

Chapter 4

Previous studies & research questions

4.1 Introduction

Many studies have investigated traumatized children living in war or under occupation in different regions and cultures of the world. This chapter will focus on the Middle East such as Israel, Lebanon, Iraq, Kuwait, Afghanistan and Palestine. It will also provide a brief synopsis of the main studies carried out in each geographical area such as Middle East, Far East (e.g. Cambodia, India, Sri Lanka), The Balkan Region (e.g. Croatia, Bosnia), African Countries (e.g. South Africa, Uganda, Angola, Kenya).

4.1.1 The Middle East

4.1.1.1 Israel

Rosenbaum and Ronen (1992) studied the effects of violence on 277 Israeli children. A high rate of anxiety was found, especially in the evening, when it was very high in the first weeks after the trauma, but started to decrease in the fifth week. Females were more anxious than males, and there were similarities between the perception of the child and that of his or her parents with regard to danger. Another study compared Israeli children in a high-exposure area with a low-exposure area (Solomon, 1994). Children from shelled areas reported more coping strategies than children in non-shelled areas. Children who focus on threat reported more psychological stress than children who focus on avoidance.

4.1.1.2 Lebanon

In a study conducted by Sibai and Sen (2000) participants from Lebanese and Palestinian refugees who had experienced an event related to the war in Lebanon from 1975-1992 were studied. The study found that among this population, more than two thirds (66%) of the group suffered from depression. This condition was more prevalent among the Palestinian subgroup (n=22129) when compared to the Lebanese subgroup (n=16129), of whom 55% experienced depression. It means that the impact of living as refugees depends on the location of refugees,

for example the Lebanese were refugees in their country but the Palestinians were out of their home country.

4.1.1.3 Iraq

Ahmad *et al.*, (2000) tested 45 families who were randomly selected among the survivors in two displacement camps five years after the military operation “Anfal” in Iraqi Kurdistan. The result showed that PTSD was reported in 87% of children and in 60% of their care-givers. In other words, the effects of exposure to traumatic events might show up later, depending on the personality of individuals and the strength of the support system, particularly the family support.

4.1.1.4 Kuwait

Nader *et al.* (1993) tested 51 Kuwaiti children and adolescents between the ages of 8-21 years: 86% knew people who had been captured, 76% knew people who had been injured, 59% knew a deceased person and 65% saw injured or dead people. This study found 31% had severe post-traumatic reactions, 40% moderate, 29% low, and 4% of children reported no reaction. Total exposure to traumatic events correlated significantly with the number of PTSD symptoms. It means whenever the individuals were exposed to frequent traumatic events, it led to an increase the symptoms of PTSD.

In another study, Abdel-Khalek (1997) conducted a survey of the fear-eliciting stimuli associated with Iraqi aggression amongst 2083 Kuwaiti children and adolescents between the ages of 13-17 years. This study used a fear schedule of 30 items, which was administered 5.7 years after the Iraqi invasion of Kuwait. This study found that girls had significantly higher mean scores than boys in all 30 items as well as the total score. This study concluded that the Iraqi invasion’s aversive effects had persisted over 5.7 years since the traumatic experience had occurred.

4.1.1.5 Afghanistan

Mghir *et al.* (1995) interviewed 38 refugees from Afghanistan between 12 and 24 years of age with the Structured Clinical Interview for DSM-III-R. The results suggested that a significant proportion of adolescent and young adult Afghan refugees in the community suffer from severe but undiagnosed psychiatric disorders.

4.1.1.6 Palestine

Qouta and El-Sarraj (2004) found that 32.7% of Palestinian children in the Gaza Strip started to develop acute PTSD symptoms that needed psychological intervention, while 49.2% of them suffered from moderate level of PTSD symptoms. Also, the results of this study showed that the most prevalent types of trauma exposure for children are for those who had witnessed funerals (94.6%), witnessed shooting (83.2%), saw injured or dead people who were not relatives (66.9%), and saw family member injured or killed (61%).

In a study in 2003 340 students aged 12 years (194 males and 146 females), were randomly selected from the UNRWA's Gaza Schools, 48 children who got highest score of PTSD, divided equally between female and male in two case groups (control and experimental) (Hawajri, 2003). This study found that there is significant positive correlation between levels of neuroses and the level of PTSD within the whole sample. However, females reported more symptoms of PTSD than males. Also, the individuals who had low Socio-Economic Status (SES), showed a high level of exposure to trauma which increased their symptoms of PTSD. The PTSD and neuroses symptoms were alleviated for the experimental group (both males and females) after implementing a counseling program.

A study by Thabet *et al.* (2002) compared 91 children who were exposed to home bombardment and demolition during Al-Aqsa Intifada with 89 children that had been exposed to other types of traumatic events related to political violence as a control group. More of the children who were exposed to bombardment and home demolition reported symptoms of post-traumatic stress and fear when compared to the control group. Exposure to bombardment was the strongest traumatic predictor of post-traumatic stress reactions. The children who were mainly exposed to such events through media and adult's reports had more anticipatory anxiety and cognitive expressions of distress than children who were directly exposed. These findings suggest that children living in war zones can express acute distress from various traumatic events through emotional problems that are not usually recognized compared with the physical disorders.

Thabet & Vostanis (2000) conducted a longitudinal study among the Palestinians children in the Gaza Strip who suffered from symptoms of PTSD. Symptoms of PTSD decreased from 41

to 10% between 6 and 10 months after the war and conflict have been reduced with implementation of the Oslo Agreement (1993-2000).

In a study on 11-12 years old Palestinian children, Qouta (2000) showed that the more traumatic experiences they had and the more they participated in the Intifada, the more concentration, attention, and memory problems they had.

In a previous study, Punamaki (1996) showed that 35% of a sample of Palestinian children had symptoms of fear, 22% showed withdrawal behaviour, 27% difficulties sleeping, 92% nightmares, and 80% were afraid that the Israeli army would attack their homes. The researcher later found that strong ideological commitment in children between the age of 10 and 16 had reduced the effects of anxiety, insecurity, and depression.

In an earlier study Punamaki (1989) also found the more the mother is socially embedded, politically active, and ideological (or religiously) committed, the better her mental health and that of her children. Punamaki (1987) tested 168 Palestinian and 185 Israeli children who were interviewed during the first Intifada. 45% of the Israeli children had seen or heard an explosion. 87% of the Palestinian children had been involved in violent confrontations against Israeli soldiers. 29% of the Israeli and 37% of the Palestinian children had wounded relatives. 76% of the Israeli children's fathers and 40% of the Palestinian children's fathers took part in the war and 67% of the Palestinian children had a relative in prison.

4.1.2 USA

Grover (1999) examined a sample of 206 inner-city, young adolescents. The participants were 6th-, 7th- and 8th-grade students from a parochial school in Brooklyn, New York. The results of this study showed that adolescents who were exposed to violent events, either as witnesses or direct victims, had greater PTSD levels than adolescents who had not experienced such events. However, the direct victims of violent events had actually greater PTSD levels than the witnesses. Although females witnessed more violent events overall, males and females showed similar levels of PTSD. Also, this study showed that social support was not found to moderate the relationship between exposure to violence and PTSD.

4.1.3 Far East

4.1.3.1 Cambodia

40 Cambodian adolescents living in the USA were studied by Kinzie *et al.* (1986). Within this population 90% had lived in age-segregated camps in Cambodia, 83% had been separated from their family, 98% endured forced heavy labour, 68% looked like skeletons, 43% had oedema, 43% witnessed murder and 18% had family members killed. Amongst these people a 50% prevalence rate of PTSD and a 53% prevalence rate for depression were found, four years after they fled Cambodia.

In another study, Hubbard *et al.* (1995) examined 59 Cambodian young adults (29 male and 30 female) who survived massive trauma as children. The results showed that a significant number of those with PTSD (59%) had one or more additional DSM-III-R Axis I disorders. Major depression and generalized anxiety disorder were the most common co-morbid disorders. Somatoform pain disorder was also found to coexist with PTSD but only among females.

4.1.3.2 India

In a study conducted on children who had escaped from Tibet and found refuge in Tibetan settlements in India, the results showed that 11.5% of the children met DSM-IV criteria for PTSD (Servan-Schreiber *et al.*, 1998). Children who had arrived from Tibet in the previous 18 months showed a tendency for greater prevalence of PTSD than children who had been refugees for longer. It means that refugees who spent a longer time far from their home country, could be developing some coping strategies which could help them to adjust within the new environment of refuge. However, some refugees who spent more time far away from their home countries, showed more psychological and social problems (e.g., Qouta and El-Sarraj, 2004).

4.1.3.3 Sri Lanka

Soysa (2002) investigated 60 9-16 years old children from two villages on the northern and eastern borders of the war zone in Sri Lanka who displayed patterns of PTSD symptomatology. The most consistent difference between categories of PTSD symptoms was that re-experiencing was more reported than avoidance and numbing by both the children and

their mothers. Children reported higher levels of PTSD than the mothers. War exposure was associated with all categories of PTSD symptoms in children. Both war exposure and maternal trauma were related to a child's PTSD. It appears that coping, perceived social support and maternal trauma may have a greater impact on the child's levels of PTSD in the context of exposure to lower war trauma.

4.1.4 The Balkan Region

4.1.4.1 Croatia

Zivcic (1993) found that depressive symptoms were equally high among Croatian children during the war and among those living in refugee circumstances. Refugee children reported more sadness and fear than local children who had not moved from their homes. Kinzie *et al.* (1989) found in a follow up study with 27 of the children from the previous study, that 47% still suffered from PTSD, and 41% from depression.

In 1998 Ajdukovic investigated 45 adolescents aged between 14-19 years who were displaced in the Republic of Croatia as a result of the war. The most frequently reported stressful events they encountered were the loss of their home (80%), the loss of personal belongings (66.7%), separation from family members (66.7%), damage to their property (48.9%), exposure to enemy attacks (46.7%) and death of a family member or friend (37.8%). The exposure to a greater number of stressful events was related to increased depression. More post-traumatic stress reactions were observed in females, in adolescents who were exiled for longer periods of time and in the children whose parents were more anxious. Moreover, adolescents who manifested a higher number of stress reactions had poorer expectations regarding their future.

In another study on Croatian children, Kukerovac *et al.*, (1994) investigated two groups (64 non-displaced versus 70 displaced children) to assess the amount of stress exposure and reactions among children subsequent to a war situation. The results showed that a majority of Croatian children had been exposed to armed combat. However, displaced children had been significantly more exposed to the destruction of their homes and schools as well as to acts of violence and bereavement. Displaced children had significantly higher symptoms of PTSD. Girls had a significantly higher overall as well as symptoms PTSD than boys.

4.1.4.2 Bosnia

Smith *et al.*, (2001) investigated the risk and the moderating factors of children's psychological reactions to war in 339 Bosnian children aged between 9-14 years, their mothers and their teachers. The self-report data from these children revealed high levels of post-traumatic stress symptoms and grief reactions, but normal levels of depression and anxiety. The mothers' self-reports also indicated high levels of post-traumatic stress reactions, but normal levels of depression and anxiety. The child's distress was related to both their level of exposure and to their mother's reactions.

In another study, Husain *et al.*, (1998) surveyed 791 children and adolescents from Sarajevo aged between 7-15 years to assess their symptoms of PTSD and level of deprivation under siege conditions in Sarajevo. The results showed that a loss of family members and deprivation of basic needs were associated with more symptoms of PTSD and personal experiences of siege, which are related to increased stress.

4.1.5 African Countries

4.1.5.1 South Africa

Dawes *et al.* (1989, 1990) found that 9% of women and children who were involved in riots in South suffered from PTSD. The suffering was especially high in children whose mothers suffered from PTSD.

4.1.5.2 Uganda

A study on Sudanese refugee children in North Uganda showed that these children suffered significantly more from the effects of war than Ugandan children in the same area (Paardekoper *et al.*, 1999). 94% of these children's families lost their property, 81% lost a family member, 92% suffered from a lack of food and water, 62% had no medical care, 28% of the children had been tortured and 25% had been lost or kidnapped. Compared to the Ugandan children, the Sudanese children reported significantly more PTSD complaints such as troubles to sleep, nervousness, traumatic memories, behavioural problems, depressive symptoms and psychosomatic complaints.

4.1.5.3 Angola

Ventura (1997) observed three groups of Angolan adolescents differing in their degree of war exposure. A representative sample of these groups was studied 6 months after the 1993 war. The results showed that the prevalence and symptoms of PTSD were greater in refugee groups (90%), compared to 82% of non-refugees living in Lubango and 22% of Angolans adolescents who at the time of the study had resided for more than one year in Portugal. There was a relationship between increased war exposure and an increase in anxiety, depression, adjustment, and behavioural problems and a decrease in intellectual functioning and self-concept.

4.1.5.4 Kenya

In a study conducted by Seedat *et al.* (2004) 2041 boys and girls from 18 schools in Cape Town and Nairobi completed anonymous self-report questionnaires. The researchers found that more than 80% reported exposure to severe trauma, either as victims or witnesses. The researchers concluded that although the lifetime exposure to trauma was comparable across both settings, Kenyan adolescents had much lower rates of PTSD. This difference may be attributable to cultural factors.

4.1.6 Summary and comment

Several conclusions can be drawn from the previous studies, but it is clear that traumatic stressors among children in war circumstances vary a great deal across countries and ethnic groups.

4.1.6.1 Several factors can lead to PTSD

There are several factors which can lead to an increase in the symptoms of PTSD for children living in war, such as living as refugees, poverty, and siege (e.g., Sack *et al.*, 1994; Paardekoper *et al.*, 1999; Ventura, 1997).

4.1.6.2 Living as a refugee and PTSD

Children who had been refugees for longer than 18 months showed less prevalence of PTSD than children who recently became refugees (Servan-Schreiber *et al.*, 1998). Also, children who are refugees away from their home countries showed more symptoms of PTSD than

children who are refugees in their home country, for example Palestinians and Lebanese refugees in Lebanon (Sibai and Sen, 2000) and Sudanese and Ugandan refugees in North Uganda (Paardekooper *et al.*, 1999). On the other hand, children living in shelled areas showed more coping strategies than children from non-shelled areas (Solomon, 1994).

4.1.6.3 Appearance of PTSD symptoms much later after the traumatic event

The symptoms of PTSD can appear much later after the first exposure to traumatic events, for example in Iraq after five years (Ahmed *et al.*, 2000); in Kuwait after five years and seven months (Abdel-Khalek, 1997) and after four years among Cambodian adolescents in the USA (Kinzie *et al.*, 1986).

4.1.6.4 PTSD and gender

In addition, research showed that females show higher symptoms of PTSD than males in the Gaza Strip (Hawajri, 2003; Qouta *et al.*, 2003), Kuwait (Abdel-Khalek, 1997) and Croatia (Ajdukovic, 1998). Moreover, somatoform pain disorders were found to coexist with PTSD only among females (Hubbard *et al.*, 1995). However, males and females showed similar levels of PTSD (Grover, 1999; Ajdukovic, 1998; Kukerovac *et al.*, 1994) in some studies.

4.1.6.5 The impact of PTSD on people close to children who are suffering from PTSD

PTSD badly affects children and others close to them such as their parents and care-givers (Ahmad *et al.*, 2000; Dawes *et al.*, 1989, 1990; Smith *et al.*, 2001). However, children showed higher levels of PTSD than their mothers (Soysa, 2002).

4.1.6.6 Type of trauma and PTSD

The level of PTSD depends on the type of traumatic event. For example, American adolescents who are exposed to traumatic events had greater PTSD levels than others who were not exposed to the events. The actual victims of violent events also demonstrated greater PTSD levels than the witnesses of violent events (Grover, 1999). Furthermore, children and adolescents who had been exposed to traumatic events in Sarajevo, lost one or more of their family members and were deprived of basic needs, had more symptoms of PTSD (Husain *et al.*, 1998).

4.1.6.7 Exposure to traumatic events cause PTSD and others psychological disorders

Exposure to traumatic events are not just only the cause of PTSD symptoms, it might also lead to other psychological disorders (Kinzie *et al.*, 1986).

4.1.6.8 Rate of PTSD and exposure to trauma

High rates of anxiety and PTSD symptoms are found in the first weeks after the trauma, but these rates start to decrease in the fifth week after the initial event (Rosenbaum and Ronen, 1992); Khmer (Cambodia) adolescent in US showed 21% of PTSD (Sack *et al.*, 1994); Cambodian adolescents in the US showed a 50% prevalence rate of PTSD (Kinzie *et al.*, 1986), Croatian children suffered 47% of PTSD symptoms (Zivcic,1993) and 9% of African children in South Africa suffered from PTSD (Dawes *et al.*, 1990). Also, 80% of African boys and girls reported exposure to severe trauma (Ajdukovic, 1998).

4.1.6.9 Moderating factors of PTSD

Kenyan adolescents showed much lower rates of PTSD compared to other PTSD sufferers in Africa, because this difference may be attributable to cultural factors(Seedat *et al.*, 2004). Also, the culture, social support and coping strategies might have alleviated some of the symptoms of PTSD among the children in wartime in Sri Lanka and Nairobi (Seedat *et al.*, 2004; Soysa, 2002).

4.1.6.10 Lack of hope and PTSD

A study found that Croatian adolescents who had poorer expectations of hope for a good future, showed higher symptoms of PTSD (Ajdukovic, 1998).

4.1.6.11 Amount of trauma and PTSD

Increase in exposure to war leads to an increase in PTSD, anxiety, depression and behavioural problems (Ventura, 1997). However, children from shelled areas reported more coping activities than children in non-shelled area (Solomon, 1994).

4.1.6.12 Exposure to trauma and PTSD in Palestine

Several studies found that Palestinian children in the Gaza Strip who were exposed to traumatic events showed psychosocial problems (e.g., fear, withdrawal behaviour, difficulties sleeping, nightmares, nail-biting, depression, bed-wetting, speech difficulties and anxiety)

which range from 8.3% to 66.9% of PTSD symptoms (e.g., Qouta, 2000; Husain *et al.*, 1998; Thabet, Abed, & Vostanis, 2002). Also, Thabet *et al.* (2002) found that children who were exposed to bombardment and home demolition showed more symptoms of PTSD than the control group that had been exposed to other types of traumatic events. It is clear that severe types of traumatic events have damaging psychological effects on the Palestinian children.

PTSD decreased from 41% to 10% 6 to 10 months after the conflict known as the first Intifada (1987-1993) stopped with the beginning of the implementation of the Oslo Agreement (Thabet & Vostanis, 2000; Qouta, Punamaki & El-Sarraj, 1995b; Qouta *et al.*, 2001). Another study found that Palestinian children in the Gaza Strip who were exposed to traumatic events showed educational problems (Qouta, Punamaki & El-Sarraj, 1997). Moreover, some studies found that Palestinian children in the Gaza Strip who were exposed to traumatic events showed somatoform disorders (Baker, 1990; Kanninen *et al.*, 2003). The ideological commitments of Palestinian children, for example, or a belief in the right of freedom fighting, alleviates the effects of traumatic experiences (Punamaki, 1996).

Palestinian children who were exposed to serious trauma such as witnessing the killing of family member, exposure to bombardment or witness of the demolishing of their homes, had a high level of psychological symptoms (e.g., Punamaki *et al.*, 2001; Thabet *et al.*, 2002; Qouta, Punamaki & El-Sarraj, 1997). Palestinian children who are living in refugee camps and in war zones long-term are at a high risk of suffering from PTSD and psychological problems (e.g., Thabet, Abed, & Vostanis, 2004, Qouta & El-Sarraj, 2004).

Low socio-economic status increases the risk of developing PTSD more than high socio-economic status of Palestinian children (Hawajri, 2003; Thabet *et al.*, 2002). Other studies showed that the media influences more anticipatory anxiety and cognitive expressions of distress than children who were directly exposed during Al-Aqsa Intifada (Thabet *et al.*, 2002). 94.6% of the Palestinian children had witnessed funerals and 83.2% witnessed shootings (Qouta and El-Sarraj, 2004).

4.1.6.13 The impact of intervention programmes

The implementation of counselling programs and emotive behavioural therapies significantly reduced the symptoms of PTSD among Palestinian children in the Gaza Strip (Hawajri, 2003;

El-Khosondar, 2004).

Over the last 60 years, Palestinians in the Gaza Strip and the West Bank have suffered a variety of traumatic events directly (witnessing on the ground or by media) or indirectly (exposure to trauma in person) which including witnessing violence, beatings, imprisonment, shooting, night raids, bombardment, shelling, and loss of family members, witnessing killing & destruction and torture. In the Gaza Strip and the West Bank the people face repeated and continuous trauma.

4.1.6.14 Rationale for the current study

Previous studies found the Palestinian children and their families living in high risk of suffering from PTSD (e.g., Qouta & El-Sarraj, 2004; Thabet & Vostanis, 2004; Kanninen *et al.*, 2003). However, the current study aims to fill in some gaps and to generate some new thoughts as shown below:

- a) The Palestinians people have faced a constant disruption of normal life and a recurring cycle of war from one generation to the next. On-going trauma is particularly noticeable in Gaza Strip where the situation is growing worse since the last studies (Qouta & El-Sarraj, 2004; Thabet & Vostanis, 2004). In addition, most of these previous studies were conducted during the first Intifada (1987-1993) and not in the second Intifada (2000-2007) in which the amount of violence and suffering has gradually increased.
- b) The studies conducted in the Gaza Strip were only focused on a small number of traumatic experiences (12 traumas or less). But the current study included a measure of exposure to a large number of possible traumatic events (34 traumatic events grouped into five types: (Direct individual experience, Indirect individual experience, Proximate, Direct material damage, Proximate, Distant).
- c) Most of these previous studies used a small sample, but the present study examined a large sample (1,137) of the Palestinian children from 10 to 18 years.
- d) The current study updated five questionnaires/scales to be more related to culture, environment and research questions, which is not highly considered in the other

studies. For example, the current researcher could not find clearly the functional disturbance or problems (e.g. Social behavioural problems, academic performance problems) in the other questionnaires of symptoms of PTSD which were conducted on the Palestinians children in the Gaza Strip such as the Child Post Traumatic Stress Reaction Index CPTSD-RI (Pynoos, Frederick, & Nader 1987; 1994; El-Khosondar, 2004; Hawajri, 2003). In spite of DSM-IV mentioned briefly through diagnosis of PTSD about the functional disturbance among patients such as achievement (job, school, university) and social life (World Health Organization ICD-10, 1992; American Psychiatric Association DSM-IV).

- e) Most of the previous studies investigated prevalence of the traumatic events, levels of PTSD and the relation between exposure to traumatic events and symptoms of PTSD without enough consideration for the moderating factors. The current study, however, has focused on the most important factors that might moderate PTSD amongst Palestinian children in the Gaza Strip such as gender, age, type of trauma, place of residence (clashing or non-clashing area), family size, monthly family income, educational level of the parents and individual personality traits. Moreover, there do not seem to be any studies concerned with the relationship between symptoms of PTSD and a network of psycho-social support which included support of family, friends, schools, relatives and neighbours, spiritual and religious, governmental and NGOs, and national pride.
- f) Most studies conducted in the Gaza Strip used quantitative studies, and few of them used qualitative studies. The current study used both in order to make the research questions more comprehensive. Moreover, the current study also investigated the reasons which lay behind the different reactions of children exposed to chronic trauma.
- g) The current qualitative study explored in more depth, the moderating factors relating to Palestinian children who have been exposed to chronic traumatic experiences, particularly the children who show low levels of PTSD. This was done in order to understand the reasons why they are doing well. Most other qualitative study research

only used samples from children who suffered from symptoms of PTSD.

- h) The current research was concerned with exposure to chronic traumatic experiences in the Gaza Strip which none of the previous studies had investigated when describing chronic trauma. In addition, the chronic traumatic experience in the current research means that the participants should meet the conditions as shown below: Firstly, the long period of potential and actual exposure to traumatic events (six months or more above); secondly, the high number of actual traumas experienced (three or more).

Thus, one of the main objectives of this study is to recognize the effects of chronic traumatic experiences among the Palestinian children and to find out the actual reasons which are responsible for differences in the reactions of the children, despite the fact that they have been exposed to the same level of traumatic events.

Another objective is to help psychologists in clinics, schools and psychiatric hospitals to develop relevant, effective programmes which provide four fundamental aspects (prevention, counselling, rehabilitation and therapeutic treatment) in order to reduce and alleviate the symptoms of PTSD, because if this traumatised society gets no help in the near future, then the community will become too weak to recover.

4.2 Aims and research questions

4.2.1 Aims

The quantitative study aimed to examine the psychological, social, somatic and educational effects of chronic traumatic experience on Palestinian children over the fifth year of the Al-Aqsa Intifada. To achieve this aim the following areas were investigated:

1. The prevalence of the children's exposure to traumatic experiences
2. The types of traumatic experiences that the children were exposed to;
3. The levels of the children's PTSD symptomatology
4. The relationship between exposure to the traumatic experiences and symptoms of PTSD
5. The factors that possibly moderate the effects of PTSD

7.3 Research Questions

The main research questions for quantitative study are as follows:

- A) What is the prevalence of traumatic experiences among Palestinian children in the Gaza Strip?
- B) What types of traumatic experiences have Palestinian children in the Gaza strip been exposed to?
- C) What are the levels of PTSD symptomatology among Palestinian children in the Gaza Strip?
- D) What is the relationship between exposure to traumatic experiences amongst Palestinian children in the Gaza strip and their symptoms of PTSD?
 - Does exposure to the traumatic experiences lead to an increase in symptoms of PTSD?
 - What types of traumatic events are most likely to be associated with the development of PTSD?
 - What variables are mostly likely to be associated to symptoms of PTSD among children in clashing areas?
- E) What factors might moderate PTSD symptoms amongst Palestinian children in the Gaza strip?
 - Does gender moderate PTSD symptoms?
 - Does age moderate PTSD symptoms?
 - Does the type of trauma moderate PTSD symptoms?
 - Does the place of residence (clashing or non-clashing area) moderate PTSD symptoms?
 - Does family size moderate PTSD symptoms?
 - Does monthly family income moderate PTSD symptoms?
 - Does the educational level of the parents moderate PTSD symptoms?
 - Do individual personality traits moderate PTSD symptoms?
- F) Does psychosocial support influence the PTSD symptoms?