is notable for the number of deaths of children and adolescents (Amnesty International Press Release, 2003). According to Elbedour (1998), who used the Derogatis Psychiatric Rating Scale (i.e., SCL-90-R; Derogatis, 1983), between 12% and 18% of Palestinian youth were found clinically to meet the criteria for PTSD during the first Intifada. Garbarino and Kostelny (1996) explored this topic and found similar estimates of psychological distress among the Palestinian children.

The current findings must be interpreted with some caution. In particular, this study utilized a cross-sectional design and, thus, it is difficult

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to determine whether the psychological disturbances reported by the participants were the direct result of the increasingly violent nature of the occupation, and/or whether they were exacerbated by the absence of social services and the poor fabric of community and governmental institutions in Gaza. As stated by Summerfield (1995), trauma is more a by-product of the collapse in social justice than it is a medical problem. Consequently, although trauma victims seek psychological assistance, it is more important that they receive social justice (Summerfield, 1995). In Gaza, which has a population density of 2,150 people per km<sup>2</sup> (Thabet & Vostanis, 2000), 78% of the 825,000 inhabitants are still labeled refugees (Thabet & Vostanis, 2000), and because of the unresolved conflict between the Israeli and Palestinians, more than 50% still live in "permanently temporary" shantytowns (Yahya, 1991), which are "places where people exist rather than live" (McDowall, 1989, p. 20). In such a disintegrated climate it is difficult to receive the social, community, and interpersonal support needed to cope with or protect against the anxieties and worries of an uncontrollable environment (Elliot, 2002). Schools that typically function as a secure base are unprepared to deal with large-scale crises. These realities are relevant factors that may precipitate or intensify the severity of their traumatic exposure and thus predict deficits in their sense of safety, power, and protection.

Another potential concern is that the data obtained in the present study were not extracted via multiple data sources (e.g., teachers, parents, peers), but were based only on adolescents' own evaluations. In addition, it should be noted that no Palestinian control group was available for comparison because the whole Palestinian population is affected by the ongoing Al-Aqsa Intifada. The present findings also are limited by the fact that these data were collected using instruments that have been developed outside the cultural and linguistic context of the Palestinian sample. That is, the instruments used were not normed using local populations (i.e., Palestinian adolescents). Thus, it is possible that this limitation may have skewed the reported prevalence of PTSD, depression, and/or anxiety among the participants. However, it should be noted that every effort was made by the researchers to minimize error in translation, for example, by using the translation-back translation method (Herrera et al., 1993). Further, it should be pointed out that the score reliability indices pertaining to all measures used in the present study were in the acceptable range (i.e., > .70; Nunnally & Bernstein, 1994).

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According to Pynoos, Kinzie, and Gordon (2001), proactive strategies are highly recommended for shattered communities who have undergone political, social, and community disintegration. Regardless of the outcome of the Israeli and Palestinian peace talks, the international community must assist the Palestinian children growing up in enclaves known as refugee camps. Indeed, unresolved trauma, absence of humane and therapeutic concerns, coupled with the aversive impoverished socio-economic conditions, are potent risk factors that continue to damage the lives of adolescents and their families. In essence, severe and prolonged unresolved conflict will serve to reinforce the community's pre-occupation and fixation with war and violence.

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