IMPACT OF EXPOSURE TO ARMED CONFLICT ON POST-TRAUMATIC STRESS DISORDER (PTSD) AND DEPRESSION OF THE PALESTINIAN SCHOOL CHILDREN

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Abstract: Due to the ongoing conflict, Palestinian children are suffering from depression, Post-Traumatic Stress Disorder (PTSD) and anxiety among other negative mental symptoms. All these hinder the progression of the normal healthy life of a child, which can also lead to symptoms that persist throughout that child's lifetime and may even lead to major depression followed by suicide.

This study, in collaboration with HBSC, aims to assess the impact of the issue facing Palestinian children. This assessment includes a questionnaire to assess the psychological effects of the conflict on schoolchildren from a representative sample of Palestinian students. Determining the exact way in which witnessing violence affects the mental state of schoolchildren can be a rough indicator of how additional plans are implemented. The results from this study may begin to improve the quality of life of Palestinian youth and the Palestinian population in general.

Key words: Depression, post-traumatic stress disorder, mental state, quality of life, psychological treatment

1. Introduction

Epidemiological studies have shown that armed conflicts are associated with a wide range of child mental health outcomes. These may range from a number of symptoms. Some cases would show resilience to exhibit any symptoms of distress as a form of coping mechanisms, while other cases may present by increased psychological distress and heightened prevalence of mental disorders to include symptoms of post-traumatic stress disorder (PTSD), depression, loss of interest and anxiety disorders among others [1].

Research in the past few decades has documented the many aspects in which exposure to war-related traumatic events contributes to subsequent mental health distress, and in some extreme cases longer-term psychopathology in children and adolescents [2].

Researchers have documented the ways in which exposure to war-related traumatic events contributes to subsequent mental health distress including post-traumatic stress disorders (PTSD), and in some cases, long-term psychopathology in children and adolescents. Children witnessing violence, tend to display problematic behaviors including aggression, withdrawal, hyperactivity, poor academic performance, tobacco use, and anti-social behaviors. As a result, children should be provided with ways to cope with these conflicts and circumstances and to express their emotions and thoughts to help them deal with these stressful situations [5].

For instances, some countries implement post-conflict activities to help children and adolescent cope with the consequences of the conflict. Since only a small number of children show resilience to any negative outcomes the conflict may cause, such activities by any superior authority are crucial for maintaining a healthy mental state [1].

Due to the ongoing conflict, Palestinian children are suffering from depression, Post-Traumatic Stress Disorder (PTSD) and anxiety among other negative mental symptoms. All these hinder the progression of the normal healthy life of a child, which can also lead to symptoms that persist throughout that child's lifetime and may even lead to major depression followed by suicide. Up to my knowledge, there are no studies that accordingly evaluate the size and intensity of the problem facing Palestinian children [3].

A child's exposure to violence through armed conflict leads to certain upsets in the mental health of the child. Countless children live in areas where armed conflict has been reported [4]. As a result of the ongoing conflict between the Palestinians and the Israelis, the vulnerability of children and adolescent has caused them to be a target to the negative effects exposure to violence has on the mental health of this population. Even though the conflict has been ongoing for more than half a century, the size of the problem has yet to be evaluated. Moreover, a strategy to address this problem in order to allow children to deal with their frustration and any other symptoms they may suffer from is still absent [5].

Effects of conflicts on children's psychological health

Psychosocial effect

The prolonged occupation has touched every Palestinian in one way or another. The effect includes injuries, constant fear, and loss of loved ones. Although most research studied the profound impact of armed conflict on the psychological well-being of children, most of them have exclusively focused on their effect on post-traumatic stress disorder, depression and fear especially in the Palestinian Territories [6]

Recently, children in Gaza and the West Bank have been the focus of many studies regarding post-traumatic events, all conducted using different research methods Although the studies outcomes were wide-ranging, they all showed that the post-traumatic effect on the population as a whole was remarkable (or significant) [3] [7] [8]. Physical injuries, fear, consequences related to the death of loved ones, behavioral problems, social impairment, and psychosomatic disorders are events a child is at risk of having during or after armed conflict. In most cases, it leads to depression and post-traumatic stress disorders due to the fact that the psychosocial well-being is affected by the holistic health of human [6].

Posttraumatic Stress Disorder

According to the American Psychological Association (APA), PTSD is defined as "an anxiety problem that develops in some people after extremely traumatic events, such as combat, crime, an accident or natural disaster" [9]. In order to be diagnosed with PTSD, one should be exposed to certain events, and show certain symptoms. There are four main stressors and events that lead to PTSD which are: death of a loved one, life-threatening event, physical injury or endangerment, and sexual violence. [10]. The national institute of mental health categorizes the symptoms into three main categories. The first category is re-experiencing the symptom, which includes flashbacks of the incident and may be accompanied by physical symptoms, terrifying dreams and frightening thoughts which usually occur on a daily basis. The trigger for re-experiencing symptoms varies from a thought, feeling or a similar event that caused the PTSD in the first place. The second category is the avoidance symptoms, symptoms in this category causes change in someone's daily life, symptoms include avoiding specific places and events that remind them of the incident, feeling depressed, worried, guilty, emotionally numb and loss of

interested in previously pleasing activities. The last category is the hyper arousal symptom, where one has difficulty sleeping, is easily frightened, and usually suffers from angry outbursts. The most difficult aspect of this category is that the symptoms are usually constant which makes it almost impossible to complete simple life essential activities such as sleeping, eating and walking [11] [10] [12] [13].

In Palestine, the prevalence rates of PTSD are also high. A 2010 report showed that on average, 35.5% of students in Gaza and the West Bank have or had PTSD at some point in their lives [14]. In 2012, another study reported that 56.8% of adolescents experienced some form of PTSD.] An additional report by Dimitry (2012) showed that Palestinian children and adolescents have the highest prevalence rates of PTSD compared to other countries in the region including Lebanon, Iraq and Israel [15].

Depression

PTSD is not the only topic of interest in regard of the psychosocial well-being in Palestine; symptoms and consequences of depression are also highly studied topics.

In Palestine, the prevalence of depression in 2012 studied by Madianos (2012) [8]. He used the international diagnostic and statistical Manual for mental disorders also known as DSM-IV for his examinations. The results yielded lifetime prevalence rates of about 24.3 % for Major depression episodes and also demonstrated the direct association between experiencing a traumatic event and the risk of having depression. It should be mentioned that gender was taken into consideration as a way of limiting one of the confounding factors, and the results showed that there were almost no significant differences in gender [8].

However, a study conducted by Canetti in 2010, showed that men were more likely to develop major depression compared to women. The main support for this claim is nearness to the political violence exposure as men are more likely to involve directly with the armed conflict and violence in general [16]. This emphasizes that men are at a higher risk for developing major depression in times of exposure to armed conflicts. In most instances, socio-political stressors were the leading causes of major depression in women [16].

A recent study conducted on the children of the Gaza Strip showed that experiencing fear and traumatic event during the war in 2009 has resulted in problems in friendship and siblings' relation problems as children tended to be more violent and isolated. Isolation is one of the signs of developing Major depression [17]. The aforementioned association was also supported by a study that focused on the political violence impact on depression among the Palestinian children. The study used the Beck Depression Inventory (BDI). The results of the study showed the 188% of the sample of the sample 18.8% topped the cut-off score in the depression scale. The exposed group scored significantly higher and acuter degree of depression. Other confounding factors were taken into account such as the family income, age, place of residence, and gender but the results did not show and significant association [18].

This study aims to investigate the relationship between exposure to armed conflict and children's psychological health and to assess the prevalence, the impact of armed conflict on post-traumatic stress disorder (PTSD) and depression among school children of the West Bank.in the West Bank.

2. Methodology

2.1. Survey design

A representative sample of Palestinian Arab students in grades 5-9 (ages 10-15) from 93 single-sex and 7co-ed schools in the West Bank and East Jerusalem, participated in the study which was administered by the Palestinian Authority or the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA).

The 100 schools were randomly selected and stratified by school authority (60 governmental, 40 UNRWA) and by region (proportional to population size). From each selected school, 60 students were randomly selected, stratified by grade (twelve students from each grade level), yielding a gross sample of 5,981 students. Some of the selected schools had less than twelve students in one or more of the targeted grades. Twice as many girls' schools than boys' schools met the sampling requirements, hence girls were overrepresented in the student sample (4,004 girls and 1,957 boys). Data collection included: (1) an in-class student questionnaires regarding bullying, political violence, home violence, self-disclosure to parents and friend, school satisfaction etc. and (2) a parental background questionnaire including their education level (paper and pencil – administered at home). Due to the nature of the sample and the data collection method (in class group administered surveys), participation rates were high. All student-reported instruments were higher than 95%, parental questionnaire was 84%. After deleting cases with missing values, 5713 cases 95.5% of the original 5981 remained. Below we detail the measures used in the study.

2.2. Measures

Palestinian students' exposure to armed conflict was measured using a scale called Subjective Threat from Armed Conflict Events (STACE). STACE mainly

addressed the intensity of event as well as the physical consequences of the exposure to ACE. The students were first asked if they were exposed to an Armed Conflict Event (ACE) and using a "Guttman-Scale" approach examined the nature of the exposure. The questionnaire included 10 levels of questions to measure the intensity of the exposure as follows:

1. I witnessed the arrest of someone I know by the Israeli army.
2. I witnessed the injury of somebody I know by the Israeli army.
3. I witnessed the demolishment of the house of somebody I know.
4. I have been threatened with violence by the Israeli army.
5. I heard about the death of somebody I know by the Israeli army.
6. I have personally been arrested by the Israeli army.
7. My house has been raided at night or during the day by the Israeli army.
8. I have been hurt either physically or emotionally by the Israeli army.
9. I witnessed the demolishment of my own house by the Israeli army.
10. I witnessed the death of somebody I know by the Israeli army.

The previously mentioned levels are scaled according to the intensity of the event. The intensity increases from 1-10. Levels 1-3 are categorized as low intensity exposure, 4-7 are considered as intermediate exposure, and finally 8 through 10 are considered to be of high intensity.

In order to determine the negative effect of the exposure to armed conflict, the questionnaire also includes questions regarding a range of issues including smoking, parental, school and peer support, youth violence, depressive symptoms, and symptoms of PTSD.

Analyzing depressive symptoms from the questionnaire include a series of statements that addresses the students' perspective on the negative aspects of their lives. The set of statements allows 3 options as potential answers (always, sometimes or never), and are as follows:

1. I feel like I'm about to cry.
2. I consider running away.
3. I experience stomach ache.
4. I feel like life is worthless.
5. I suffer from nightmares.
6. I experience extreme loneliness.
7. I experience severe misery.
8. I feel bored.

The support system of the students was also examined by asking a series of questions regarding the parents' support they might or might not receive as well as the peer support from friends and finally support from the school that comes directly from the teachers and the school system itself. The questions concerning support range from mistreatment, to bullying, to easiness of making conversations with parents, friends and teachers.

2.3. Study Variables

The main purpose of the study is to use the STACE scale developed by Harel et al. 2010 [14] on the newly collected data set form HBSC study 2013 [19]. The first aim was to assess the social determinants of PTSD the depression symptoms of exposure to armed conflict events and its associated levels of subjective threat. The second aim was to investigate the anticipating relationship between the levels of STACE and two gatherings of psycho results: (1) positive prosperity (positive life recognitions and life fulfillment), and (2 mental problems (PTSD and Depression). The third aim was to discover the role of parents and schools supports in reducing the impact of armed

conflict on the psychological outcomes across the Palestinian children.

2.4. Statistical analysis

Differences between demographic variables and in social support, school satisfaction, mental health and exposure to armed conflict events were examined using χ^2 for categorical variables, one-way ANOVAs for continuous variables. Analyses were performed using SPSS version 20.0 for windows (IBM, 2011).

Sets of Hierarchical linear regression models were constructed for study population for each of the three dependent variables: GSS (PTS), exposure intensity level and Posttraumatic stress symptoms. The independent variables were gender, age, exposure to armed conflict events as measured by STACE, and parental support.

3. Results

Participant socio-demographic characteristics by age group and gender are presented in Table 1. Participants are distributed uniformly between different age groups and genders; the sample was stratified according to grade level and gender type in about 20 % of each grade. The respondents were distributed as 33% boys and 67% girls. Some of the selected schools had less than twelve students in one or more of the targeted grades. Twice as many girls' schools than boys' schools met the sampling requirements, hence girls were overrepresented in the student sample (3,813 girls and 1,902 boys).

Table 1. Study participants distribution by grade and gender

	Boys		**Girls**		**Total**
Grade	**N**	**%**	**N**	**%**	**N**
5	386	20.3	761	20.0	1147
6	377	19.8	770	20.2	1147

7	380	20.0	769	20.2	1149
8	389	20.5	760	19.9	1149
9	370	19.5	753	19.7	1123
Total	1902		3813		5715

The global symptoms scores, the exposure intensity level, Posttraumatic stress symptoms, Positive Health, and Global Symptom Score distribution by gender are presented in table 2. The girls have more exposure intensity levels than boys (55.8%, 28.1%) respectively. Girls double exposed to posttraumatic stress symptoms than boys (42.2%, 21.4%) respectively.

Table 2. Study variables distribution by gender

	Boys		**Girls**	
	N	**%**	**N**	**%**
exposure intensity level	1573	28.1	3121	55.8
Positive Health	435	7.9	822	14.9
Posttraumatic stress symptoms	1179	21.4	2321	42.2
Global Symptom Score (GSS)	1065	19.2	2058	37.1

A chi-square test of independence was performed to examine the relation between the subjective threat from armed conflict events (STACE) and the study variables. Table 3 shows that the relations between these variables were strongly significant in all study variables. Results in table 3 shows that girls most likely to

show higher significance than boys mainly in perceiving peer support, X2 = 11.8, 10.4 girls boys respectively.

Table 3. Chi-Square analysis for STACE study variables and gender

	Boys	Girls	Total
Depressive symptomatology	18.6***	44***	62.2***
Global depressive symptomatology	35.9***	64***	98.5***
Positive health	17.9***	47.3***	62.4***
Parent support group	16***	42.5***	58***
Family support group	21***	55.3***	74.7***
peer support group	10.4**	11.8***	22.1***
Grade	22.1**	38.3***	54.4***
Authority	1.7	2.1	0.5

* P<0.05, **<0.001, ***<0.0001

Table 4 shows the relation between the subjective threat from armed conflict events (STACE) and the study variables. Table 4 shows that the relations between these variables were strongly significant in all study variables. Results in table 3 shows that public school students reported higher impact than UNRWA students except for the global depressive symptoms (PTSD) the UNRWA students most likely reported higher significance to the subjective threat from armed conflict events, X2 = 58.8, 42.9, P<0.0001, P<0.001 UNRWA and public students respectively.

Table 4. Chi-Square analysis for STACE study variables and supervised authority

	Public	**UNRWA**
Depressive symptomatology	33.5***	30.9***
Global depressive symptomatology	42.9***	58.8***
Positive health	44.6***	24***
Parent support group	49.2***	12.7***
Family support group	43.7***	31.3***
peer support group	17.3***	6.1*
Grade	36.1***	22.7***
Gender	**0.2**	**8.1****

* P<0.05, **<0.001, ***<0.0001

Table 5 shows the relation between the subjective threat from armed conflict events (STACE) and the study variables. Table 5 shows that the relations between these variables were strongly significant in all study variables. Results in table 4 shows that grade 5 and most likely reported higher significance than higher grades. The social support (Parents, family and peer) was highly significance at grade 5, 8 and 9, while for grades 6 and 7 was less significance. Furthermore, the global depressive symptoms (PTSD) were higher at grade 7 than other grades, X^2 =22.9, 16.5, 38.3, 14.4 and 15.6, P<0.0001, 0.0001,0. 0001,0.001, for grades 5,6,7,8, and 9 respectively.

Table 5. Chi-Square analysis for STACE study variables and Grade

	Grade 5	Grade 6	Grade 7	Grade 8	Grade 9
Depressive symptomatology	16.9***	13.3**	13.374**	9.472**	8.419
Global depressive symptomatology	22.9***	16.451***	38.325***	14.433**	12.568**
Positive health	16.7***	14.962**	21.757***	8.498	3.703
Parent support group	11.8***	5.016	2.738	17.768***	17.705***
Family support group	16.7***	12.67**	3.491	13.936**	21.803***
peer support group	1.7	12.426**	6.245	5.207	1.053
Gender	1.5	3.191	5.892	0.475	0.914
Authority	0.8	2.175	0.408	0.618	0.81

* P<0.05, **<0.001, ***<0.0001

Study Variable Inferential Analysis:

Table 6 shows a logistic regression analysis was conducted to predict global depressive symptomatology using STACE, age and gender as predictors for Public Schools. A test of the full model against a constant only model was statistically significant, indicating that the predictors as a set reliably distinguished between those with and without symptoms (chi square = 43.8, p < .000 with df = 2). The Wald criterion demonstrated that age (p=0.045), parent support (p=.039) and peer support (p=.032) made a significant contribution to prediction. Gender was not a significant predictor. EXP(B) value indicates that when STACE is raised by one unit the odds ratio is 1.4 times as large and therefore children are 1.4 more times likely to experience global depressive symptomatology. Likewise, EXP(B) value indicates that when age is raised by one unit (one year) the odds ratio is 1.27 times as large and

therefore children are 1.27 more times likely to experience global depressive symptomatology

Table 6. Logistic Regression Models Predicting the Level of GSS by study variables

	Public				**UNRWA**			
	B	**S.E.**	**P Value**	**β**	**B**	**S.E.**	**P Value**	**β**
Subjective threat from armed conflict events (STACE)	.367	.347	.290	1.444	.706	.531	.184	2.026
Gender (Female(1=Yes))	-.113	0.088	.201	.893	-.003	0.1	.974	.997
Age1(Grade 5-6)	-.226	0.112	.045	.798	-.182	0.134	.172	.833
Age2 (Grade 7-8)	-.038	0.11	.730	.963	.048	0.133	.719	1.049
Parent Support	.238	0.115	.039	1.268	.064	0.137	.643	1.066
Family Support	-.128	0.114	.261	.880	-.087	0.136	.524	.917
Peer Support	-.182	0.085	.032	.833	-.020	0.103	.843	.980

A logistic regression analysis was conducted to predict global depressive symptomatology using STACE, age and gender as predictors for UNRWA Schools as shown in table 6. A test of the full model against a constant only model was statistically significant, indicating that the predictors as a set reliably distinguished between those with and without symptoms (chi square = 61.6, $p < .000$ with $df = 2$). The Wald criterion demonstrated that STACE, age, peer support, family support, parent support and gender were had no significant predictor. EXP(B) value indicates that when STACE is raised by one unit the odds ratio is 2 times as large and therefore children are 2 more times likely to experience global depressive symptomatology. Likewise, EXP(B) value indicates that when age is raised by one unit (one year) the

odds ratio is 1.1 times as large and therefore children are 1.1 more times likely to experience global depressive symptomatology.

Table 7 shows a logistic regression analysis was conducted to predict Level of Depressive symptomatology using STACE, age and gender as predictors for Public Schools. A test of the full model against a constant only model was statistically significant, indicating that the predictors as a set reliably distinguished between those with and without symptoms (chi square = 60.2, p < .000 with df = 2). The Wald criterion demonstrated that STACE (p=0.000), age (p=0.000) and parent support (p=.000) made a significant contribution to prediction. Gender was not a significant predictor. EXP(B) value indicates that when STACE is raised by one unit the odds ratio is 3.7 times as large and therefore children are 3.7 more times likely to experience Level of Depressive symptomatology. Likewise, EXP(B) value indicates that when children did not perceive enough parent support the odds ratio is 1.6 times as large and therefore children are 1.6 more times likely to Level of Depressive symptomatology.

Table 7. Logistic Regression Models Predicting the Level of Depressive symptomatology

	Public				**UNRWA**			
	B	**S.E.**	**P Value**	**β**	**B**	**S.E.**	**P Value**	**β**
Subjective threat from armed conflict events (STACE)	1.310	0.363	.000	3.707	1.222	0.512	.017	3.393
Gender (Female(1=Yes))	-.002	0.093	.987	.998	-.026	0.105	.802	.974
Age1(Grade 5-6)	-.446	0.119	.000	.640	-.309	0.142	.029	.734

Age2 (Grade 7-8)	-.076	0.119	.522	.927	-.056	0.143	.693	.945
Parent Support	.436	0.119	.000	1.546	.257	0.143	.073	1.293
Family Support	-.182	0.117	.120	.833	-.194	0.142	.172	.824
Peer Support	-.161	0.089	.069	.851	-.151	0.108	.161	.859

A logistic regression analysis was conducted to Level of Depressive symptomatology using STACE, age and gender as predictors for UNRWA Schools as shown in table 7. A test of the full model against a constant only model was statistically significant, indicating that the predictors as a set reliably distinguished between those with and without symptoms (chi square = 96.3, $p < .000$ with df = 2). The Wald criterion demonstrated that STACE ($p=0.017$) and age ($p=0.029$) made a significant predictor. The peer support, family support, parent support and gender were had no significant predictor. EXP(B) value indicates that when STACE is raised by one unit the odds ratio is 3.4 times as large and therefore children are 3.4 more times likely to experience Level of Depressive symptomatology. Likewise, EXP(B) value indicates that when children did not perceive enough parent support the odds ratio is 1.3 times as large and therefore children are 1.3 more times likely to Level of Depressive symptomatology.

4. Conclusion

The results showed that Palestinian school-age children were very highly vulnerable to armed conflict, with a large number of children reporting symptoms of PTSD. This high prevalence can be compared to the rate of PTSD found in children exposed to the pressure of extreme political violence. The high rates of PTSD symptoms in Palestinian children are likely to be attributed to living under conditions

of constant political persecution, experiences of death, destruction and excessive demands. Children who developed post-traumatic symptoms reported having been subjected to political trauma, such as being injured, killed, imprisoned, beaten or destroyed, the results of this study showed a specific relationship between PTSD in children and some characteristics of children including sex, age, child work and child residence.

The findings from this research study have important implications for the prevention of PTSD and depression. This may include public education on the link of social and economic conditions and the family environment to childhood, PSTD; and routine screening of PSTD symptoms among children living in conflict zones. Continuous psychosocial intervention and additional support for children with PTSD can be performed. It is clear that children with PTSD benefit from efforts that support their expression of fear and fear. A favorable family environment can relieve stress and act as a source of stability for post-traumatic stress adaptation, so strengthening services designed to support and educate families in imperfect situations should be a major goal of psychosocial intervention. The professional survey helps create a unified work front to increase children's well-being and resilience as well as facilitate positive family interaction patterns.

5. References

1. Attanayake, V., et al., *Prevalence of mental disorders among children exposed to war: a systematic review of 7,920 children.* Medicine Conflict and Survival, 2009. **25**(1): p. 4-19.

2. Betancourt, T.S. and K.T. Khan, *The mental health of children affected by armed conflict: Protective processes and pathways to resilience.* International review of psychiatry, 2008. **20**(3): p. 317-328.

3. Khamis, V., *Post-traumatic stress and psychiatric disorders in Palestinian adolescents following intifada-related injuries.* Social Science & Medicine, 2008. **67**(8): p. 1199-1207.

4. Schauer, E. and T. Elbert, *The psychological impact of child soldiering*, in *Trauma rehabilitation after war and conflict*. 2010, Springer. p. 311-360.

5. Qouta, S., R.-L. Punamäki, and E. El Sarraj, *Child development and family mental health in war and military violence: The Palestinian experience.* International Journal of Behavioral Development, 2008. **32**(4): p. 310-321.

6. Giacaman, R., et al., *Health status and health services in the occupied Palestinian territory.* The Lancet, 2009. **373**(9666): p. 837-849.

7. Kolltveit, S., et al., *Risk factors for PTSD, anxiety, and depression among adolescents in Gaza.* Journal of traumatic stress, 2012. **25**(2): p. 164-170.

8. Madianos, M.G., A.L. Sarhan, and E. Koukia, *Major depression across West Bank: a cross-sectional general population study.* International journal of social psychiatry, 2012. **58**(3): p. 315-322.

9. Cho, G.-J. and J. Kang, *Type D personality and post-traumatic stress disorder symptoms among intensive care unit nurses: The mediating effect of resilience.* PloS one, 2017. **12**(4): p. e0175067.

10. Frances, A., *Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, big pharma and the medicalization of ordinary life.* Psychotherapy in Australia, 2013. **19**(3): p. 14.

11. Egger, H.L., et al., *The NIMH Child Emotional Faces Picture Set (NIMH-ChEFS): a new set of children's facial emotion stimuli.* International journal of methods in psychiatric research, 2011. **20**(3): p. 145-156.

12. Brewin, C.R., B. Andrews, and J.D. Valentine, *Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults.* Journal of consulting and clinical psychology, 2000. **68**(5): p. 748.

13. Barron, I.G., G. Abdallah, and P. Smith, *Randomized control trial of a CBT trauma recovery program in Palestinian schools.* Journal of Loss and Trauma, 2013. **18**(4): p. 306-321.

14. Harel-Fisch, Y., et al., *Psychosocial outcomes related to subjective threat from armed conflict events (STACE): Findings from the Israeli-Palestinian cross-cultural HBSC study.* Child abuse & neglect, 2010. **34**(9): p. 623-638.

15. Dimitry, L., *A systematic review on the mental health of children and adolescents in areas of armed conflict in the Middle East.* Child: care, health and development, 2012. **38**(2): p. 153-161.

16. Canetti, D., et al., *Exposure to prolonged socio-political conflict and the risk of PTSD and depression among Palestinians.* Psychiatry: Interpersonal and Biological Processes, 2010. **73**(3): p. 219-231.

17. Peltonen, K., et al., *Military trauma and social development: The moderating and mediating roles of peer and sibling relations in mental health.* International Journal of Behavioral Development, 2010. **34**(6): p. 554-563.

18. Sulayeh, K. and C. Mormont, *The Degree of Facing Violence and its Differences with Depression for Palestinian Children in Gaza Strip.* مجلة الجامعة الإسلامية للبحوث الإنسانية, 2016. 16 (2).

19. Inchley, J., et al., *Health behaviour in school-aged children (HBSC) study: International Report from the 2013/2014 survey.* Health policy for children and adolescents, 2016. **7**: p. 1-277.