

Resilience and Psychological Problems among Palestinians Victims of Community Violence

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المشاكل النفسية لدى الفلسطينيين ضحايا العنف المجتمعي وعلاقتها بالصمود النفسي

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Abstract

Aim: The present study examined the relationship between psychological problems in families' of victims of community violence and resilience in the Gaza Strip. **Method:** 255 participants were selected; 120 were males (47.1%) and 135 were females (52.9%). Participants were interviewed using a socio-demographic scale and Arabic versions of the Symptom Checklist-90-Revised and the Resilience Attitude Scale. **Results:** Participants' mean psychological symptoms were 121.48. Females reported more somatization, obsessive compulsive, anxiety and phobic anxiety symptoms than males. Hostility was greater in low income families, paranoia was greater in people from moderate income families, psychosis was greater in those from low income families. While mean resilience was 60.84, males had more resilience than females, were more committed, more able to control, and more challenging than females. People living in north Gaza were less resilient and less challenging than people living in Gaza or Khan Younis. Psychological problems, obsessive compulsive, depression, anxiety, phobic anxiety, paranoia, and psychosis were correlated negatively with resilience. Also, total psychological problems, sensitivity, and phobic anxiety were correlated negatively with commitment. Sensitivity, anxiety and phobic anxiety were negatively correlated with control. With total psychological problems, obsessive compulsive, sensitivity, depression, anxiety, paranoia and psychosis were correlated negatively with challenge. **Conclusion:** Palestinians in the Gaza Strip reported more psychological problems due to long-standing stress and trauma arising from community violence. Resilience was an outcome of experiences of stress and trauma and coping strategies; social support was affected by the presence of psychological problems among Palestinians whereby people with more psychological problems showed less resilience. This study highlights the need for community reconciliation between the factions and increased effort in social reconciliation. More psychoeducational programs may help increase coping and resilience. Also, families affected directly by such community violence should be targeted with their children by programs including psychological intervention, social and community support group, stress management, and parenting training.

Keywords: Community violence, psychological problems, resilience, Gaza Strip

Declaration of interest: None.

Introduction

Palestinians in the Gaza Strip have been victims of political violence from the last decades. In 2005, Israeli military forces left the Gaza Strip which called for unilateral Israeli withdrawal. In 2006, after Hamas' legislative victories this has continued, politically and sometimes militarily, up to this day. The community conflict, which erupted between the two main Palestinian parties, Fatah and Hamas, resulted in the split of the Palestinian Authority into two parties. However, both parties see themselves as the true representatives of the Palestinian people – the Fatah ruled Palestinian National Authority in the West Bank and the Hamas Government in the Gaza Strip.

In early June 2007, another wave of community violence erupted. Gunfire and rocket propelled grenades could be heard from the streets of Gaza Strip. Within six months, more than 150 Palestinians were killed in factional

fighting between Fatah and Hamas sparking fear of a civil war in the Gaza Strip. Another round of community fighting erupted from 10 June until 14 June 2007. Across the four days of fighting, people in the Gaza Strip experienced different types of traumatic events, e.g. mainly hearing gunfire sounds in the street, witnessing killing of relatives and neighbors, watching people being wounded and killed on television, and being personally injured. Hamas had taken control of the Gaza Strip from Beit Hanoun in the north to Rafah in the south. Such fighting resulted in more risk and adversity for the Palestinian community in the Gaza Strip and increased the level of mental health problems among children and parents.¹

Studies demonstrate that people who are resilient display a greater capacity to quickly regain equilibrium physiologically, psychologically and in social relations following stressful events. Second, and equally

important, is sustainability, or the capacity to continue forward in the face of adversity.² Resilience is considered a multidimensional, dynamic construct made up of a variety of personal qualities (e.g. spirituality, personal competence, social competence, family cohesion, social resources, and personal structure). Individuals who possess these personal qualities are more likely to positively adapt when exposed to a traumatic event.^{3, 4, 5, 6, 7}

Resilience refers to a class of phenomena characterized by good outcomes in spite of serious threats to adaptation of development. It usually arises from normative functions of the human adaptation system with the greatest threats to human development being those that compromise these protective systems. Resilience involves an ordinary rather than extraordinary outlook in terms of human development and adaptation as well as direction for policy and practice aimed at enhancing the development of children at risk for problems and psychopathology.⁸ However, specific operational definitions for resilience vary widely in the literature as do the factors that define the construct. For example, Connor and Davidson⁵ identified resilience as personal qualities that enable individuals to flourish in the face of adversity. Newman⁷ defined resilience as positive adaptation in the face of a traumatic event. Richardson⁹ described resilience as an internal motivational force that drives each individual to seek wisdom, self-actualization, altruism, and inner spiritual peace. In our view, resilience is best defined as an outcome of successful adaptation to adversity. Characteristics of the person and situation may identify resilient processes, but only if they lead to healthier outcomes following stressful circumstances.

Very little is known about individual mental health and of resilience¹⁰ although Nruham et al.¹¹ conducted a longitudinal study on a subset of a representative sample of 2,464 students and revealed that resilience is a moderator of lifetime violence. Roy et al.¹² suggested a possible role for resilience as a protective factor mitigating the risk of making a suicide attempt for an individual who has experienced childhood trauma events and attempted suicide. This is supported in a study¹³ involving a survey of 475 active duty Marines attending a random sample of mandatory Transition Assistance Program workshops before leaving the military and responding to follow-up mail or web surveys for an average of six months after returning to civilian life. The finding that resilience was only associated with mental health when functional impairment was included suggests that the effect of resilience may be in its ability to maintain an individual's functionality despite mental

health problems and may not directly impact the risk of mental health symptoms per se.

The purpose of the present study is to examine the relationship between psychological problems and resilience in families' of victims of community violence due to factional fighting in the Gaza Strip between Fatah and Hamas parties.

Material and Methods

Subjects

The sample consisted of 161 Palestinian families affected by factional fighting between two political factions in the Gaza Strip (Fatah and Hamas) on July 2007; 50 of those families were randomly selected for the present study. Three of the five areas of the Gaza Strip were selected randomly. The sample consisted of 255 subjects: 120 were males (47.1%) and 135 were females (52.9%). The age ranged from 18-67 years ($M = 31.77 \pm 14.84$).

Study procedure

In the present study, the data collection team consisted of six trained female field workers who attended a training session with the two researchers to inform them about the questionnaire and sampling process. The researchers used the available data about the distribution of the population and randomly selected the sample. Formal letters were obtained from an ethical committee at the start of the study. Participants were interviewed inside their homes. They were informed about the study objectives and told that their names would not be included and the data would be kept in a safe place with the researchers.

Instruments

Sociodemographic data

The participants' demographic data were collected by questionnaire and included gender, age, income, marital status, and place of residence.

Symptoms Checklist-R¹⁴

Mental distress was evaluated by the self-report, 90-item Symptom Checklist (SCL-90-R), which is a general standardized measure of psychopathology. It has been tested and employed in various cultural and clinical settings including those concerning trauma victims in the Palestinian society.¹⁵ The symptom level of each item of the SCL-90-R is rated by the subject on a five-point scale of distress, from 'not at all' (score 0) to 'extremely' (score 4). The average of the scores of these 90 items, called the global severity index (GSI), indicates an overall degree of mental distress. The items of the SCL-90-R are known to factor into nine primary symptom

dimensions, denoted by somatization (1, 4, 11, 29, 40, 42, 48, 49, 52, 58, 71), obsessive-compulsive (3, 9, 10, 28, 38, 45, 46, 51, 55, 65), interpersonal sensitivity (6, 21, 34, 36, 37, 41, 61, 69, 73) depression (2, 5, 14, 15, 20, 22, 26, 27, 28, 30, 31, 32, 54), anxiety (12, 17, 23, 33, 39, 57, 72, 79, 80, 86), hostility (13, 24, 63, 67, 74, 81), phobic anxiety (25, 47, 50, 70, 75, 78, 82), paranoid ideation (8, 18, 43, 68, 76, 83), and psychoticism (7, 16, 35, 62, 77, 84, 85, 87, 88) are usually not reported (19, 44, 53, 59, 60, 64, 66, 89). For each of these nine dimensions, the average score of the items comprising this dimension constitutes the score of that dimension. Since a relatively large number of subjects will usually have a score 0 (not at all) for a given item, and the score digits range from 0 to 4, the mean scores for a large group often obtain values less than 1. This instrument was validated in Arab countries and in Palestine and showed high reliability (Cronbach's $\alpha = .92$).¹⁶ In the present study, the internal consistency of the complete SCL-90-R was high (Cronbach's $\alpha = .96$) and split half was 0.86.

The Resilience Attitude Scale¹⁷

The scale contains 47 items covering the resilience characteristics of commitment, feelings of control and willingness to take challenges. Children were instructed to evaluate on a three-point scale how well the feelings and thoughts describe their own feelings: 'not at all' (0), 'to some extent' (1), and 'very well' (2). The total score ranges from 0–141 with higher scores reflecting greater resilience. Three subscales were constructed: Commitment (16 items, e.g., 'I care a lot about problems and things that happen around me'; 'I care for all possible initiatives that may help my family and community'), Control (14 items, e.g., 'I think luck and accidents play a major role in my life'; 'I think people's lives are influenced by external forces that they cannot control') and Challenge (17 items, e.g., 'I am curious to

know the unknown'; 'When I have solved one problem, I enjoy moving on to solving another one'). The Resilience Attitudes Scale has been validated in the Arabic culture in Egypt¹⁷ and has been found reliable among Palestinians in the Gaza Strip (Cronbach's $\alpha = 0.84$ and split half = .84)¹. In this study the internal consistency was (Cronbach's $\alpha = .86$).

Statistical analysis

Data analysis was carried out using a statistical software SPSS version 16.0. Descriptive statistics were used to report socio-demographic variables. Internal consistency was assessed by Cronbach's α coefficient. For continuous variables, mean and standard deviation were used for data reporting and statistical tests used for comparison were t-test when comparing two groups. One way ANOVA tests were used to test differences between psychological problems and resilience and more than two groups of continuous variables such as place of residence and family income. Rank correlation (Spearman's rho) was used to assess the correlation between the psychological symptoms scores and resilience scores.

Results

Sociodemographic characteristic of the study

The sample responding to the interview were 255 participants with a response rate of 96%; it consisted of 120 males (47.1%) and 135 females (52.9%). The age ranged from 18-67 years with mean age being $M = 31.77 + 14.84$. According to place of residence, 34.1% were from North Gaza, 30.2% were from Gaza, and 35.7% were from Khan Younis. Regarding marital status, 50.2% were single, 41.6% were married, and 8.2% were widowed. Regarding the family monthly income, 3.5% had high monthly income (above \$751), 79.24 % of the families had moderate (\$251-750) monthly income, and 17.3% of families had low (less than \$250) monthly income.

Table 1. Sociodemographic characteristics of the study sample (N = 255)

Variable	N	%
Gender		
Males	120	47.1
Females	135	52.9
Age 18-67 years, Mean = 31.77 years, (SD= 14.84)		
Place of residence		
North Gaza	87	34.1
Gaza	77	30.2
Khan Younis	91	35.7
Marital status		

Single	128	50.2
Married	106	41.6
Widowed	21	8.2
Place of residence		
North Gaza	87	34.1
Gaza	77	30.2
Khan Younis	91	35.7
Family monthly income		
High income (\$751 and more)	9	3.5
Moderate income (\$351-750)	202	79.2
Low income (less than \$350)	44	17.3

Means and standard deviations of psychological symptoms (SCL-90 and subscales)

The results showed that the subjects of the sample with psychological symptoms ranged from 17 to 219 symptoms (mean =121.48, SD = 40.78), somatization ranged from 0-39 (mean = 17.40, SD = 9.93), obsessive compulsive symptoms ranged from 2-30 (mean = 16.17, SD = 6.72), interpersonal sensitivity ranged from 0-24

(mean = 11.90, SD = 4.70), depression ranged from 0-42 (mean = 22.06, SD = 9.77), anxiety ranged from 2-31 (mean = 13.41, SD = 6.70), hostility ranged from 1-20 (mean = 8.67, SD = 4.75), phobic anxiety ranged from 0-26 (mean = 8.37 , SD = 4.91), paranoid ranged from 0-18 (mean = 8.74 , SD = 4.412), and psychosis ranged from 0-26 (mean = 12.03, SD = 7.29).

Table 2. Mean and standard deviations of the SCL-90 items

	Minimum	Maximum	Mean	SD
Total SCL-90	17	219	121.48	40.78
Somatization	0	39	17.40	9.93
Obsessive-compulsive	2	30	16.17	6.72
Sensitivity	0	24	11.90	4.70
Depression	3	42	22.06	9.77
Anxiety	2	31	13.41	6.70
Hostility	1	20	8.67	4.75
Phobic anxiety	0	26	8.37	4.91
Paranoid	0	18	8.74	4.21
Psychosis	0	26	12.03	7.29

Differences in psychological symptoms and sociodemographic variables

In order to find differences in gender and psychological symptoms, t independent test was conducted in which total mental health problems and subscales were entered separately as the dependent variable and gender as the independent variable. The results showed that females reported more somatization than males ($t = -4.51, p = 0.001$), more obsessive compulsive symptoms ($t = -6.13, p = 0.001$), more anxiety symptoms ($t = -5.14, p = 0.001$), and more phobic anxiety symptoms ($t = -8.22, p = 0.001$). No gender differences in other psychological problems.

Psychological problems and sociodemographic variables

ANOVA tests were done in which each of the mental health subscales were the independent variables and marital status, place of residence, income as dependent variables. Post hoc test using Tukeys test showed that hostility was more in low-income families when

compared to moderate or high income ($F = 5.37, p = 0.005$), paranoia was more in people from families of moderate monthly income rather than low or high monthly income ($F = 6.32, p = 0.002$), psychosis was more in people coming from families of low monthly income rather than of moderate or high monthly income families ($F = 7.07, p = 0.001$). Regarding place of residence, phobia was more apparent in people living in north Gaza than in Gaza or Khan Younis ($F = 50.33, p = .001$) ($F = 4.97, p = 0.008$).

For marital status, somatization symptoms were more in married than single or widowed ($F = 50.33, p = .001$), obsessive symptoms were more in single than in married or widowed ($F = 15.55, p = 0.001$), sensitivity was higher in widowed than single or married ($F = 4.63, p = 0.01$), anxiety was higher in widowed than single or married ($F = 3.24, p = 0.04$), phobia was higher in single than married or widowed ($F = 3.80, p = 0.02$).

Resilience in Palestinian families

Participants reported from 24 to 98 resilience items with mean = 60.84 (SD = 12.25), commitment subscale items ranged from 8 to 49 with mean = 24.17 (SD = 4.99),

control subscale items ranged from 7 to 39 with mean = 17.41 (SD = 4.97), and challenging subscale items ranged from 5 to 30 with mean = 19.26 (SD = 4.49).

Table 3. Mean and standard deviations for resilience

	Minimum	Maximum	Mean	SD
Total resilience	24	98	60.84	12.25
Commitment	8	49	24.17	4.99
Control	7	39	17.41	4.97
Challenge	5	30	19.26	4.49

Gender differences in resilience

In order to investigate gender differences when using resilience, t independent test was performed in which gender and age were the dependent variable and resilience, commitment, control, and challenging as

independent variables. The results showed that there were significant differences between males and females in total resilience toward males ($t = 3.38$, $p = 0.001$), commitment ($t = 2.68$, $p = 0.01$), control ($t = 3.44$, $p = 0.001$), and challenging ($t = 3.75$, $p = 0.001$).

Table 4. Gender differences in resilience and subscale

	Gender	Mean	SD	MD	T	p
Commitment	M	25.27	5.44	3.381	3.38	0.001
	F	23.19	4.34			
Control	M	18.28	5.43	2.684	2.68	0.01
	F	16.63	4.40			
Challenge	M	20.27	4.95	3.438	3.44	0.001
	F	18.37	3.84			
Resilience	M	63.82	13.54	3.752	3.75	0.001
	F	58.19	10.32			

Resilience and sociodemographic variables

ANOVA tests were done in which total resilience and each of the subscales was the independent variables and marital status, place of residence, income as dependent variables. Post hoc test using Tukeys test showed that people living in north Gaza reported less resilience and less challenge than people living in Gaza or Khan Younis ($F = 5.98$, $p = 0.003$; $F = 4.18$, $p = 0.01$).

Regarding other socioeconomic items, the results showed no significant differences according to marital status or economic status of the families (low, moderate, high income). In terms of the relationship between psychological problems and resilience, in order to find the relationship between psychological problems and resilience subscales such as commitment, control, and challenge, a correlation coefficient Spearman test was done. The results showed that total psychological problems was correlated negatively with total scores of resilience ($r = -0.28$, $p = 0.02$), obsessive compulsive ($r =$

-0.16 , $p = 0.05$), sensitivity ($r = -0.31$, $p = 0.001$), depression ($r = -0.24$, $p = 0.04$), anxiety ($r = -0.28$, $p = 0.001$), phobic anxiety ($r = -0.36$, $p = 0.001$), paranoid ($r = -0.19$, $p = 0.02$), and psychosis ($r = -0.25$, $p = 0.03$) were also correlated negatively with total scores of resilience.

Total psychological problems ($r = -0.27$, $p = 0.02$), sensitivity ($r = -0.26$, $p = 0.001$), and phobic anxiety ($r = -0.22$, $p = 0.01$) were correlated negatively with commitment. Also, sensitivity ($r = -0.18$, $p = 0.03$), anxiety ($r = -0.21$, $p = 0.02$), phobic anxiety ($r = -0.29$, $p = 0.001$) were negatively with and challenge. Total psychological problems ($r = -0.44$, $p = 0.001$), obsessive compulsive ($r = -0.23$, $p = 0.01$), sensitivity ($r = -0.38$, $p = 0.001$), depression ($r = -0.36$, $p = 0.001$), anxiety ($r = -0.34$, $p = 0.001$), paranoid ($r = -0.35$, $p = 0.001$), and psychosis ($r = -0.41$, $p = 0.001$) were correlated negatively with control.

Table 5. Correlation coefficient of resilience and psychological problems

		1	2	3	4	5	6	7	8	9	10
Commitment	R	-.27[*]	-.04-	-.14-	-.26^{**}	-.21-	-.20[*]	-.01-	-.29^{**}	-.14-	-.27-
	p	0.02	0.57	0.09	0.00	0.08	0.02	0.85	0.00	0.09	0.02
Control	r	-.042-	-.079-	-.049-	-.16-.06-		-.18[*]	0.14	-.22^{**}	-.013-	0.01
	p	0.73	0.34	0.56	0.05	0.60	0.03	0.08	0.01	0.88	0.91
Challenge	r	-.44^{**}	-.12-	-.23^{**}	-.38^{**}	-.36^{**}	-.34^{**}	-.14-	-.40^{**}	-.35^{**}	-.41-
	p	0.00	0.14	0.01	0.00	0.00	0.00	0.09	0.00	0.00	0.00
Resilience	r	-.28[*]	-.09-	-.16[*]	-.31^{**}	-.24[*]	-.28^{**}	-.001-	-.36^{**}	-.19[*]	-.25-
	p	0.02	0.25	0.05	0.00	0.04	0.00	0.99	0.00	0.02	0.03

1-Total SCL-90, 2- Somatization, 3- Obsessive-compulsive, 4- Sensitivity, 5-Depression, 6- Anxiety, 7- Hostility, 8- Phobic anxiety, 9- Paranoid, 10- Psychosis

Discussion

Our results showed that females reported more somatization, obsessive compulsive symptoms, anxiety symptoms and more phobic anxiety symptoms than males. This could be due to the cultural factors in which females in non-western society express their emotional problems physically through somatic symptoms. Hostility was higher in low-income families when compared with moderate or high income, paranoia was more in people from families of moderate income than low or high income, psychosis was more in people coming from families of low income than of moderate or high income families. The above mentioned findings showed that mental health problems were more common in poor families, which indicated that poverty is one of the risk factors for developing mental health problems in Palestinian society with more than 38.5% of families under living below poverty (PCBS, 2010).¹⁸ Phobia was more in people living in north Gaza than in Gaza city or Khan Younis. This could arise from the fact that this area is a border area with many repeated incursions and bombardment in the last decade. Similar study in the area showed that adults reported higher levels of anxiety and fears.¹ Our study found higher rates of psychological problems when compared with other studies, such as a study of African-American and Caucasian-American students, which showed that the mean SCL-90 was 79.41 for African-Americans and 96.61 for Caucasian-Americans.¹⁹ This difference could be a result of the current situation in the Gaza Strip with continuity of the siege and closure of the area and repeated shelling and bombardment. Such chronic stressors and traumatic events are the cause of higher rates of mental health problems; including anxiety, depression, and posttraumatic stress disorder (PTSD).

Our study findings showed that male Palestinians were more resilient, committed, controlling, and challenging in the face of traumatic events due to factional fighting

between Hamas and Fatah. Gender differences in resilience levels have been investigated less often, but one consistent finding is that resilient women tend to elicit and provide more social support for overcoming their adversities and problems. Other studies found that women reported significantly higher levels of using 'social support' than men whereas men reported sub-significantly higher levels of 'personal competence than women'.²⁰ One explanation for our finding is that females are more willing to report or acknowledge their negative events and emotions, which might threaten and lower their psychological resilience. Another reason is that women are thought to be more sensitive to problems under high stress conditions. When encountering difficulties or stresses, females tend to evade or use maladaptive coping strategies whereas males choose positive coping strategies that focus on the immediate problem.²¹ However, others found no gender comparison reached statistical significance in terms of resilience in previous research (Campbell-Sills et al., 2006).⁴

The results showed that people who scored higher on psychological problems, including obsessive compulsive, sensitivity, depression, anxiety, phobic anxiety, paranoia, and psychosis had been less resilient. People with more total psychological problems, sensitivity and phobic anxiety had less commitment. People with sensitivity, anxiety and phobic anxiety had less control. Also, people with more psychological problems, obsessive compulsive, sensitivity, depression, anxiety, paranoia, and psychosis were less challenging. Our findings were consistent with Friberg et al.²² in which sample patients in Norway reported that resilience was negatively related to mental health problems. Also, King et al.²³ found that several factors, including higher levels of both perceived ('functional') and structural (e.g. membership in organizations) social support were associated with a lower likelihood of PTSD. Others postulated that resilient people are typically characterized by optimism,

positive coping, and hardiness, and these characteristics are associated with better physical and mental health outcomes and more positive adaptive behaviors to negative life events (Connor and Davidson).⁵ Compared with young adults with low levels of resilience, those with high levels of resilience are less likely to have mental health problems, interpersonal conflicts, behavioral disorders, and poor academic performance.²⁴ It is important to understand the relationships between mental health problems and other variables (e.g., personality traits and social support), and to test the possible moderating effect of resilience between negative life events and mental health problems. Resilience enables people to thrive in the face of adversity. Improving resilience must be an important goal for treatment and prophylaxis.²⁵ Negative life events may lead to mental health problems, such as depression or anxiety, but an individual with a high level of resilience may cope with the difficulties more effectively and remain healthy.

Conclusion and clinical implication

The present study findings demonstrated that Palestinians in the Gaza Strip reported more psychological problems due to long-standing stress and trauma due to community violence. Resilience as an outcome of experiences of stress and trauma and coping strategies, social support was affected by the presence of psychological problems among Palestinians in which people with more psychological problems showed less resilience. The present study highlights the need for community reconciliation between the factions and increased effort in social reconciliation; more programs for psycho-education of subjects, which may help to increase coping and resilience. Also, families affected directly by such community violence should be targeted with their children by programs, including psychological intervention, social and community support groups, stress management, and parenting training. Our study had several limitations, such as we did not examine other Palestinian families affected by other political violence; children were not included in this study; and other factors such as political affiliation, social, and family support were not included.

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المخلص

الهدف من هذه الدراسة هو فحص العلاقة بين المشاكل النفسية في ضحايا الأسر الفلسطينية التي عانت من العنف المجتمعي والصمود النفسي في قطاع غزة. تألفت عينة الدراسة من البالغين ممن تتراوح أعمارهم ما بين 18 – 67 عاماً مع متوسط العمر كان 31.71 عاماً وقد تم جمع البيانات من المشاركين بواسطة استبيان يشمل المعلومات وقائمة الأعراض النفسية – 90 بند المراجع، ومقياس الصمود النفسي للبالغين. أظهرت الدراسة بأن متوسط الأعراض النفسية كان 121.48 ، ومتوسط أعراض الجسدية كان 17.40 ، وأعراض الوسواس القهري كان 16.17، 11.90، ومتوسط أعراض الحساسية الشخصية كان 11.90، وكان متوسط الإكتئاب 22.06، والقلق كان 13.41، وأعراض العدائية كانت 8.67، ومتوسط رهاب القلق كان 8.37، ومتوسط جنون العظمة كان 8.74، ومتوسط أعراض الذهان كانت 12.03. أظهرت النتائج بأن الأنات أظهرن أعراض الجسدية والوسواس القهري، والقلق أكثر من الذكور. وكان العداء أكثر في الأسر ذات الدخل المنخفض عنه عن الأسر ذات الدخل المتوسط والعالي، بينما كانت أعراض جنون العظمة أكثر في الناس من العائلات ذات الدخل المتوسط أكثر من الأسر ذات الدخل المنخفض والعالي. بينما الذهان كان أكثر في الأشخاص المنحدرين من أسر ذات دخل منخفض عنه ذات الدخل المتوسط أو العالي. أما بالنسبة للصمود النفسي وكل من محاوره وهي الإلتزام، والتحكم، والمنافسة فقد كان أكثر في الذكور عنه في الإناث. وأظهرت النتائج أن الناس الذين يعيشون في شمال قطاع غزة هم أقل في الصمود النفسي عنهم عن الذين يعيشون في مدينة غزة أو خان يونس. وقد أظهرت النتائج أن مستوى الصمود النفسي يرتبط عكسياً مع وجود المشاكل النفسية، وكذلك مع الوسواس القهري، والاكتئاب والقلق، ورهاب القلق، وجنون العظمة والذهان، وبالأخص كان هناك ارتباط عكسي بين الإلتزام كجزء من الصمود النفسي مع المشاكل النفسية عموماً، ومع الحساسية التفاعلية، ورهاب القلق، بينما كان هناك أيضاً ارتباطاً سلبياً ما بين التحكم والحساسية التفاعلية، والقلق ، ورهاب القلق. وكان هناك ارتباط عكسي ما بين التحدي كجزء من الصمود النفسي وكل من أعراض الوسواس القهري، والحساسية التفاعلية، والاكتئاب، والقلق وجنون العظمة، والذهان. أظهرت نتائج الدراسة بأن الفلسطينيين في قطاع غزة يعانون أكثر من المشاكل النفسية عنهم من أشخاص آخرين في مناطق أخرى لأنهم تعرضوا لفترة طويلة لضغوط نفسية وصدمات نفسية مستمرة حتى يومنا هذا. بالإضافة إلى العنف المجتمعي في الآونة الأخيرة بين الفصائل الفلسطينية الرئيسية في قطاع غزة والذي أدى إلى الإقتتال الداخلي. ذلك أدى إلى ظهور مزيد من المشاكل النفسية التي أدت إلى انخفاض مستوى الصمود النفسي. ولذلك يجب العمل على مساعدة الأشخاص الذين يعانون من مشاكل نفسية في البحث عن طرق تؤدي إلى بناء صمود نفسي أكثر لمواجهة الظروف الحياتية الصعبة من عنف سياسي ومجتمعي. وكذلك تعزيز قدرات سكان قطاع غزة على التكيف بشكل أفضل في حياتهم اليومية من خلال برامج تدخل متخصصة.

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