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The Degree of Facing Violence and its Differences with Depression for Palestinian Children in Gaza Strip

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Abstract: The overall aim of this study is to assess the impact of political violence on depression among the Palestinian children in Gaza Strip. Method: The sample consisted of 80 children of 13 to 16 years of age. Measures included the Beck Depression Inventory (BDI). Results: Of the sample 18.8 % (N=15) of the children exceed the cut-off score in the depression scale. The differences between the case group and the control group were statistically significant, with the experimental group scored higher a significant acuter degree of depression . We can find that gender, the family's income, mother's education, the place of residence, the age of the child and periods of exposure, were variables had no significant differences with depression. Conclusion: cumulative experience of political violence trauma constitutes a risk factor for continuing depression symptoms which needs therapy and psychological help.

درجة التعرض للعنف السياسي وعلاقته بالاكتئاب لدي الأطفال الفلسطينيين بقطاع غزة

ملخّص:الهدفَ العامَّ لهذه الدراسة هو أَنْ تُقيّمَ مدي تأثيرَ العنفِ السياسيِ على مشاعر الكآبةِ بين الأطفالِ الفلسطينيّينِ في قطاع غزة. شَملتْ عينة الدراسة علي 80 طفلاً ممنْ تتراوح أعمارهم ما بينْ 13 إلى 16 عاماً ، ًطبق عليهم مقياس Beck للاكتئاب (BDI) ، حيث أظهرت النَتائِج: بأنِ 18.8% من أفراد العينة تجاوزوا الدرجة الحادة للاكتئاب، الاختلافات واضحة لصالح المجموعةِ التجريبيةِ التي أحرزتْ أعلى درجة حادّة منْ مشاعر الكآبةِ، أيضا متغيرات الجنسِ، الدخل العائلي، تعليم الأمِّ، مكان السكنِ، العُمرِ وفتراتِ التعرّض للعنفِ لم تظهر فروقا هامّةُ للمشاعر الاكتئابيةِ للأطفال. الخاتمة: التجربة المتراكمة لصدمةِ العنفِ السياسيةِ تُشكّلُ عامل خطرِ لاستمرار أعراضِ الكآبةِ التي تَحتاجُ العلاجَ والمساعدة النفسيةَ.

1. Introduction

The Palestinian people have been facing terrible, bloody and violent events because of the political violence. At the same time, the Israeli people have faced various kinds of traumatic events, as on December 9, 1987 events of violence in the Palestinian territories erupted in the West Bank and Gaza as a mass movement of civil disobedience and rebellion against the continuous Occupation. The army's response to the current crisis in the Palestinian territories was to increase brutal and oppressive measures. There were numerous killings, detentions without trial, demolition of homes, torture, deportation, and curfews. Occupation has, in addition, waged a harsh economic war on the Palestinians in retaliation for their refusal to pay taxes and their attempts to boycott occupation products. The Palestinian schools

and universities were closed by military orders because they were seen as breeding grounds for rebellion (El-Sarraj, 1993).

Under the current policy, the occupation forces can detain any Palestinian for up to 12 months without pressing charges. The age of criminal responsibility for Palestinians has been reduced to 12. In the first 33 months of events of violence in the Palestinian territories, approximately 1,474 Palestinians were shot and killed, and 54% of them were children under the age of 14. More than 22,000 Palestinians have been physically injured, 57,000 were detained, and hundreds of homes were demolished. Occupation casualties have been few, 6 occupation civilians and 11 soldiers were killed (Nixon, 1990).In September, 2000, new Palestinian events of violence took place against the now 36-year old occupation. The immediate cause of the events of violence was the visit of the occupation Knesset Member accompanied by over 1000 occupation policemen in full riot-gear to what Muslims call the Noble Sanctuary ("El-Haram A-Sharif") on which sits Al-Aqsa Mosque. Following Friday prayers the next day, Palestinians protested against this violation of their holy place, which resulted in occupation police fatally shooting several unarmed protesters. This event provided the immediate spark for the Palestinian protests throughout the West Bank and Gaza Strip, as well as the name for the event of violence that continues up to writing this thesis. The events of violence in the Palestinian territories. The more distant cause for this second and more violent event of violence was the increasingly evident failure of the Oslo Peace Process, the impetus of which, ironically, came from the first-mainly non-violent events of 1987-1993. Instead of a lasting peace between Israelis and Palestinians, Oslo has brought economic development (Qouta,2000) including high unemployment, a 50% increase in occupation settlement building and land confiscation, and a decrease in Palestinian freedom of movement and lack of civil liberties. More than 3000 of the Palestinian had been killed, and more than 50,000 had been injured.

Children who lost both parents before the age of five exhibited many psychological disturbances. These children evidently did not have an opportunity to internalize the values of their parents or their culture. Children separated from their families, particularly their mothers, are placed at increased psychological risk. But when separation is followed immediately by an attachment with another supportive adult in a stable environmental, the immediate symptoms – such as enuresis, anxiety, and fear do not necessarily evolve into long-term psychological disturbance (Ressler, Boothby, and Steinbock, 1988).

For 38 years the Israeli and Palestinian children have suffered a variety of traumatic events including witnessing violence. In Palestine the people face repeated and continuous trauma. Some researches has been published about the psychological effect of trauma on human beings. In Israel about 40% of kibbutz children are presented with bereavement reactions of clinical significance, including behavioral problems and social impairment, three years after their father's death in war (Elizur, Kaffman, 1982).
Some studies indicate that there may also be culturally determined variations in the presentation of anxiety or trauma related disorders. (Abu Hein, Qouta, Thabet and El Sarraj, 1993). For example, found a high rate (25%) of conversion fits in Palestinian children exposed to traumatic events during the war. Palestinian children living in West Bank were also found to suffer predominantly from behavioral and psychosomatic problems (Baker, 1990). In addition to the prevalence of PTSD, mental health problems have been studied in war victims in relation to experienced traumas. Studied a small sample of Bosnian adolescents who had moved to America during the Yugoslavian war, he found that 25 % suffered from PTSD while17 from depression.

1.2. General Objective

The study described in this thesis aims first; to examine the differences between the exposure to violence and depression among the Palestinian children living in the Gaza Strip.

1.2.1. Specific Objectives

1- The prevalence depression among the Palestinian children exposed to political violence in Gaza Strip.
2- The differences between depression scores among high level of exposure in comparison with low level that can be attributed to the family's income, mother's education, gender, the place of residence, the age of the child.
3- The differences between depression among children who faced violence due to the period of exposure to traumatic events (period less than 6 months, period from 6 to 12 months and from 12 to 18 months).

1.3. Research Questions

Bearing these questions in mind, the research reported here was planned. My motivation was first to articulate a comprehensive understanding of the effects of traumatic experiences on the Palestinian children in Gaza under conditions of political violence. Second, in order to help children, it was important to specify variables that may mediate the impact of exposure to traumatic events. Explaining their mediating role can serve intervention programmers in Palestinian community. The following questions were formulated.

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1- What is the prevalence depression among the Palestinian children exposed to political violence in Gaza Strip?
2 -Are there statistically significant differences in the levels of depression in children exposed to high level of trauma in comparison with low level?
3- Are there statistically significant differences in depression scores among high level of exposure in comparison with low level that can be attributed to the family's, the age of the child, gender, the place of residence, mother's education, income.
4 - Are there statistically significant differences in the levels of depression among children who faced violence due to the period of exposure to traumatic events (period less than 6 months, period from 6 to 12 months and from 12 to 18 months)?

2. Methodology

2.1. Sampling

This study's experimental sample consists of 80 children aged between 13 and 16 years old whom are orphans (have no fathers). The sample was selected from 1562 children affected by violence, according to the Ministry of Social Affairs statistics up to April, 1st 2002 in KhanYounis city and Rafah city. The selected experimental sample consisted of 80 Palestinian children (5.1% of the total population). 80 children were between 13 and 16 years old (preparatory school).These children have been traumatized directly by political violence, even though they did not participate in violent actions, they have faced violence. Psychological and behavioral changes in these children have been noticed by, both the family and school. These subjects lost a family member, one of their family members was injured or disabled, the subject's house got demolished or his family possessions, whether industrial or agricultural, got destroyed. This information (name, age, gender, parents' education level, family's income, date when violence has been inflicted and what kind of violence it was) have been reproduced on the cover page of every child's testing protocols. The elder group was formed by 80 adolescents aged between 13 and 16. Control group whom are not orphans i.e they haven't lost any parents or family members. These 80 children have not been subject to any violence.

2.1.1. Characteristics of the study population

Our main goal was to explore the impact of the political violence on the Palestinian children, and from the beginning we hypnotized that the atmosphere of political violence will lead to various kinds of psychological suffering. The researcher hypothesized that there were some important factors that would play an important role in determining the outcome such

as the level of exposure, the income of the family, the education of the mother, gender, child's age, place of residence and the duration of exposure.

In order to complete that work the researcher used samples adolescents aged between 13 and 16. Participants have been exposed to trauma less than 6 months, for a period of 6 to 12 months and for a period of 13 to 18 months.

Table 1 shows socio-demographic characteristics of the experimental sample (children having been exposed to traumatic events)

Variable		**13 - 16years (N = 80)**	
		N	**%**
Gender	male	42	52.5 %
	female	38	47.5 %
Area of residence	town	42	52.5 %
	refugee camps	38	47.5 %
Mother's education level	elementary	21	26.3 %
	preparatory	18	22.5 %
	secondary	32	40.0 %
	university	9	11.3 %
Income	< 100 €	37	46.3 %
	100 - 200 €	33	41.3 %
	> 200 €	10	12.5 %
age	13	16	20 %

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	14		18	22.5 %
	15		15	18.7 %
	16		31	38.7 %
Period of exposure to traumatic events	< 6 months		24	30 %
	6 - 12 months		33	41.2 %
	12 - 18 months		23	28.7 %

We note that the proportions concerning gender, area of residence and age are equitably distributed through both experimental groups. Regarding mother's education level, it is noteworthy that the percentage of mothers having university level is rather small. We may also note that families' income is generally low. A small proportion of the households have income above 200 €.

N.B 100€ = (100NIS)

2.2. Instrument : Beck Depression Inventory (BDI); The BDI is a 21 items self-report rating scale measuring supposed manifestations of depression, its characteristic attitudes and symptoms (Beck et al., 1961). The BDI takes approximately 10 minutes to be completed. Clients need to have a fifth or sixth grade reading age to adequately understand the questions (Groth-Marnat, 1990).

The scores for each of the 21 questions are added up to a total score. The scores for each of the 21 questions vary between 0 and 3, thus, the highest possible total for the whole test is 63 and the lowest possible score for the whole test is 0. Beck Depression Inventory (BDI; Beck et al., 1961) has been translated into Arabic, and have been applied on the Arab culture where he modified some items to be accommodated to the Arab culture by (Abed Khaled, Ahmed, 1990).

2.2.1 Reliability, Internal consistency for the BDI ranges from .73 to .92 with a mean of .86. (Beck, Steer, & Garbin, 1988). Similar reliabilities have been found for the 13-item short form (Groth-Marnat, 1990). The BDI demonstrates high internal consistency, with alpha coefficients of .86 and .81 for psychiatric and non-psychiatric populations, respectively (Beck et al.,1988). The BDI has a split-half reliability co-efficient of .93.

Below 4 score is usually for non-patients: possible denial of depression, faking good. 05 - 09 is considered as normal , 10 - 18 Mild depression ,19 - 29 Moderate depression , 30 - 63 Severe depression
Over 40 This score is significantly above even severely depressed persons, suggesting possible exaggeration of depression; possibly characteristic of histrionic or borderline personality disorders. Significant levels of depression are still possible (Groth-Marnat, 1990).

Items and scoring

1. sadness	8. self accusation	15. retardation
2. pessimism	9. suicidal ideation	16. insomnia
3. sense of failure	10. episodes of crying	17. fatigability
4. dissatisfaction	11. irritability	18. loss of appetite
5. guilt	12. social withdrawal	19. loss of weight
6. expectation of punishment	13. indecisiveness	20. somatic preoccupation
7. dislike of self	14. change in body image	21. low level of energy

3. Results

In this article the researcher tries to pose the results in model about parametric results by using the suitable statistical methods to answer the study questions.

3.1. Prevalence of depression in the experimental adolescent sample Table 2 shows level of depression (N = 80; age: 13-16 year

Acute Degree	Frequency	%	Cumulative Percent %
35	1	1.3	1.3
31	1	1.3	2.5
30	1	1.3	3.8
29	1	1.3	5.0
28	2	2.5	7.5
26	3	3.8	11.3
25	1	1.3	12.5

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24*	**5**	**6.3**	**18.8**
23	5	6.3	25.0
22	1	1.3	26.3
21	5	6.3	32.5
20	5	6.3	38.8
19	3	3.8	42.5
18	6	7.5	50.0
17	7	8.8	58.8
16	6	7.5	66.3
15	10	12.5	78.8
14	5	6.3	85.0
13	1	1.3	86.3
12	1	1.3	87.5
11	3	3.8	91.3
10	3	3.8	95.0
9	2	2.5	97.5
8	2	2.5	100.0
Total	80	100.0	

*** Cut-off score**

Table 2 shows that 18.8 % (N=15) of the children exceed the cut-off score in the depression scale.

3.2. Comparisons of the experimental group with the control group

Table 3 shows the differences in the levels of depression between the experimental group (N = 80) and the control group (N = 80) (age 13-16 years)

	Mean	**SD**	**Mean**	**SD**		
depression	18.35	5.63	13.80	6.90	4.57	0.001**

Table 3 shows a statistically significant difference ($p < 0.001$) between the experimental group and the control group, the experimental group scored higher, which indicates that, children who have been exposed to traumatic events are suffering from a significant acuter degree of depression than children who have not been exposed to such events.

3.3 Period of exposure and depression

Table 4 shows the differences between period of exposure to traumatic events (period < 6 months, period from 6 to 12 months and from 12 to 18 months) and depression

variables	variance C	sum of squares	DF	Mean square	F	p-value
depression	between groups	19.90	2	9.90	.48	.73
	within groups	2468	77	32.20		
	total	2506.2	79			

There are no significant differences between the period of time children have been exposed to traumatic events and of depression they are subjected to, at level P. value 0.05

3.4. Gender and depression

Table 5 shows the differences between gender (males, N = 42; females, N=38, age 13-16 years) and depression

variables Variables	male (N = 42)		female (N =38)		t-Test value	p-value
	Mean	SD	Mean	SD		
depression	18.40	5.60	18.29	5.73	0.09	0.93

Table 5 shows that there is no significant difference, neither between gender and depression. at level P.value 0.05.

3.5. Age and depression

Table 6 shows the differences between age and depression (N = 80; age 13-16 years)

variables	variance C	sum of squares	DF	Mean square	F	p-value
depression	between groups	149.00	3	49.67	1.60	.20

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	within groups	2357.20	76	31.02		
	total	2506.20	79			

There are no significant differences, neither between age and depression. at level P.value 0.05.

3.6. Place of residence and depression refugee camps, N = 38) and depression

variables	**town (N = 42)**		**refugee camps (N =38)**		**t-Test value**	**p-value**
	Mean	**SD**	**Mean**	**SD**		
depression	18.85	5.47	17.79	5.82	0.84	0.40

Table 7 shows no statistically significant differences in children's levels of depression, regarding their place of residence (whether they live in town or a refugee camp). at level P.value 0.05.

3.7. Mother's level of education and depression

Table 8 shows the differences between the level of mother's education (elementary, preparatory, secondary or university level) and depression

variables	**variance C**	**sum of squares**	**DF**	**Mean square**	**F**	**p-value**
depression	between groups	95.53	3	31.84	1.00	.40

	within groups	2410.67	76	31.72		
	total	2506.20	79			

Table 8 shows that mother's level of education has no significant impact on the adolescent's of depression. at level P. value 0.05 .

3.8. Level of income and depression

Table 9 shows the differences between the family's level of income and depression (N=80 adolescents, age 13-16 years)

variables	**variance C**	**sum of squares**	**DF**	**Mean square**	**F**	**p-value**
depression	between groups	66.45	2	33.22	1.05	.34
	within groups	2439.74	77	31.69		
	Total	2506.2	79			

Table 9 shows no significant differences between the family's level of income and the degree of depression the adolescent is subjected to (F = 1.05; p = .34). at level P. value 0.05

4. Discussion

Overview, One our study's aims was to understand, to describe and to analyze how trauma and violence relate to Palestinian children's mental health and what are the possible mediating factors.

Some conclusions may be drawn from the results of our research in Gaza.

For this, we have to take into consideration two points:

Firstly, this study has been carried out in spring 2002. This period was a very sensitive and difficult period for the Palestinian people. In this period,

serious violence has extended and escalated from the West Bank in Palestine to the Gaza Strip. Secondly, the socio-economic status of the population deteriorated after a very long period of closure and collective punishment of the civilian population. These measures included road blocking, long periods of curfew in some regions, military barriers that prevented people from reaching their workplaces or that kept them from allaying their basic nutritional needs.

4.1 Main findings

1- 18.8% of the adolescent experimental group suffer from depression.

2- From the comparison of the experimental group with the control group (age between 13 and 16 years), we draw the conclusion that the case group (high trauma) got significantly higher scores of depression

($t = 4.57$; $p = 0.001$) than the control group (low trauma).

3- The period of exposure does not significantly influence the levels of depression in the group

of adolescents aged between 13 and 16.

4- Neither age nor gender is significantly related to neither depression

5- There is no significant differences between place of residence and depression.

We will consider these findings one by one.

4.2 The prevalence of depression

Our results show that 18.8% of the adolescents' suffer from depression .

Our results veer toward results of a number of studies from various war zones in different cultures. Some studies have described the immediate reactive behavior relating to trauma (Creamer et al., 1999).

The signs and symptoms of delayed response to trauma are the following.

1-Cognitive: confusion, fear of going crazy, preoccupation with the incident, denial of the event's importance.

2- Emotional: fear of reoccurrence, phobias, over-sensitivity, depression, grief, resentment, worry about physical health, self-destructive behaviors.

3- Physical: fatigue, impairment of sleep pattern, increased illness.

4- Behavioral: social withdrawal, compulsive need to talk about the events, relationship or family problems, flashback, avoidance of incident location and substance abuse.

Other reactions have received relatively little attention, but there is evidence for increased rates of depression among Lebanese (Saigh, 1991), Iraqi (Dyregrov & Raundalen, 1992), Croatian (Zivcic, 1993) and Cambodian children (Kinzie, et al., 1989) who survived war. Increased level of anxiety was also reported by Saigh (1991) among his sample of Lebanese children.

Kinzie et al. (1989) reported mixed levels of anxiety in Cambodian refugee youth. However, a similar early study by Ziv (1973) in Israel found that the anxiety level of Israeli Kibbutzim children who had been exposed to recent shelling didn't differ from those of children who had not been exposed.
Many children are bereaved during war and show grief reactions following the Gulf War. Dyregrov & Raundalen (1992) found that, amongst other symptoms, Iraqi children who had witnessed the bombing of a shelter with 750 deaths, showed significant and lasting signs of grief. Nader, Pynoos, Fairbanks, Al-Ajeel & Al Asfour (1993) assessed grief reactions in Kuwaiti children and youth (aged 8-21 years) after the Gulf War. Their findings show that 98% of the sample reported at least one symptom of grief.

The present sample reported more depressive feeling, They can not adapt after being exposed to trauma. This finding not consistent with previous finding of increased levels of depression in Croatian children during war children during the war, displaced refugee children reported more sadness and fear than local children who had not moved from their home residence (Zivcic, 1993, Mghir et al, 1995).

Our results differ from other studies taking an interest in trauma's impact on children, such as a group of British children who survived a shipping accident (Yule et al, 1990). These children express fewer depressive feelings on the same measure.. This finding suggests some adaptive coping in the majority of children in the face of adversity. It is conceivable that coping is facilitated when the whole community is affected and able to pull together to survive. There is emerging evidence that for adults in peacetime, social support may mediate a range of post-traumatic outcomes, including depression (Flannery, 1990).

4.3 Comparison between the adolescent case group and the control group for depression

Our findings showed that the differences in the levels of depression between the case group and the control group were significantly higher in the case group. In other words, highly traumatized adolescents are suffering from an acuter degree of depression than the control group.

Adolescents in the case group seemed to experience sadness over time, remaining afraid of losing their family and feel that friends and family do not really understand what they are going through. A majority did not talk with their parents about their feelings. Many adolescents worried that they would not lead a normal life and they had become more pessimistic about the future over time. Both intrusive thoughts and fear from the war, as well as avoiding thinking and behavior, bothered the youngsters. Again,

these findings are corroborated by PTSD studies in the literature, Approximately, 25% to 30% of individuals who witness a traumatic event may develop chronic Post-Traumatic Stress Disorder (PTSD) and other forms of mental disorders (e.g., depression), (Yehuda, Resnick, Kahana, & Giller, 1993). Approximately 50% of individuals who develop PTSD continue to suffer from its effects decades later without treatment (Meichenbaum, 1994).

4.4 The differences between duration of exposure to traumatic events and depression

Our findings show no significant influence of the period of exposure on depression. These results were not awaited, as may be supposed that the longer the period of exposure to traumatic events, the more suffers the person. However, we have to take into consideration that Palestinian children are living constantly under potentially traumatizing conditions. Supposedly, there is an effect of habituation to some kinds of trauma. The American psychiatric Association (APA, 1994), has defined trauma as an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. If an individual has experienced, witnessed, or been confronted with such events, his responses may include intense fear, helplessness, or horror. In children, this may be expressed instead through disorganized or agitated behaviors (DSM – IV, 1994). Some findings indicate that neurotic symptoms and psychological suffering decrease during the past three years, especially among children who have experienced many kinds of traumatic events. Such results corroborate children's considerable plasticity (Qouta, 2003).

Additionally to examining the prevalence of PTSD and other disorders, recent research centered on the degree children have been exposed to trauma. In contrast to peacetime disasters, stresses during war are generally multiple, diverse, chronic, and repeated including the violent death of a parent, witnessing the killing of close family members, separation and depression, terror attacks, bombardment and shelling (Macksoud, Dyregrov, & Raundalen, 1993). Several studies have reported significant differences between the amount of such war experiences and subsequent reactions (Chimienti, Nasr & Khalifehi, 1989; Gupta et al, 1996; Kuterovac et al., 1994; Mghir, Freed, Raskin & Katon, 1995; Nader et al., 1993). These findings go along with evidence of a relatively straight forward relationship between amounts of exposure and reactions.

There is emerging evidence that the type of trauma also plays an important role. Dyregrov and Raundalen (1992) found that exposure to dead bodies and body parts were the best predictor of intrusive symptoms of PTSD.

These authors suggest that very strong sensory impressions enhance psychological reactions.

4.5 The differences between gender and age, and depression 4.5.1 Gender

Our findings state that there is no significant difference between males and females in their responses towards the traumatic events.

Our results are consistent with the results of Qouta et al. (1995). These researchers found no differences between boys and girls in their reaction to exposure to traumatic events.

Our findings differ from those of other studies. Thabet et al. (2001) found that boys were significantly more often exposed to high traumas than girls were. They interpreted this finding as resulting from the socialization of girls in contemporary Palestinian society. At their homes, girls are under stricter surveillance and protection, whereas boys are rather participating in the activities and events of violence. According to the Arabian culture, girls are expending their time at home helping their mothers in homework, so they are exposed to less traumatic events than boys. This might hearken back to Eastern constrained society, which doesn't give full freedom to women, and imposes a lot of social restrictions on her. We live in a closed society which does not allow freedom to girls and put restrictions on woman's activities and their participation in society. When we consider the cultural and societal characteristics exposed above, we might conclude that girls can not develop their adaptive skills with trauma as a result of imposed cultural restrictions. Another argument may be that, in the Arabian culture, girls display more openly grief symptoms than boys do.

Some studies suggest that father's absence may increase aggressiveness in girls and perhaps allow them to develop less traditionally feminine sex roles (Tuttle Jr., 1990).

These findings are contrary to the results of Thabet et aI (2001), Punamaki et al.'s (1995), as well as Macksoud's (1996), (Dyregrov, Gupta, Gjestad & Mukanoheli, 2000; Kuterovac et al., 1994) The studies indicate that girls are more vulnerable to develop post-traumatic stress disorder than boys.

Abu Nada (2003), Qouta (2000) and (Qouta et al 2003) emphasize that girls developed more post-traumatic stress disorder reactions than boys. Their results also brought out that there was more parental support for girls than for boys. This may also be related to Palestinian culture and religion, in which girls are considered as weak and sensitive persons. They have the right to express their fears and worries more openly than boys. Doing so, they attract the attention of their parents. Beside this, the Islamic religion urges Muslims to offer kindness to females and not to abuse them by any manner

or under any condition. This might result from the fact that the Palestinian parents also have been exposed to many traumatic events beside the heavy burden of life, this might increase the level of aggressiveness from parents toward their children.

4.5.2 Age

Our findings revealed that children of different ages are not significantly different in their responses towards traumatic events.

Our results are not consistent with those of a study of Ahmad (1992). He found that a variety of symptoms were more frequent among Kurdish children who had been exposed to a military attack and who where older than 11 years than in younger children who had been exposed to the same military attack. The younger children may have been rather protected from traumatic perceptions by their parents, or they may be less interested in attending to such a scene. Thus, exposure's effects might be less intrusive.

Our findings also differ from the results of another epidemiological study with an other sample of Palestinian children, aged between 9 and 13 years Thabet et al(2002). Children reported high rates of significant anxiety problems (21.5%). The highest prevalence rates have been considered in 12 to 13 years old children. While, Qouta & Punamaki (2003) found that younger children who have been exposed to military violence are the most vulnerable for psychological suffering.

4.6. Differences between family's income and depression

Palestinian Central Bureau of Statistics reports that 70% of Palestinian people are living under poverty line. Most families income level is less than 200 € monthly (Palestinian Central Bureau of Statistics reports, April 2003).

Our findings indicate that children from families with low or moderate income (less than 100 € and between 101 and 200 €) show higher levels of depression than children from families with higher income (more than 201 €). This might be interpreted by the fact that, people with good income can seek help, buy medications, visit specialist, in contrary to the poor people who are hesitated to expend money on health issues and priorities the money to feed themselves.

Our results are similar to those of Thabet and Vostanis (2002), even though this is an epidemiological study with a different and older sample of Palestinian children. Children reported high rates of significant anxiety problems (21.5%) and similar findings to western populations. Anxiety symptoms were associated with low socio-economic status.

4.7. Differences between place of residence and depression

Our findings indicate no significant differences between town children and refugee camps' children in their response towards traumatic events.

Despite these findings, we would like to emphasize the concrete differences between living in refugee camps and in the city. Refugee camps' populations have minimal health care. Their houses stand very close one to another and in one room live ten persons. People receive services and care form the United Nations (UNRWA). life in refugee camps is very difficult compared to life in the city. Refugee camps' habitants suffer from violent actions, their houses are destroyed and they are bothered day and night.

The results in our study show no significant differences in depression between cities and refugees camps' children.

Our findings could be interpreted by the fact that, all the Palestinian people are present under ongoing traumatic events that affects all the group ages, communities, places of residency, therefore the results are demonstrated as the same on different places of residency.

Studies about childhood in Bosnia (Rune et al., 2002) put to the fore that children living in refugee camps were more traumatized than children living in the cities. Studies on Croatian children during the war also found that children in refugee camps were more affected by trauma than children living in cities (Zivcic, 1993). Our results differ from these findings.

Another question that might be pertinent is, whether children living in refugee camps and cities witness similar traumatic situations?

Our findings differ from the results of Abu Nada (2003) putting to the fore that the type of residency plays a role in the level of traumatic events exposure. Children from a rural area were significantly more likely to have high exposure levels to traumatic events than children living in camps or an urban area. Thabet et al (2001) findings are quite opposite to Abu Nada's (2003). Thabet et al. (2001) found that children living in an urban area were significantly more likely to have high exposure levels to traumatic events than children living in camps or in rural areas. Our findings are not in line with other studies' results in Lebanon. The latter indicated that Lebanese children residing in certain regions (e.g. 'outside greater Beirut' or 'in the southern suburbs') experienced a greater number of traumatic events than children from other regions (e.g. near the demarcation line or in East Beirut) (Macksound, 1992). Macksound (1996) indicated that children living in the south of Lebanon reported less post-traumatic stress disorder symptoms than children living in East Beirut or in the Southern suburbs.

4.8. Conclusion

Our research sample was relatively small. Thus, it does not allow drawing general conclusions that might answer general epidemiological questions. We are not in a position to state about the percentage of Gaza children who are at risk of developing serious mental health problems in consequence of military violence. Such information would be necessary to plan mental health and educational services for families in Gaza. Still, our findings, drawn from the present sample, indicate how common personal exposure to traumatic events is. The latter imply imprisonment, night raids at homes or being wounded during violent events. This information is crucial for human right activists, but for mental health workers it provides relatively little information about how to improve children's creative ways of mastering and enduring military violence.

Finally, our research was limited to a particular cultural group. One characteristic of Palestinians as a national group is the fact that they are not passive victims of violence and humiliation. They rather display a determination to struggle in order to change the prevailing order. We cannot understand our children's behavior by simply applying conventional explanations of trauma. As far as we know, the data we have collected have not been replicated in comparable political conditions, such as in South Africa before liberation, for example. Our results describe the special conditions of people who have been uprooted from their country and who have engaged in a national struggle for their independence that is still going on today. Nonetheless, our study can contribute to the literature about trauma as the researcher used reliable methodology and standardized measurements. They could present the basis for further follow-up and comparative studies. Many other perspectives remain to be explored, such as the role of child affiliation, the effects of Palestinian- Israeli's violence on familial and societal dynamics and trans-generational experiences of dramatization. Another question that needs further analysis is that of children's understanding of the concepts of struggle and peace. For example, most American or Western-European children consider peace as the normal way of life. By contrast, the lives of Palestinian children have been constantly concerned with the threat of violence as they struggled to regain their own country and to end military occupation. In fact, Palestinian children have learned that struggle and enemies are normal elements of their life. However, empirical evidence must be provided to actually verify any idea that Palestinian children may have been "socialized" to an atmosphere of political violence and trauma.

Understandably, there is an insecurity and a destabilization in Palestinian youth because of their experiences.

Moreover, the currently unresolved political situation, in addition to representing a very uncertain and insecure future, will continue to put pressure on them. There is no doubt that this will cause psycho-social problems of different kinds. The consequences of these psycho-social implications are not only true for the children themselves, but also for their nuclear and extended family and the community in general, as well as for following generations of Palestinian people (Qouta, 2000).

Psychological factors also reflect in their physiological state, as they have an increase or loss in the appetite, which affects their growth. At night, they fear the darkness or the inability of their parents to assure their security and basic requirements, as regards to long borders' blockades and loss of income. Beside this, their daily vocabulary has been affected by expressions such as rubber bullets, sound bombs, smoke, tear gas and bombs.

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