

Social Support of Palestinian Adults with Disabilities in the Gaza Strip

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تحديد نوع وطبيعة الدعم الاجتماعي التي يتلقاها الفلسطينيون المعاقون وعلاقتها مع المتغيرات الاجتماعية الديموغرافية

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Abstract

Aim: The present study aimed to determine the social support levels perceived by Palestinian adults with disabilities and to compare the data with socio-demographic variables. **Method:** N=416 participants (n=263 men, n=53 women); ages ranged from 19-70 years (M= 33.56 years) were selected randomly from the databases of two NGOs for people with disabilities. **Instruments:** Demographic data were collected via questionnaire for gender, age, class, and place of residence and attitudes and perceptions about social adaptation, life status, social role, self-esteem and self-concept were via the Social Support Scale. **Results:** The most commonly reported items in the Social Support Scale included feeling the need for security (69.6%), not feeling satisfied about quality of life (39%), understanding the demands of a new life (53.3%), feeling the need for love and social recognition (69.4%), and being aware of personal potential and ability (69.4%). Men with disabilities reported higher self-esteem than women with disabilities. Those who had no income had less social adaptation, less life status, less social role, and less self-concept. **Conclusion and clinical implications:** The importance of focus for improving the social support, self-esteem, and well-being of disabled Palestinian adults and families. Self-esteem enhancement interventions offered in this context might well have an increased effect when combined with the other services available through independent living. Culturally sensitive interventions need to be developed to further enable people in all strata of the social hierarchy to understand their own worth and bring about changes in their lives and communities. Psychosocial interventions can play a useful role in supporting awareness and the development of accurate and positive appraisals of the self, alongside the process of adjusting to life of disabled people.

Key words: Adults, disability, Gaza Strip, social support, self-esteem, self-concept.

Declaration of interest: None

Introduction

In May 1976, the World Health Organization (WHO) adopted a resolution at the 29th World Health Assembly to approve the publication, for trial purposes, of the International Classification of Impairments, Disabilities and Handicaps (ICIDH).¹ This ICIDH classification scheme was proposed as a supplement to the ICD and is illustrated by the disablement model (1) Impairment: Any loss or abnormality of psychological, physiological or anatomical structure or function; (2) Disability: Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being; (3) Handicap: Disadvantage for a given individual, resulting from an impairment or a disability that limits or prevents the fulfillment of a role that is normal (depending on age, gender, and social and cultural factors) for that individual. The WHO² has estimated that 15% of the world's population lives with some form of disability, of

whom 2% to 4% experience significant difficulties in functioning.

Over the past decades, there has been a great shift from a medical model of disability towards a more social model. This shift was evident with the introduction of the International Classification of Functioning, Disability and Health (ICF) in 2001.³ According to the ICF, disability does not result from individuals' health conditions alone, but when the negative aspects of their health conditions (impairments) are confronted with unfavorable environmental (physical, social and attitudinal) and personal factors.³ The inclusion of such contextual factors in the ICF framework validates their role as the important determinants of disability. Other definitions of disability adopted in some studies conducted in the United States included difficulty in bodily functions or cognitive difficulties in performing social roles or other daily activities; diagnostic criteria were whether the person had difficulty completing

activities of daily living (ADL) and independent activities of daily living (IADL).^{4,5,6} China's four national health surveys were based on the WHO World Health Survey,⁷ which defined disability as the loss or limitation of a person's ability to perform or function in daily life.

Hosseinpoor et al.,⁸ analyzed data on 218,737 respondents participating in the World Health Survey 2002–2004. A composite disability score (0–100) identified respondents who experienced significant disability in physical, mental, and social functioning irrespective of their underlying health condition. Disabled persons had disability composite scores above 40. Wealth was evaluated using an index of economic status in households based on ownership of selected assets. Socioeconomic inequalities were measured using the slope index of inequality and the relative index of inequality. The results showed that median age-standardized disability prevalence was higher in the low- and lower middle-income countries. In all the study countries, disability was more prevalent in the poorest than in the richest wealth quintiles. Pro-rich inequality was statistically significant in 43 of 49 countries, with disability prevalence higher among populations with lower wealth. Median relative inequality was higher in the high- and upper middle-income countries. Another retrospective analysis of data from the World Health Survey (WHS)⁷ for nationally representative samples of civilian, non-institutionalized populations in 54 countries study was conducted. A disability was measured as having at least one severe or extreme difficulty with bodily functions (seeing, concentrating) and activities (moving around, self-care) based on an individual's self-reports. In the 54 countries under study, severe or extreme functional or activity difficulties are highly prevalent. For all countries, disability prevalence is estimated at 14% for all adults. Low and middle-income countries have higher disability prevalence compared to high-income countries. Among subgroups, disability prevalence stands at 12% among working age adults and 39% among the elderly. Women have higher prevalence than men.⁹ Interestingly, a study based on the disability module, which is part of the National Health and Morbidity Survey 2015 in Malaysia, was implemented using a multi-stage stratified sampling design. A locally validated Washington Group questionnaire was used to collect data on disability. Based on the definition of having at least one domain scored "a lot of difficulty or unable to do at all" or at least "some difficulty" scored in two domains, the prevalence of disability among adults in Malaysia was 11.8%. Logistic regression analysis performed showed that population at risk of having disability in Malaysia were those of older people, ethnic minority, low level of education, single, obese,

physically inactive and having mental health problems. Among older people, disability was significantly higher among those with no formal education, having mental health problems and physically inactive^{10,11} in a national Survey was conducted in 2014, including a sample of 47,275 adult participants drawn from 16,044 households from urban and rural areas proportioned to population size. The sample's socio-demographic characteristics were collected in a face-to-face interview. Then it was screened for disability using the Washington Group Short Set of Questions on Disability. Results showed that the overall disability prevalence among Moroccan adult population was 9.5%, with important geographical disparities. Older age, lower education rates, unemployment, being single, and living in rural areas, were associated with higher disability prevalence rates. Visual and motor deficiencies were the most common disability modalities, and the prevalence of moderate to extreme disability that is associated with more significant functioning limitations was 2.6%.

An original definition of social support made by Cobb¹² stated, "Social support is defined as information leading the subject to believe that he is cared for and loved, esteemed, and a member of a network of mutual obligations". Cohen, Underwood, and Gottlieb,¹³ theorized that social support affected physical and mental health, which has a larger effect on an individual's overall emotional well-being, physical illnesses, perceptions of support, and healthy behaviors. Some studies have considered the social model's application in understanding the experiences of people living with acquired cognitive impairments, specifically related to younger people with dementia.^{14,15,16} Social support, is an important factor in solving difficult situations, can be understood as: an available aid, resources provided by interpersonal interaction, the consequences of belonging to a society, or satisfying one's needs in different situations by significant others and reference groups.¹⁷

Studies focused primarily on two broad models of disability: One is the medical-psychological model, which views the disabled person's impairment as a "problem," therefore focusing on curing and "fixing" the physical and psychological condition of the disabled individual. The second is the social model, based on the view that society creates barriers that prevent disabled people from wholly participating in their local communities, therefore focusing on modifying society to meet the needs of disabled people^{18,19} posited that the sense of self (i.e., self-identity), which is privately owned and outwardly presented, may be denied in social interactions with others who respond to the person as "disabled" first (i.e., focusing on appearance rather than identity), thereby losing sense of the person's real self.

Self-esteem has been defined as an individual's global, subjective and emotional evaluation of their perceived worth as a person^{20,21} calls for consistency in how researchers conceptualize self-esteem and proposes the following definition: "The attitudinal, evaluative component of the self; the affective judgments placed on the self-concept consisting of feelings of worth and acceptance, which are developed and maintained as a consequence of awareness of competence, sense of achievement, and feedback from the external world. Others reported that there are some similarity between self-esteem and other related concepts such as self-concept (appraisals made about multiple dimensions of the self), self-confidence (anticipation of successfully overcoming challenges or obstacles) or self-identity.²²

Based on the holistic model of disability, the aim of the current study was to explore several sets of factors, which might be associated with disability in Palestinians. These include demographic factors (gender, education, and employment status), health- and disability-related factors (type of disability, i.e., congenital or acquired, visibility of the disability, and disability duration), and social support factors (social adaptation, life status, social role, self-esteem, and self-concept).

Method

Participants

The random sample consisted of N=416 disabled adults, of which $n=263$ were men (63.21%) and $n=153$ were women (36.79%). The age ranged from 19 to 70 years with mean age of 33.56 years ($M = 33.56 + 12.4$).

Instruments

Socio-demographic data:

The participant's demographic data was collected by questionnaire and included gender, age, class, and place of residence.

Characteristics of disability

This included type, duration, and cause of disabilities.

Social Support Scale

The Social Support Scale was developed and validated in the Gaza Strip (Abu Qamar, 2009), which consists of 47 items with 5 subscales. It measures social adaptation (9 items), life status (10 items), social role (10 items), self-esteem (8 items), and self-concept (10 items). The score ranges from 0= not true, 1= sometimes true, and 2= true.

In the present study, the internal consistency (Cronbach's alpha) for social coping $\alpha=.75$, life status $\alpha=.87$, social role $\alpha=.84$, self-esteem $\alpha=0.70$, and self-concept $\alpha=0.74$.

Study procedure

Community health rehabilitation workers who give support for such target group conducted the fieldwork. They were 25 professionals familiar with this target group and had been working with them in the community for a long time. They were trained for research and data collection, and they visited the families according to prepared lists of number of adults selected to the Database of the NSR (National Society for Rehabilitation) and PMER (Palestinian Medical Relief Society) working with such group. The field workers presented an information letter to the participants, and if agreed, they obtained written permission for their participation. Participants were interviewed individually at their homes and each interview lasted approximately 60 minutes. The interviewers informed the participants that there was no right or wrong answer, provided guidance in filling-up the scales. Participants were also informed that they were free to withdraw from the study at any time. The data collection was done between August and September 2009.

Statistical analysis

Data analyses were performed using SPSS Version 20 (SPSS, Inc. Chicago, United States). The frequencies of categorical data were presented. Differences in mean scores for death, social factors and socio-demographic variables were tested using independent t test for two groups and One-way ANOVA for more than three groups. The relationship between social support subscales was investigated using the Pearson correlation test. The level of significance was set at $p < 0.05$.

Results

Socio-demographic characteristic of the Study

The sample responded to the interview were 418 participants with response rate of 100%, it consisted of 263 men (63.2%) and 154 women (36.8%). The age ranged from 19 to 70 years with a mean age of 33.56 ($SD=12.4$). According to place of residence, 12% were from North Gaza, 30.1% were from Gaza, 28.7% were from Middle area, 19.1% were from Khan Younis, and 10% were from Rafah area (south of Gaza). According to type of residence, 50.1% live in cities, 34% live in villages, and 15.9% live in camps. In looking for the

family monthly income, 39.7% had no income, 46.9% of the family's monthly income was less than \$250 US per

month, 10.8% earned \$251-500 US, and only 2.6% earned more than \$501 US.

Table 1. Sociodemographic characteristic of the study sample (N = 416)

Variable	N	%
Gender		
Men	263	63.2
Women	153	36.8
Total	416	100.0
Age	Mean =33.46 years	
Address		
North Gaza	50	12
Gaza	126	30.1
Middle area	120	28.7
Khan Younis	80	19.1
Rafah area	42	10
Education		
Uneducated	71	17.1
Elementary	70	16.8
Primary	108	26
Secondary	89	21.4
Vocational	3	0.7
Diploma	27	6.5
University	48	11.5
Place of residence		
City	205	50.1
Village	139	34
Camp	65	15.9
Family monthly income		
No income	165	39.7
less than \$250 US	195	46.9
\$251-500 US	45	10.8
More than \$501 US	11	2.6
Job		
Student	25	6.5
Unemployed	232	60.6
Employee	37	9.7
House wife	46	12
Simple worker	43	11.2

Characteristics of disability

Results showed that 54.4% of participants had physical disability, 23.8% had vision disability, 9.3% had multiple disabilities, 5.4% had mental disability, 4.76 % had hearing impairment, and 2.5% had speech disability. According to cause of disability, the results showed that 10.1% reported that their disability was attributed to heredity factors, 24.76% were due to congenital problem,

8.25% were due to road traffic accidents (RTA), were 7.28% due to home accidents, and 29.61% were due to last war on Gaza on 2009. According to time of disability, 60.7% reported that their disability was back to several years, 16.3% was back to less than one year, and 22.9% was before 6 months of the study. Regarding the rehabilitation status of cases, 56.3% of the disabled persons were currently active cases with both societies, and 43.7% were closed (non- active cases).

Table 2. Characteristics of sample disability

	N	%
Type of disability		
Physical	222	53.4
Visual	101	24.3
Multiple	37	8.9
Mental	23	5.5
Hearing	21	5
Speech	12	2.9
Total	416	100
Cause of disability		
War	102	29.61
Congenital	30	24.76
Other	122	19.90
Inherited	42	10.19
Road traffic accidents	34	8.25
Home accidents	82	7.28
Duration of disability		
Less than 6 months	94	22.9
Less than one year	67	16.3
More than one year	249	60.7
Rehabilitation state of the case		
Active	220	56.3
Not active	171	43.7

Measurement of social support of disabled adults

This part of analysis discussed the responses of the adults about the social support, which consisted of 5 subscales based on the variables of measurement of social support.

Mean and standard deviations of social support subscales

The results showed that mean social adaptation was 9.40 (*SD* = 3.92), life status mean was 10.02 (*SD*= 4.20), social role mean was 11.97 (*SD*=4.37), self-esteem mean was 6.09 (*SD*=3.73), and social concept mean was 14.25 (*SD*=5.17).

Table 3. Means, SD, and percentage of social support subscales

	N	Minimum	Maximum	Mean	SD
Social adaptation	418	0	18	9.40	3.92
Life status	418	0	19	10.02	4.02
Social role	418	0	20	11.97	4.37
Self-esteem	418	0	16	6.09	3.73
Social concept	418	0	22	14.25	5.17

Frequency of social support subscales

The present study showed the most common social adaptation items were feeling for the need for security (69.6%), I do not feel oppression from others (42.1%), I feel flexible in new situations (41.6%). While life status commonly reported items were I do not feel satisfied

about my life level (39%), I have adequate health care (38%), rehabilitation organization services are not sufficient (36.4%). However, social roles common items were: I understand the demands of a new life (53.3%), I understand my personal abilities in achieving my goals (51.7%), I understand the change of my social role. Common self-esteem items were: I feel the need of love

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and social recognition (69.4%), I feel the need for knowledge and exploring things (66.7%), I feel the need to belong (66.3%), I feel the need for success (63.4%).

Final the most common self-concept items were: I know my potentials and abilities (69.4%), I feel I can succeed. (56.7%), and I feel I take responsibility (54.8%).

Table 4. Percentage of social support subscales in disabled adults

	Social Adaptation	True	True to some extent	Not true
1	Feeling the need for security.	69.6	18.4	12
2	I feel I'm different from others.	39.7	34.4	25.8
3	I feel embarrassed from others.	33.7	24.6	41.6
4	I feel weakness in front of others.	29.4	26.3	44.3
5	I feel pity from others.	31.6	25.6	42.8
6	I feel my marriage future is not safe.	28.9	20.8	50.2
7	I respond to new experiences properly.	38.5	42.1	19.4
8	I do not feel oppression from others.	42.1	27.8	30.1
9	I feel flexible in new situation	41.6	41.9	16.5
	Life status			
10	I feel that my social needs are met.	30.1	33.5	36.4
11	I feel that my basic needs are available.	32.3	31.6	36.1
12	I feel my education right is not affected.	30.1	17.7	52.2
13	I have adequate health care.	38	33.7	28.2
14	My life style is positive.	31.8	37.1	31.1
15	I do not feel satisfied about my life level.	39	30.4	30.6
16	I feel reassured and socially secured.	28.5	34.2	37.3
17	I feel neglected by family.	11.5	18.9	69.6
18	Rehabilitation organization services are not sufficient.	36.4	43.1	20.6
19	I feel graces when receiving services.	33.3	34.9	31.8
	Social role			
20	I understand the demands of a new life.	53.3	33.3	13.4
21	I do not feel embarrassed to modify my personal expectations.	39.5	35.9	24.6
22	I am not hesitant to compete for public vacancies.	37.8	23.9	38.3
23	I understand the change of my social role.	51.4	32.8	15.8
24	I find difficulties responding to what is required.	29.7	45.5	24.9
25	I feel I am able to share others.	45.9	34	20.1
26	My social status is changed.	26.3	28.2	45.5
27	I feel difficulty in decision-making.	27.8	34.4	37.8
28	I understand my personal abilities in achieving my goals.	51.7	29.2	19.1
29	I respond to new attitudes positively.	42.3	39.2	18.4
	Self-esteem			
30	I feel the need for love and social recognition.	69.4	20.8	9.8
31	I feel the need for knowledge and exploring things.	66.7	19.4	13.9
32	I feel the need to belong.	66.3	22.5	11.2
33	I feel the need to take responsibility	59.1	20.1	20.8
34	I feel the need for success.	63.4	21.3	15.3
35	I find difficulties in making social relations with my peers.	27.5	26.6	45.9
36	I feel suspicious of others' attitudes toward me.	24.9	31.8	43.3

37	I feel that my belonging to family is disturbing.	23.7	26.3	50
	Self-concept			
38	I know my potentials and abilities.	69.4	17	13.6
39	I feel I can succeed.	56.7	25.6	17.7
40	I feel I can learn.	46.5	23.5	30
41	I feel that opportunities for success are limited	40.2	32.1	27.8
42	I feel I am insignificant.	22.2	25.4	52.4
43	I feel my goal is realistic.	45.9	35.4	18.7
44	I feel I take responsibility	54.8	28.5	16.7
45	I feel I can control my desires.	51.7	33.5	14.8
46	I feel I depend on others.	26.3	34.7	39
47	I'm proud of my social life	51.9	29.4	18.7

Differences in social support subscales regarding socio-demographic variables

The results indicated that there was a statistically significant difference between men and women

regarding self-esteem of disabled adults, men having more self-esteem than disabled women ($t(389) = 2.46, p < 0.01$).

Table 5. Independent t test for differences in gender and social support subscale

		N	Mean	SD	SE	t	p
<i>Social adaptation</i>	Men	263	9.60	3.92	.24	1.35	.17
	Women	153	9.07	3.90	.32		
<i>Life status</i>	Men	263	9.84	3.85	.24	-1.13	.25
	Women	153	10.30	4.27	.35		
<i>Social role</i>	Men	263	12.17	4.31	.27	1.25	.21
	Women	153	11.61	4.49	.36		
<i>Self-esteem</i>	Men	263	6.45	3.72	.23	2.46	.01
	Women	153	5.52	3.67	.30		
<i>Social concept</i>	Men	263	14.24	5.22	.32	.01	.98
	Women	153	14.24	5.12	.41		

Post hoc test using Tukey test showed that there were no statistically significant differences according to age groups of disabled adults. The present study showed that disabled adults with no income had less social adaptation than other with better socioeconomic status ($F(3, 412) = 5.75, p = 0.001, \eta_p^2 = 0.07$), disabled adults with no

income had less life status ($F(3, 412) = 5.71, p = 0.001, \eta_p^2 = 0.06$), disabled adults with no income had less social role ($F(3, 412) = 3.31, p = 0.02, \eta_p^2 = 0.06$), and disabled adults with no income had less self-concept ($F(3, 412) = 5.16, p = 0.001, \eta_p^2 = 0.07$).

Table 6. One Way ANOVA of family monthly income and social support

		Sum of Squares	df	Mean Square	F	Sig.
Social adaptation	Between Groups	256.267	3	85.422	5.75	.001
	Within Groups	6116.423	412	14.846		
	Total	6372.690	415			
Life status	Between Groups	268.035	3	89.345	5.71	.001
	Within Groups	6442.674	412	15.638		
	Total	6710.709	415			
Social role	Between Groups	186.262	3	62.087	3.31	.02
	Within Groups	7739.466	412	18.785		
	Total	7925.728	415			
Self-esteem	Between Groups	88.876	3	29.625	2.14	.09
	Within Groups	5698.884	412	13.832		
	Total	5787.760	415			
Social concept	Between Groups	400.223	3	133.408	5.16	.001
	Within Groups	10659.937	412	25.874		
	Total	11060.160	415			

Relationships between social support subscales

In order to find the relationship between social support subscales, Pearson correlation coefficient test was performed. The result showed that there was significant

correlation between total social adaptation and life status ($r=0.40$, $p=0.001$), social role ($r=0.60$, $p=0.001$), self-esteem ($r=0.24$, $p=0.001$), and social concept ($r=0.54$, $p=0.001$).

Table 7. Pearson correlation coefficient test between social support subscales

	Social adaptation	Life status	Social role	Self-esteem
Social adaptation				
Life status	.40**			
Social role	.60**	.46**	1.00	
Self-esteem	.24**	.16**	.14**	1.00
Social concept	.54**	.42**	.72**	.08

Discussion

The present study aimed to determine the social support levels perceived by Palestinian adults with disabilities and to compare the data with socio-demographic variables. The prevailing disability for adults (65.6% of the sample) was attributed to heredity and congenital; this was consistent with findings of Gomaa²³ who reported that genetic diseases may be responsible for two-thirds of childhood blindness in Arab societies,

ranging from 47% in Tunisia to 86% in Kuwait. It is, internationally estimated that 50% of hearing impairment in infants is due to genetic factors.²⁴ The other factors that caused disability in Palestinians was referred war, home accidents, and road traffic accidents. This is consistent with Hakim and Jaganjac²⁵ in which they reported that high rate of accidents were related to disability in the Arab countries. The present study showed that there were no statistically significant

differences according to age groups of adults with disabilities.

The results indicated that there was a statistically significant difference between men and women regarding self-esteem of adults with disabilities, men having more self-esteem than women with disabilities. Our study showed that there were no statistically significant differences according to age groups of adults with disabilities. The present study showed that adults with disabilities who had no income had less social adaptation than others with better socioeconomic status, adults with disabilities who had no income had less life status, adults with disabilities who had no income had less social role, and adults with disabilities who had no income had less self-esteem. The result showed that there was significant correlation between total social adaptation and life status, social role, self-esteem, and social concept.

Social support comes in a variety of forms (e.g. emotional, instrumental informational) and from a variety of sources (e.g. family, friends, significant others). This was consistent with another study, conducted among a sample of 251 adult residents of a sociodemographically diverse community in Colombia, United States, that found perceived social support moderated the relationship between perceived social discrimination and psychological well-being, such that high levels of perceived social support were found to reduce the harmful impact of perceived social discrimination on the severity of psychological symptoms and mental health.²⁶

In another study conducted among a sample of 642 Dutch people with physical disabilities Van Campen,²⁷ found that people with physical disabilities who feel they are participating in social life (less discriminated against) are more likely to experience higher levels of subjective well-being compared to people with physical disabilities who don't feel welcome to participate in society.

A study conducted among 53,456 adults with disabilities of various types from 35 states in the United States, the District of Columbia, and Puerto Rico; for example, found that lower educational achievements were significantly associated with severe psychological distress, due to the tendency to avoid reaching out to health care services.²⁸ One of the few studies related to the moderating role of perceived social support in the association between perceive,²⁹ was conducted in Miami-Dade County, Florida. Its findings suggested that when a

person with disability perceives discrimination against her or him, the existence of social support might reduce the negative consequences of the discrimination.

Bogart³⁰ in a study of adaptation to congenital or acquired disability studied 226 participants with congenital and acquired mobility disabilities. The study involved a cross-sectional online questionnaire measuring satisfaction with life, self-esteem, disability identity, disability self-efficacy, and demographic information. Self-esteem, disability identity, disability self-efficacy, and income were significant predictors of satisfaction with life. Congenital onset predicted higher satisfaction with life; disability identity and disability self-efficacy, but not self-esteem, partially mediated the relationship. New evidence suggests that having at least one close friend with a disability is associated with higher life satisfaction among people with disabilities.³¹ Kagan et al.,³² assessed the association between demographic factors (gender, education, and employment status), health- and disability-related factors (type of disability, visibility of the disability, disability duration, and self-rated health), and psychosocial factors (perceived discrimination and perceived social support), and psychological distress among 433 people with physical disabilities. The findings suggest negative associations between education, employment status, duration of disability, self-rated health, and perceived social support, and psychological distress among physical disabilities. In addition, the findings indicate a positive association between perceived discrimination and psychological distress. No association was found between gender, type of disability, and visibility of the disability, and psychological distress. More recently, von Soest et al.,³³ in study used 2-wave data from the population-based NorLAG study in Norway (N 5,555; Mage 58 years; 51% women) and combined self-report data on self-esteem and personality with registry-based information on socioeconomic status (education, income, unemployment), health problems (sick leave, lifetime history of disability), and social relationships (cohabiting partner, lifetime history of divorce and widowhood). Results from latent change score models revealed that lower socioeconomic status, not having a cohabiting partner, unemployment, and disability were each uniquely associated with lower levels of self-esteem and/or steeper declines in self-esteem over the 5-year study period. Moreover, associations of disability and of emotional stability with self-esteem level were weaker with advancing age. Among women, self-esteem level was more strongly associated with emotional stability and less strongly with openness, compared to men.

Study limitations

One limitation of the present study is the cross-sectional nature of this survey because it did not include all adults with disabilities in the Gaza Strip, which may prevent the identification of causal relationships between identified factors and disability.

Conclusions

Findings contribute to the emerging body of evidence that worsening socioeconomics due to siege and closure of the Gaza Strip for the last 12 years conditions for many disabled Palestinians beside their disabilities are bringing negative self-esteem and less adaptation to other life adversities. It highlights the importance of focus for improving the social support, self-esteem, and well-being of disabled Palestinian adults and families. Self-esteem enhancement interventions offered in this context might well have an increased effect when combined with the other services available through independent living. Such interventions may include workshops with trained health professionals; printed educational materials, such as brochures, posters, or workbooks; and interactive websites. Also, the finding that low self-esteem, self-cognition, and social isolation indicates the importance of intervening with caregivers, physiotherapists, other people working with people who have disabilities to inform them about the damaging effects of overprotection and offer them training to develop skills that will help their people with disabilities understand their value and potential. Culturally sensitive interventions need to be developed to further enable people in all strata of the social hierarchy to understand their own worth and bring about changes in their lives and their communities. To lower the disability levels in the early life of children, efforts must be focused earlier in the life course on preventing or delaying onset of major chronic health problems. Psychological interventions can play a useful role in supporting awareness and the development of accurate and positive appraisals of the self, alongside the process of adjusting to life after a brain injury. To increase persons with disabilities sense of self (in line with their values and social roles) is vital in supporting people to derive meaning from their experiences, alongside the acceptance of limitations or impairments to allow for functional adjustment, adaptation and compensation. The varied results of the included studies could be suggestive of a need to build individualized programs of care, taking a holistic approach to rehabilitation given the complex relationships between neurological and psychological factors. Additionally, there is strong evidence to suggest

that higher levels of physical health problems and lower levels of functional independence are associated with and predictive of lower self-esteem.

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المخلص

الهدف: هدفت هذه الدراسة إلى تحديد نوع وطبيعة الدعم الاجتماعي التي يتلقاها الفلسطينيون المعاقون وعلاقتها مع المتغيرات الاجتماعية الديموغرافية.

الطريقة: تألفت العينة من 416 مشارك مسجل كحالة إعاقة. وتكونت العينة من 263 ذكراً ما نسبته 63.21% و153 أنثى ما نسبته 36.79%. وتراوحت اعمارهم ما بين 19 و70 سنة وبلغ متوسط العمر 33.56 سنة، وتم اختيارهم عشوائياً من قاعدة البيانات لمنظمتين غير حكوميتين تعملان مع هذه الفئة في قطاع غزة (اللجنة الوطنية للمعاقين، والإغاثة الطبية).

الأدوات: تم جمع البيانات الديموغرافية للمشاركين من خلال استبيان المتغيرات الاجتماعية الديموغرافية. وتشمل الجنس والعمر والدخل الشهري ومكان الإقامة، ومقياس نوع الإعاقة والسبب والمدة بالإضافة لمقياس الوظائف الاجتماعية المختلفة مثل التكيف الاجتماعي، وتقدير الذات، والمفهوم الاجتماعي.

النتائج: أظهرت النتائج أن متوسط التكيف الاجتماعي كان 9.40، وكان متوسط الرضى عن الحياة كان 10.02، وأن متوسط الدور الاجتماعي كان 11.97، وأن متوسط تقدير الذات كان 6.09، وكان متوسط المفهوم الاجتماعي 14.25 .

أظهرت الدراسة أن أكثر بنود التكيف الاجتماعي شيوعاً كان الشعور بالحاجة إلى الأمان (69.6%)، بينما كان أكثر بنود حالة الرضا عن الحياة التي تم الإبلاغ عنها هي أنني لا أشعر بالرضا عن مستوى حياتي (39%). ومع ذلك، كان أكثر بنود الدور الاجتماعي هي أفهم مطالب الحياة الجديدة (53.3%). كان أكثر بنود الشعور بتقدير الذات هو أنني أشعر بالحاجة إلى الحب والاعتراف الاجتماعي (69.4%)، وأخيراً أكثر بنود المفاهيم الاجتماعية هي أنني أعرف قدراتي وقدراتي (69.4%). أشارت النتائج إلى أن الذكور المعاقين لديهم تقدير ذاتي أكثر من الإناث المعوقات. وأظهرت الدراسة أن البالغين المعوقين الذين دخلهم ضعيف لديهم تكيف اجتماعي ورضى عن الحياة، ودور اجتماعي، وتقدير ذاتي، ومفهوم اجتماعي أقل .

الخلاصة والتطبيقات السريرية: تسلط النتائج التي توصلنا إليها الضوء على أهمية التركيز على تحسين الدعم الاجتماعي واحترام الذات والرفاهية لدى المعاقين الفلسطينيين وعائلاتهم. وقد يكون لتدخلات مثل برامج تعزيز احترام الذات التي يتم تقديمها في هذا السياق تأثير متزايد عند دمجها مع الخدمات الأخرى المتاحة من خلال مساعدة المعاقين على العيش معتمدين على أنفسهم في المستقبل. ويجب تطوير تدخلات تضع في الحسبان الثقافة الموجودة لتمكين المعاقين من فهم قيمتهم الخاصة وإحداث تغييرات في حياتهم ومجتمعاتهم. ويمكن عمل تدخلات نفسية اجتماعية والتي يمكن أن تلعب دوراً مفيداً في دعم الوعي وتطوير تقييمات دقيقة وإيجابية للذات، جنباً إلى جنب مع عملية التكيف مع الحياة للمعاقين.

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