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Evaluation of Selected Therapeutic Interventions Implemented in Mental Health Clinic of the Palestinian Ministry of Health for Gaza Children after Crisis.

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بسم الله الرحمن الرحيم

﴿ قَالُوا۟ سُبْحَـٰنَكَ لَا عِلْمَ لَنَآ إِلَّا مَا عَلَّمْتَنَآ ۖ إِنَّكَ أَنتَ ٱلْعَلِيمُ ٱلْحَكِيمُ ﴿٣٢﴾ ﴾

سورة البقرة

صدق الله العظيم

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Abstract

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Evaluation of Selected therapeutic interventions Implemented in the mental health clinic of the Palestinian Ministry of Health for Gaza children after Crisis.

This study of the knowledge of the researcher, is considered as important because it evaluates selected psychotherapeutic interventions that done for a group of children after Gaza war, and complaints of PTSD. The aim of this study is to know the useful psychotherapeutic interventions that can be selected for such a group of children.

The general objective for this study is the Evaluation of selected therapeutic interventions implemented in the mental health clinic of the Palestine Ministry of Health for children in Gaza Strip after Crisis.

The problem of the study has identified the following research questions;

1. What are the types of psychological interventions that were used with children by Mental Health Clinic in Ministry of Health? How they were used?
2. To what extent the psychological interventions that were provided for children in Mental Health Clinic of Ministry of Health were effective?
3. To what extent parents were satisfied with psychological interventions that provided for their children after crisis?
4. What are the recommendations and suggestion for improving psychological interventions implemented in Mental Health Clinic in Ministry of Health?

The sample was estimated 30 cases of PTSD from children, A sample of around 15 children who received pharmacological interventions with their parents, and other 15 children who received psychological interventions with one of their parents were registered in governmental mental health clinic during the year 2009 selected from population and all sample collected without any droped out.

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The researcher used 6 types of tools; the first one is Socio demographical survey, which has 10 questions about social and economical status for the child.

The second one is PTSD Questionnaire which has a scale for 17 questions to check the degree of PTSD for child.

The third one is SDQ, which has 25 questions designed for parents to talk about the personality manner for their child.

The Fourth one is a survey to evaluate the service in governmental mental health hospital and has more than 50 questions.

The fifth one is a focus group that done for selected community mental health workers. And the last one is collecting data from patient's records.

Descriptive statistics in addition to inferential non parametric statistics including Mann-Whitney test.

Results showed that;

1. Cognitive behavioral therapy not used in professional and theoretical manner in mental health clinic ministry of health.
2. Children who are using play therapy or medication are improved equally after treatment.
3. Play therapy group improved better then medication group from family perspective.
4. Play therapy group were satisfied more than medication group with regard to hospital services.

Recommendations for this study are;

1. Policy Makers and managers in mental health clinic-Ministry of health should be informed with the results of this study to take necessary steps to improve psychotherapeutic interventions for children (especially cognitive behavioral therapy).
2. Mental health workers should be encouraged to increase their knowledge and skills regularly through continuous education.
3. Evaluate all types of psychotherapy that used by mental health clinic- Ministry of health.

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الملخص

اسم الباحث: رانية محمد طلب عياش

اسم المشرف: د.سناء ابراهيم أبودقة

تقييم لبعض الطرق العلاجية المستخدمة في مركز الصحة النفسية بوزارة الصحة الفلسطينية لأطفال غزة بعد الأزمة الاخيرة

هذه الرسالة تعتبر من الرسائل المهمة لأنها تقيم بعض الطرق العلاجية المستخدمة في مركز الصحة النفسية بوزارة الصحة الفلسطينية لأطفال غزة بعد الأزمة، والذين يعانون من مشاكل ما بعد الصدمة التي تعرضوا لها . والهدف العام من هذه الدراسة هو تقييم بعض الطرق النفسية العلاجية المستخدمة في عيادة الصحة النفسية بمستشفى الطب النفسي التابع لوزارة الصحة للأطفال بعد حرب غزة.

مشكلة الدراسة تتلخص في الأسئلة التالية:

1. ما هي طرق العلاج النفسي المستخدمة مع الأطفال في عيادات الصحة النفسية التابعة لوزارة الصحة؟
2. ما مدى فعالية بعض طرق العلاج النفسي المستخدمة في عيادات الصحة النفسية التابعة لوزارة الصحة ؟
3. ما مستوى رضا الأهل عن الطرق العلاجية المستخدمة مع الأطفال ؟
4. ما هي التوصيات والاقتراحات لتحسين الخطة العلاجية النفسية المستخدمة في عيادات الصحة النفسية التابعة لوزارة الصحة؟

العينة هي عبارة عن 30 حالة من الأطفال الذين يعانون من كرب ما بعد الصدمة، 15 طفل تلقو العلاج بالدواء بوجود أحد الوالدين، و15 طفل أخرين تلقو علاج نفسي بوجود أحد الوالدين أيضا، وكانوا قد سجلوا في عيادات الصحة النفسية خلال العام 2009. وجميع العينة لم تفقد وتم اختبارها بشكل كامل.

الباحثة استخدمت 6 أدوات تتضمن، استبانة الحالة الاجتماعية والاقتصادية، والتي تحتوي على 10 أسئلة عن الحالة الاجتماعية والاقتصادية للطفل.

الثانية هي استبانه قياس مشكلة معينة للأطفال بعد الصدمة وتحتوي على 14 سؤال لمعرفة درجة الصدمة التي يعاني منها الطفل.

والثالثة هي عبارة عن استبانة قياس الصعوبات للوالدين للأطفال من عمر 4-16 سنة وهي عبارة عن 25 سؤال يقوم بتعبئتها أحد الوالدين لمعرفة طبيعة شخصية الطفل.

الرابعة هي استبانة لتقييم الخدمات المقدمة من عيادات الصحة النفسية التابعة لوزارة الصحة وتحتوي على 50 سؤال.

الخامسة هي مجموعة مركزة للمعالجيينن بعيادة الصحة النفسية بغزة والسادسة هي ملفات المرضى.

تم استخدام التحليل الوصفي بالاضافة الى ، تكرار الجداول، و اختبار مان وتني.

بينت نتائج الدراسة التالي:

1. العلاج المعرفي السلوكي لا يستخدم بطريقة علمية وصحيحة في العيادة النفسية بمستشفى الطب النفسي..

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2. الأطفال الذين يستخدمون العلاج باللعب والدواء يتحسنون بالتساوي بعد العلاج
3. الأطفال الذين يتعالجون باللعب يتحسنون أكثر من الأطغال الذبن يستخدمون الدواء من وحهة نظر الأهل.
4. العائلات التي تستخدم العلاج باللعب راضية عن خدمات المستشفى أكثر من الذين يستخدمون الدواء.

التوصيات لهذه الدراسى هي كالاتي:

1. اطلاع المسئولين بالعيادة النفسية بمستشفى الطب النفسي عن نتائج هذه الدراسة للتغلب على أي عيوب في خدمات برامجهم و بخاصة العلاج المعرفي السلوكي.
2. تشجيع العاملين في العيادة النفسية بمستشفى الطب النفسي على استكمال دراستهم لتنمية خبراتهم ومهاراتهم.
3. تقييم جميع طرف العلاج النفسي بمستشفى الطب النفسي لتحسينها

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Dedication

I dedicated this thesis to the souls of my mother &

My father

To my husband

To my sons

To my brothers & sisters

To my sweat friends & colleagues

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Acknowledgment

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List of Abbreviations

ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
BCL	Behavior Checklist
BSI	Brief Symptom Inventory
CBT	Cognitive Behavioral Therapy
CES	Charities Evaluation Service
CMWU	Coastal Municipalities Water Utility
CIS	Critical Incident Stress Management
CISD	Critical Incident Stress Debriefing
CPR	Cardiopulmonary Resuscitation
CPT	Cognitive Processing Therapy
CPTS-RI	Posttraumatic Stress Disorder Reaction Index
DSRS	Depression Self-Rating Scale
DSM1V	Diagnostic and statistical manual for mental disorder
HRW	Human Right Watch
IES	Impact of Event Scale
MOH	Ministry of Health
NIMH	National Institute of Mental Health
NGO	Non Governmental Organization
PCBS	Palestinian Central Bureau of Statistics
PHC	Primary Health Care
PTS	Post Traumatic Stress
PTSD	Post Traumatic Stress Disorder
SDQ	Strengths and Difficulties Questionnaire
SIT	Stress-Inoculation Training
UN	United Nation
WHO	World Health Organization
UNA	United Nation Agencies

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UND	United Nations Document
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency

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Chapter 1

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Chapter 1

Introduction

Justification, research questions, and objectives

1.1. Introduction:

In December 1987, the Palestinian popular uprising, or Intifada, against the Israeli military occupation opened a dramatic new chapter in the Palestinian-Israeli conflict with far-reaching psychological, political, and socio-economic consequences. From the beginning, children were active in the core events of the Intifada and came to be known as "the children of the stones (Qouta. 2000)." The events and the responses of the Israeli occupying forces in the Gaza Strip and West Bank resulted in more than 22,000 Palestinians being injured, over 1,474 killed, and more than 500 homes sealed or demolished during the first three years of the Intifada. Approximately 57,000 Palestinians were arrested, many of whom were subjected to systematic physical and psychological torture (PCBS, 2006).

Most of Gaza's children experienced physical or psychological violence or they may have witnessed it directed towards their families and friends. Furthermore, these experiences occurred in the specific historical context of Palestine, and were resonant with the uprooting of their families from their country in 1948 (Qouta, 2000). During the Intifada, a generation of children was subjected to severe forms of violence. In addition, they were denied their social, political, and economic rights, as well as their right to self-determination (Qouta, 2000).

Nowadays, people of Gaza including suffered severely from Recurrent crisis. Situation for around 1.5 million Palestinians in the Gaza Strip became worse than it has ever been since the start of the Israeli military occupation in 1967 (NACC, 2008).

The war on Gaza which started on December 27th 2008 has further deteriorated the already miserable situations. This situation has manifested itself in an increased unemployment rates-more than 50%, an increase in the prevalence of poverty- more 75%, collapse of economy and rapidly increasing dependence on food aid than ever before (more than 85% of population received food aid assistance) (NACC, 2008). During the war and the post war periods, causalities have dramatically increased and the provision of basic primary health care services has

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significantly deteriorated due to accessibility problems affecting both health providers and clients abilities to reach health centers, destruction of six primary health care clinics and the inability to provide needed medical commodities (NACC, 2008).

According to the Gaza Ministry of Health (MOH), as of January 2009, Israeli attacks in Gaza had killed at least 1303 Palestinians - both civilians and combatants - and wounded another 5300. More than 500 children and 300 women are among the dead; more than 1,947 children and 626 women had been wounded. According to the United Nation (UN), more than 40 percent of the dead and 50 percent of the wounded are women and children (MOH, 2009). "Gaza was in the midst of a humanitarian crisis even before this fighting started due to Israel's unlawful blockade, aided by Egypt's cooperation in keeping its border with Gaza closed, and now it is facing a catastrophe (HRW, 2009). The wounded are getting only rudimentary care from facilities that lack equipment, material and personnel. Hospitals have been running full-time on generators since December 30, when Gaza's only power plant stopped functioning, and in some hospitals, generator fuel is running low. According to humanitarian agencies and medical officials, many patients are needlessly dying because of a lack of timely medical care. A key problem has been the inability to transfer seriously wounded persons out of Gaza. According to the MOH, at least 413 wounded were in critical condition as of January 11 (MOH, 2009). While many wounded people still require medical care, particularly surgical procedures or post-operative care, the population in the Gaza strip is also in need of social and psychological assistance.

Particularly in its first six months, the year 2008, had witnessed massive reduction of fuel supply and the progressive decrease of the electricity supply to Gaza had affected all the sectors and life aspects including health services. Entry of goods and movement of people to Gaza were severely restricted resulted in shortage of drugs, supplies, spare parts and collapse of construction related industry and so on. As evidenced by health and demographic reports, the described above situation has negatively affected the physical and psychological health status of the population. Also, the unprecedented division of Palestinians resulted in problems that negatively affected the ability of health services to meet the increasing needs and demands of the population (NACC, 2008).

Current human right reports still documented hard conditions for people in Gaza as Gaza's civilians are facing dire shortages of food, water, cooking gas, fuel and access to medical care. Human Rights Watch (HRW) said that United Nations agencies (UNA) have only been

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able to reach a small portion of those dependent on aid - which includes more than 80 percent of the population - since the Israeli offensive began on December 27, 2008. The electricity supply has slightly improved in recent days but remains low, and in some places open sewage is spilling into the streets. The ongoing fighting is preventing many families from leaving their homes to purchase food or obtain food aid. Children, who make up 56 percent of Gaza's residents, are especially vulnerable (HRW, 2009).

Everyone in Gaza was exposed to the insecurity during the Israeli army's incursion, as there was neither safe place nor any possibility of escape. The psychological effects are normal given the period of intense insecurity they have endured. "Nightmares, insomnia, weight loss, irritability, poor concentration, hyper vigilance, or psychosomatic signs like headaches and stomach pains often occur after periods of high stress. If these persist more than one month they may be considered symptoms of post-traumatic stress disorder (PTSD) or another psychological disorder (Diagnostic and statistical manual for mental disorder (DSM IV), 1996).

Crisis can happened to any individual at any time through the course of life, for children traumatic events can affect their lives significantly in various ways. It is important to remember that children are people, but they are not mature adults, subsequently, they have inherent tendency toward emotional growth and have the capability for positive self direction. Furthermore, children can demonstrate their ability to or not to speak, and will take the therapeutic experience where they need to be, so it is important to have a good effective psychosocial interventions that can help Gaza's children after crisis. Studies of Qouta, Thabet, & others showed that there is a high prevalence of PTSD among Palestinian children who exposed to military violence.

1.2. Justification of the Study:

Psychological interventions play an important role in overcoming the child reactions to traumatic Experiences. Many of these programs have been defined as variations of 'debriefing' (critical incident stress or psychological) and 'trauma/grief-focused' therapy, although these terms have been used for different types of interventions that have been designed for the family, the individual child, or a group of children exposed to similar events (Thabet, 2008).

Research showed that psychological interventions have been empirically proven to benefit the emotional well-being of children suffering from trauma-related psychological

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concerns such as crisis. Relaxation techniques, problem solving, aggression management, grief resolution, narratives, stress inoculation, and medication are examples of ways to help children cope with natural disasters; social support may offer important protection for mental health in the context of traumatic events, including the trauma of war (Feeny, 2004). Cognitive-behavioral interventions, mainly in group settings, have been associated with decrease in PTSD symptoms among children who experienced single incident stressors and chronic abuse (Walser, 2009).

Studies have described or evaluated different models of interventions for traumatized Children who had suffered abuse, experienced natural disasters, or exposed to community violence. These predominantly adopt psychodynamic or cognitive therapeutic frameworks, medication, and a variety of techniques. All therapeutic interventions have not been as well evaluated with children as with adult victims of trauma. The treatment aimed at facilitating communication, discussion of fears, myths and beliefs, discharge of feelings, and empowerment in building their future. Drawing, storytelling, role-play, and medication were used also too reduce fears especially, for the number of children who are at risk of developing emotional and behavioral problems (Walser, 2009).

Hopefully this study will help in identify good practices of psychological interventions within Palestinian context, Know factors that contribute to child and parents satisfaction with psychological treatment, to become more aware and sensitive to the risks of war on mental health among children during crisis period, and to use protective interventions in war zone.

1.3. Significance of the study:

Theoretical significance:

This study will guide researchers to conduct further studies related to evaluation of services provided by Mental Health Clinic in the Palestinian Ministry of Health or other institution dealing with treatment of psychological trauma among Palestinian children. This eventually will assist in building a Palestinian model in this field.

Practical significance:

By analyzing the study results, the researcher will provide suggestions and recommendations to improve the quality of interventions in mental health clinic of the Palestinian Ministry of Health.

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1.4. General Objective:

The overall objective of the study is the evaluation of selected therapeutic interventions implemented in the Mental Health Clinic of Palestinian Ministry of Health for children in Gaza Strip after Crisis.

1.5. Specific Objectives:

1. To identify the types of psychological interventions used by mental health clinic in Ministry of Health.
2. To explore the extent the psychological interventions that provided for children in Mental Health Clinic of Ministry of Health after Gaza crisis were effective.
3. To know if parents were satisfied with the psychological interventions used with the children.
4. To provide recommendations and suggestions for improving psychological interventions in Mental Health Clinic in Ministry of Health.

1.6. Research Questions:

1. What are the types of psychological interventions that were used with children by Mental Health Clinic in Ministry of Health?
2. To what extent the psychological interventions that were provided for children in Mental Health Clinic of Ministry of Health were effective?
3. To what extent parents were satisfied with psychological interventions that provided for their children after crisis?
4. What are the recommendations and suggestion for improving psychological interventions implemented in Mental Health Clinic in Ministry of Health?

1.7. Research Hypothesis:

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1. There are no statistical significant differences in PTSD total score between medication and play therapy group after treatment.
2. There are no statistical significant differences in SDQ total score in medication group before and after treatment
3. There are no statistical significant differences in PTSD total score in medication group before and after treatment.
4. There are no statistical significant differences in SDQ total score between medication and play therapy group after treatment
5. There are no statistical significant differences in PTSD total score in play therapy group before and after treatment.
6. There are no statistical significant differences in SDQ total score in play therapy group before and after treatment
7. There are no statistical significant in parents general satisfaction total score between medication and play therapy group.
8. There are no statistical significant in satisfaction performance among community mental health worker total score between medication and play therapy group.
9. There are no statistical significant in benefits from psychotherapy total score between medication and play therapy group.
10. There are no statistical significant in satisfaction in hospital services total score between medication and play therapy group.
11. There are no statistical significant in satisfaction with psychotherapeutic guidance total score between medication and play therapy group.
12. There are no statistical significant in satisfaction with place of service total score between medication and play therapy group.

1.8 Operational Definitions:

1.8.1 Evaluation:

It is the systematic acquisition and assessment of information to provide useful feedback about some object (William, 2006). In this study, the operational definition of evaluation refers to tools used like socio-demographical questionnaires, PTSD questionnaires, Strengths and

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Difficulties Questionnaire (SDQ), & evaluation of service questionnaires to address the research problem.

1.8.2. Psychological Interventions:

IT is an intentional interpersonal relationship used by trained psychotherapists to aid a client or patient in problems of living. It aims to increase the individual's sense of their own well-being. Psychotherapists employ a range of techniques based on experiential relationship building, dialogue, communication and behavior change and that are designed to improve the mental health of a client or patient, or to improve group relationships (Crowdy, 2001. In this study, psychological interventions refer to those interventions used in Palestinian context to help patients psychologically including cognitive behavioral therapy (CBT), play therapy, medication, and family therapy.

1.8.3 .Children:

A child (plural: children) is a human being between the stages of birth and puberty. The legal definition of "child" generally refers to a minor, otherwise known as a person younger than the age of majority. "Child" may also describe a relationship with a parent or authority figure, or signify group membership in a clan, tribe, or religion; it can also signify being strongly affected by a specific time, place, or circumstance, as in "a child of nature (Free dictionary, 2009).

1. 8. 4 Mental health clinics, Palestine Ministry of Health:

It is a clinic that followed psychiatric hospital in Gaza, to resolve many psychological problems that outcome with repeated crisis for both adult and children, around 12 mental health worker worked in this clinic which divided in five governmental areas (Gaza city, Al Nusiraat, Abushbaak, AL Shjaeiaa, and Rafaah). (AL Khawaja, 2009).

1.8.5 Crisis:

A crisis is any critical incident that involves death, serious injury, or threat to people; damage to environment, animals, property and/or data; disruption of operations; threat to the ability to carry out mission; and/or, threat to the financial welfare and image of the university. It

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is an emotionally stressful event or traumatic change in a person's life (Khansas, 2009). In this study crisis refer to Gaza war.

1.9. Context of the Study:

1.9.1. Geographical Context:

Gaza Strip is a narrow band of land located on the south of Palestine, constituting the coastal zone of the Palestinian territory along the Mediterranean Sea between Egypt and Israel. More than 1,443,814(37.13%) of the total Occupied Palestinian Territories (3,888,292) live in the Gaza Strip, with a population density of 3988 persons/Km2 (PCBS, 2006) .About two third of them are registered refugees it is 45 Kilometers long and 6-12 kilometers wide with an area of 362 square kilometers. (MOH, 1999). Currently, the Gaza Strip is composed of five provinces: North Gaza, Gaza City, Mid Zone, Khan Younis and Rafah. The population was estimated with 3.6 million at the end of 2006. There of 2.3million in the population in Palestine are refugees (PCBS, 2006).

1.9.2. Economical Context:

After the outbreak of Al-Aqsa Intifada in 2000, the Israeli Government took security, political and administrative measures in response to the Palestinian Intifada. Life in Gaza is accompanied by extensive decline in living conditions due to the turn down in most families' income and accessibility to basic services, mainly health and education. The Israeli Government prevented most of the Palestinian laborers (125,000) who used to work in Israel, in the fields of agriculture, constructions, hotels and restaurants, from reaching their workplaces for security reasons. This measure increased the unemployment rate in Gaza to be 25% and the poverty rate to reach 65%. 32% of Gaza households are living in extreme poverty (PCBS, 2006).

Although it withdrew from the Gaza Strip unilaterally, Israeli Government continues watching and controlling the Palestinian movement in an out the Strip. The measures taken by Israel and its partners against the Palestinians after January 2006 elections will worsen the situation more and more.

1.9.3. Health Context :

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According to the World Health Organization's (WHO) definition, health is not only freedom from illness and sickness but also a physical, psychological and social stability. Based on this definition the health status in the Gaza Strip can be considered very bad because of the Israeli cruel measurements imposed on the Palestinian people (WHO, 2006). There are 24 hospitals (general, specialized (psychiatry), rehabilitation, maternity) in the Gaza Strip of which 12 are managed by Ministry of Health, 10 by non governmental organization (NGOs) and two private. The total number of hospitals' beds is 1917 of which 1462 for MOH, 416 for NGOs and 39 for private. The population/hospital ratio is 57,098 which is considered very low. This level of capacity makes it difficult for people to receive sufficient and adequate services (MOH, 2009).

Hospitals suffer from inability to provide some kinds of treatme7nts such as lack of modern medical equipment and professionals in the field. Moreover, many people can't afford paying their health insurance fees due to their difficult economic situation.

1.9.4. Health Context During Gaza War in December 2008:

Israel started its latest vicious war on Gaza on December 27, 2008. in the south of Palestine . Regarding to ministry of health in Gaza, the following list presents the evident results of continuous air strikes and aggression against Gaza over 23 days. Number of Palestinians in Gaza killed: 1,303 and counting, as bodies and corpses are dug out from under the rubble of the destroyed buildings, number of children killed: 500, number of women killed: 100 and number of elderly people killed: 105. Total number wounded: more than 5,300. Most were severely injured; if they survive their injuries, they will live with a permanent disability. Gaza was in the mildest of a humanitarian crisis even before this fighting, and that due to recurrent Israeli wars, siege, and Palestinian group fighting (MOH, 2009).

All of these crisis effect mental health for Palestinian people , which result on 60.1 /100000 mentally ill patient (MOH, 2009), and this percentage will raise dramatically after these continuous crisis , which need a great effort from mental health worker to do, and to have good plan to help such a people.

1.9.5. Children & Crisis:

Children in Gaza have been subjected to repeated and direct Crisis. Children faced threats of shooting; they also repeatedly witnessed their parents and/or family members being under

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such threat. They, children- more than 780,000 making up 55% of the population- have been vulnerable from a psychological point of view to nocturnal enuresis, hyper-arousal, sleep disorders, speech disturbances, anxiety, and lack concentration are frequently observed.

Therefore, there is an urgent and strong necessity for children to be cared for. It requires intervention at multiple levels, including immediate support, training and competency development (Psychiatry and the Palestinian Population, 2002).

1.10. Study setting:

1.10.1 Psychiatric status in Gaza:

Until 1979 Gaza referred its psychiatric patients requiring admission to hospital to the Bethlehem psychiatric hospital on the West Bank. In 1979 a 20-bed unit was opened, expanded to 32 beds, based in El-Naser Psychiatric Hospital in Gaza. There is also a vigorous community mental health program based in Gaza and an out-patient clinic in Khan Younis. The Gaza Community Mental Health Program has held a number of conferences on psychiatry, with international participation (Thabet, 1999).

In May 1994, the Palestine Council of Health, formed in July 1992, began its implementation of an Israeli/Palestinian agreement on health care on the West Bank and in Gaza (Psychiatry and the Palestinian population, 2002). In regard to psychiatry, its objectives included reduction of alcohol and drug misuse, reduction in disability associated with mental illness, decrease in mortality and disability associated with interpersonal and self-directed violent behavior and the revitalisation of the psychiatric hospitals on the West Bank and Gaza, as well as of the community psychiatric health clinics in various Palestinian cities.

1.10.2. Psychiatric hospital:

Psychiatric hospital in Gaza is a unique one that followed Ministry of health, and has five clinics, which branched in five governmental areas in Gaza. 12 mental health workers from different educational background (Social worker, nurses, psychologist, and doctors) worked in it as the therapist for people who are having different psychological problems. Psychiatry hospital focused in traumatized people after war, especially the children. They tried to decrease suffers on people by different ways, and that regarding to the traumatic experience that the patient has it

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through different interventions like cognitive therapy, behavioral therapy, debriefing, telling stories, drawing , and play therapy (AL Khawajah, 2009).

1.10.3. Activities of Psychiatric hospital in Gaza:

Admission: Psychiatry hospital has more then 30 beds divided between male and female ward. Admission applied for chronic and acute cases like sever depression and schizophrenia.

Follow up: Follow up applied for different cases , in five governmental areas through clinic, and that done by mental health workers during psychotherapeutic sessions like; behavioral therapy, which contains exposure therapy and Play therapy. Debriefing as early intervention which include talking, relaxation techniques, breathing exercise, and others. Community Work, and that done through home visit for boarder areas in buffer zone, people with traumatic experience, Chronic cases who cant come to the hospital, Clients who missed follow up. Last service is Hot line, they used to answer people in the phone who can't come to the hospital by giving advice, especially during the war time (AL Khawajah, 2009).

There are many cases that followed by psychiatric hospital like Depression (Major depression, Dysthymic, Non-specific depression, Adjustment disorder with depression, Bi-polar depression), Anxiety Disorders (Panic disorder, Post traumatic stress (PTS), Social anxiety, Agoraphobia, Generalized anxiety, Obsessive compulsive disorder, Specific phobias), Schizophrenia, Childhood psychological problems (Attention Deficit Hyperactivity Disorder (ADHD), Conduct disturbance, Oppositional behavior, Separation anxiety) Impulse Control Disorders (Pathological gambling, Intermittent Explosive Disorder, Domestic Violence, Kleptomania, Pyromania, Pathological Gambling, and Trichotillomania) Personality Disorders (Obsessive compulsive, Narcissistic, and Borderline personality disorders), Adjustment disorders (Marital conflict and Job stress), and Family Problems (AL Khawajah, 2009).

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Chapter 2

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Chapter 2
Conceptual Frame work

2.1. Introduction;

In this chapter the researcher presented the conceptual framework which consists of six parts. The first concern is about Gaza Crisis, the second concern is about children, Trauma, & war, third one will be about Post traumatic stress disorder, and forth one about Psychotherapeutic Interventions and the last one will be about evaluation system.

2.2. Gaza Crisis;

2.2.1. Crisis:

Crisis has been seen and studied as the change in individual undergoing transition as the cumulative toll of major life change events and as a single of strain in a social system. Strategies of intervention follow naturally form the aspect of crisis that is emphasized, but a complete approach must deal with individual, the events, and the social system (Rosenbaum, 1988).

In the individual undergoing transition, crisis is often viewed as disequilibrium, absent in steady state of the reacting individual who find him self in hazardous situation. There are three sets of interrelated factors which can produce a set of crisis (Rosenbaum, 1988). (1) a hazardous events that poses some threat, (2) a threat (to an instinctual need) which is symptomatically linked to earlier threats that have resulted to vulnerability to conflict; and (3) an inability to respond with adequate coping mechanism. Generally the term crisis is preferred to the older term stress because it offers the idea of the positive turning point rather than the image of a burden or load under which a person either survives or breaks (Kansas, 2009).

2.2.2. Background about Gaza:

The Gaza Strip is a coastal strip of land on the eastern shore of the Mediterranean Sea bordering Egypt and Israel. It is one of the most densely populated places on earth. It holds a population of 1,500,202 on an area of 360 square kilometers (139 sq mi) (HRW, 2009).

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The UN, HRW and many other international bodies and NGOs consider Israel to be the occupying power of Gaza Strip as Israel controls Gaza's airspace, territorial waters and does not allow the movement of people or goods in or out of Gaza by air or sea (Gold, 2005).

UN proposed the partitioning of Palestine into two independent States, one Palestinian Arab and the other Jewish, with Jerusalem internationalized. One of the two States envisaged in the partition plan proclaimed its independence as Israel and in the 1948 war expanded to occupy 77 per cent of the territory of Palestine. Israel also occupied the larger part of Jerusalem. Over half of the indigenous Palestinian population fled or were expelled. Jordan and Egypt occupied the other parts of the territory assigned by the partition resolution to the Palestinian Arab State which did not come into being (Hector, 2009).

In 1967 war, Israel occupied the remaining territory of Palestine, until then under Jordanian and Egyptian control (the West Bank and Gaza Strip). This included the remaining part of Jerusalem, which was subsequently annexed by Israel. The war brought about a second exodus of Palestinians (See Annex 1).

In December 1987, the Palestinian popular uprising, or Intifada, against the Israeli military occupation opened a dramatic new chapter in the Palestinian-Israeli conflict with far-reaching psychological, political, and socio-economic consequences. From the beginning the events and the responses of the Israeli occupying forces in the Gaza Strip and West Bank resulted in more than 22,000 Palestinians being injured, over 1,474 killed, and more than 500 homes sealed or demolished during the first three years of the Intifada. Approximately 57,000 Palestinians were arrested, many of whom were subjected to systematic physical and psychological torture (PCBS, 2006).

A Peace Conference on the Middle East was convened in Madrid on 30 October 1991, with the aim of achieving a just, lasting and comprehensive peace settlement through direct negotiations along 2 tracks: between Israel and the Arab States, and between Israel and the Palestinians, based on Security Council resolutions and the land for peace. A series of subsequent negotiations culminated in the mutual recognition between the Government of the State of Israel and the Palestine Liberation Organization, the representative of the Palestinian

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People, and the signing by the two parties of the Declaration of Principles on Interim Self-Government Arrangements in Washington on 13 September 1993, as well as the subsequent implementation agreements, which led to several other positive developments, such as the partial withdrawal of Israeli forces, the elections to the Palestinian Council and the Presidency of the Palestinian Authority, the partial release of prisoners and the establishment of a functioning administration in the areas under Palestinian self-rule(Hector, 2009).

The controversial visit by Ariel Sharon of the Likud to Al-Haram Al-Sharif (Temple Mount) in 2000 was followed by the outbreak of the second *intifada*. A massive loss of life, the reoccupation of territories under Palestinian self-rule, military incursions, and extrajudicial killings of suspected Palestinian militants, suicide attacks, rocket and mortar fire, and the destruction of property characterized the situation on the ground (United Nations Document, 2000).

Israel began the construction of a West Bank separation wall, located within the Occupied Palestinian Territory, which was ruled illegal by the International Court of Justice in 2004 (Gaza Strip History, 2009).

In 2005, Israel withdrew its settlers and troops from the Gaza Strip as part of its "Disengagement Plan," while retaining effective control over its borders, seashore, and airspace (Hector, 2009).

2.2.3. Gaza War (December 2008- January 2009)

Israel responded to the Hamas take over of the Gaza Strip on 15 June 2007 by closing Gaza's borders to export and severely limiting imports. This isolation of the Gaza Strip, along with a lack of effective coordination between the Palestinian Authority in Ramallah and the Hamas authorities in Gaza has resulted in shortages of medical and non medical equipment remain unavailable in Gaza stores stocks and on the local market and cannot be imported into Gaza due to the current import restrictions. This includes food, water systems, Electricity, and health (Humanitarian Affairs, 2007).

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The cease-fire, implemented unilaterally by Israel on 18 January, The cease-fire followed twenty-two days of bombardment by land, sea and air which left over 1,300 Palestinians dead and over 5,000 injured. Many of the injured will require long-term treatment (UN Report, 2009).

Many families are homeless: preliminary estimates by the Palestinian Central Bureau of Statistics indicate the complete destruction of over 4,000 residences and partial destruction to 17,000 others. Thousands still have no access to piped water. Unexploded ordnance poses a significant threat to the Gazan population and to the work of humanitarian organizations (UN Report, 2009).

Gaza's people Need re-establishment of basic services, including water, health, food, cash assistance, education and psychosocial support .Palestinian Ministry of Health (MOH) figures as of 19 January are 1,314 Palestinians dead, of whom 412 are children and 110 are women. The number of injuries stands at 5,300, of whom 1,855 are children and 795 are women (MOH, 2009).

Although hospitals still have a large number of intensive care patients, capacity is gradually freeing up for the provision of routine care for chronically ill patients who are now returning for treatment, as well as regular services such as elective surgery. Hospitals are receiving mains electricity intermittently, with generators providing back-up electricity supply. Repair of medical equipment, already a priority before the conflict when the blockade hindered the import of necessary spare parts, remains a priority, as does the import of spare parts for medical equipment (UN Report, 2009).

According to a recent report by the consultancy company Near East Consulting, about 96 percent of Gaza residents feel depressed and disheartened. The highest level of depression is in North Gaza and Rafah, where 81 percent of the respondents do not feel secure about their households and family members. This represents an increase of 17 percent since December 2008 (MOH, 2009).

Vital infrastructure has been compromised or destroyed, resulting in a lack of shelter and energy sources, deterioration of water and sanitation services, food insecurity and overcrowding. An estimated 100 000 people were newly displaced; 49 693 of them were residing in 50 shelters organized by United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA, 2009), the remaining being sheltered with host families. Fifteen hospitals and 41 primary health care (PHC) clinics in the Strip were damaged during the strike. Twenty-nine

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ambulances were damaged or destroyed. 21 out of 56 Ministry of Health (MOH) and three out of 17 UNRWA PHC centers were closed during part or all of the period of the crisis (MOH, 2009).

Specific concerns exist for the chronically sick. It is estimated that, during the military operation, 40% of the chronically ill interrupted their treatment. These concerns were exacerbated by the virtual halt of referrals of ordinary patients outside Gaza as life-threatening injuries had a higher priority in an overwhelmed system. Elective surgery and non-urgent routine medical interventions were delayed or interrupted during the crisis. This indicates that a growing number of patients, mainly with chronic conditions, are waiting treatment (MOH, 2009).

People in Gaza affected severely through this military operation, which left thousands of people especially children complaints of several psychological problem like anxiety and Posttraumatic stress disorder.

2.3. Children, Trauma, & War:

2.3.1. The Psychological effects of Trauma on children:

War has particularly brutal effects on children. They are forced to develop within contexts of seemingly permanent psychosocial trauma or what some psychologists refer to as the "normal abnormality" of violence. Situations that once seemed unimaginable - the burning of one's crops and home, the massacre of one's neighbors, the murder of one's parent or sibling - are now daily occurrences. A child constructs a sense of which he or she is and develops an identity within such violent contexts. Psychologists who work to understand and support these children have focused much of their attention on the child's experiences of sorrow or sadness from loss, on his or her traumatic experiences and their effects, and on identity development (Bintoon, 2002).

Although individual children respond in quite distinct ways to loss and traumatic events a small number of relevant studies suggest that children in situations of institutionally-structured violence generally experience higher than usual levels of fear, anxiety, insecurity and aggressiveness. They frequently have difficulties in expressing themselves corporally and/or emotionally, often experience nightmares and exhibit both psychosomatic symptoms (for example, chronic head and stomach aches, allergies, tics) and regressive behaviors such as

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bedwetting (Spitzer , 1983). These symptoms may appear immediately after an experience of extreme violence or weeks, months, or even years later. The children whose stories are told here express sorrow and loss and evidence both some of the typical psychological symptoms identified among children who have live in situations of extreme violence and some of the resources of those who, in the words of Juan, "adapt." Psychologists sometimes refer to these latter children as resilient. Continuity in the presence of family members or a trusted adult and the maintenance of one's own cultural and/or religious practices, even if one has fled one's home and/or community of origin, have been found to be important supports for children coping with the effects of war (Bintoon, 2002).

2.3.2 The Psychological effects of War on Gaza's children;

The Palestinian Ministry of Health estimated that 1, 314 Palestinians were killed in the 23 days of the military operation in the Gaza Strip. This statistics were only updated until Jan. 18th 2009, but after the Israeli ceasefire, many corpses were found under the debris and the demolished houses in many areas (Zeytoun, Al Atatra, Ezzbet Abed Rabo, and Beit Hanoun) (MOH, 2009).

The bombing and shelling caused extensive damage to civilian facilities throughout the Gaza Strip. Supplies of basic food and fuel, and the provision of electricity, water and sanitation services remain critical.

Civilians in Gaza bore the brunt of the conflict, with 412 children and 100 women killed and 5, 450 people wounded. Ten of thousands of people were rendered homeless after their areas were damaged or destroyed during bombing raids (MOH, 2009).

Children represent more than 50% of the Palestinian society, and the most vulnerable group of this society, Children have been critically affected by the daily violence, such as bombing, destruction of their houses and other measures (PCBS, 2006).

Damages to residential property, schools, health clinics and water and electricity infrastructure by Israelis are still widespread.

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45.2% of death occurrence among children was caused mainly by firearm missiles by Israeli occupation, Up to 80% of Palestinian children suffer from behavioral problems, including: Increasing level of violence, Sleeping problems, with feelings of fear and anxiety, Changes in attachment to family and community, Various emotional and cognitive problems such as inability to concentrate, and decreasing hope in the future (MOH, 2009).

Palestinian children who experience armed conflict carry the heavy emotional, social, and spiritual burdens associated with death, separation from and loss of parents, attack and victimization, destruction of homes and communities, poor economical status, and disruption of the normal patterns of living. Hundreds of children have been killed or injured, many seriously. Many others have lost their loved ones. The continuous fighting and destruction of livelihoods and basic infrastructures, severely compromise enjoyment of human rights especially in relation to health, education and family life (Mosa, 2009).

2.3.3 **Ongoing Trauma among Gaza's children:**

The unpredictability of the day-to-day situation further adds to the stress and anxiety felt by not having control over ones lives.

This is the current situation in Palestine but it comes with the memories of the conflicts of the past and ultimately with the loss of land and identity. Methods of coping with chronic instability tie into religious beliefs, community lifestyle and cultural traditions. One of the most dominant effects of the continued conflict is the loss of hope. The affects on the individual, the family, and the community will be long lasting – finding ways to overcome the traumas of the past is the only way to a brighter future.

Palestinian children experience many forms of violence from the current war, longest occupation in the world and continuous Palestinian-Israeli conflict. Those which are most likely to cause trauma among children are the death of a parent, relative or acquaintance, torture, witnessing an act of violence, separation from one or both parents for any period of time, injury, including those resulting in deformity or handicaps, engaging in violence, poverty and severe depravation, and shelling or demolition of their house (Mosa, 2009).

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2.4. Post Traumatic Stress Disorder

2.4.1. Diagnostic Features:

The essential feature of Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Herman, 1997).

The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior (American Psychiatric Association, 2000). The characteristic symptoms resulting from the exposure to the extreme trauma include persistent reexperiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, and persistent symptoms of increased arousal (Herman, 1997).

The full symptom picture must be present for more than 1 month, and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, and robbery), being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness.

For children, sexually traumatic events may include developmentally inappropriate sexual experiences without threatened or actual violence or injury. Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts.

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Events experienced by others that are learned about include, but are not limited to, violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease. The disorder may be especially severe or long lasting when the stressor is of human design (e.g., torture, rape). The likelihood of developing this disorder may increase as the intensity of and physical proximity to the stressor increase (Spitzer, 1983).

The traumatic event can be reexperienced in various ways. Commonly the person has recurrent and intrusive recollections of the event or recurrent distressing dreams during which the event is replayed. In rare instances, the person experiences dissociative states that last from a few seconds to several hours, or even days, during which components of the event are relived and the person behaves as though experiencing the event at that moment (American Psychiatric Association, 2000).

Intense psychological distress or physiological reactivity often occurs when the person is exposed to triggering events that resemble or symbolize an aspect of the traumatic event (e.g. anniversaries of the traumatic event; cold, snowy weather or uniformed guards for survivors of death camps in cold climates; hot, humid weather for combat veterans of the South Pacific; entering any elevator for a woman who was raped in an elevator) (Herman, 1997).

Stimuli associated with the trauma are persistently avoided. The person commonly makes deliberate efforts to avoid thoughts, feelings, or conversations about the traumatic event and to avoid activities, situation, or people who arouse recollections of it. This avoidance of reminders may include amnesia for an important aspect of the traumatic event. Diminished responsiveness to the external world, referred to as "psychic numbing" or "emotional anesthesia," usually begins soon after the traumatic event (American Psychiatric Association, 2000).

The individual may complain of having markedly diminished interest or participation in previously enjoyed activities, of feeling detached or estranged from other people, or of having markedly reduced ability to feel emotions (especially those associated with intimacy, tenderness, and sexuality). The individual may have a sense of a foreshortened future (e.g., not expecting to

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have a career, marriage, children, or a normal life span) (American Psychiatric Association, 2000).

The individual has persistent symptoms of anxiety or increased arousal that were not present before the trauma. These symptoms may include difficulty falling or staying asleep that may be due to recurrent nightmares during which the traumatic event is relived, hypervigilance, and exaggerated startle response. Some individuals report irritability or outbursts of anger or difficulty concentrating or completing tasks (American Psychiatric Association, 2000).

Individuals with Posttraumatic Stress Disorder may describe painful guilt feelings about surviving when others did not survive or about the things they had to do to survive. Phobic avoidance of situations or activities that resemble or symbolize the original trauma may interfere with interpersonal relationships and lead to marital conflict, divorce, or loss of job. The following associated constellation of symptoms may occur and are more commonly seen in association with an interpersonal stressor (e.g., childhood sexual or physical abuse, domestic battering, being taken hostage, incarceration as a prisoner of war or in a concentration camp, torture): impaired complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs, hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual's previous personality characteristics (Herman, 1997)..

There may be increased risk of Panic Disorder, Agoraphobia, Obsessive-Compulsive Disorder, Social Phobia, Specific Phobia, Major Depressive Disorder, Stomatization Disorder, and Substance-Related Disorders. It is not known to what extent these disorders precede or follow the onset of Posttraumatic Stress Disorder (Herman, 1997).

2.4.2. Children and Posttraumatic Stress Disorder

Individuals who have recently emigrated from areas of considerable social unrest and civil conflict may have elevated rates of Posttraumatic Stress Disorder. Such individuals may be especially reluctant to divulge experiences of torture and trauma due to their vulnerable political immigrant status. Specific assessments of traumatic experiences and concomitant symptoms are needed for such individuals (Herman, 1997).

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In younger children, distressing dreams of the event may, within several weeks, change into generalized nightmares of monsters, of rescuing others, or of threats to self or others. Young children usually do not have the sense that they are reliving the past; rather, the reliving of the trauma may occur through repetitive play (e.g., a child who was involved in a serious automobile accident repeatedly reenacts car crashes with toy cars) (Spitzer, 1983).

Because it may be difficult for children to report diminished interest in significant activities and constriction of affect, these symptoms should be carefully evaluated with reports from parents, teachers, and other observers. In children, the sense of a foreshortened future may be evidenced by the belief that life will be too short to include becoming an adult. There may also be "omen formation" - that is, belief in an ability to foresee future untoward events. Children may also exhibit various physical symptoms such as stomachaches and headaches (Spitzer, 1983).

2.4.3. Prevalence:

Community-based studies reveal lifetime prevalence for Posttraumatic Stress Disorder ranging from 1% to 14%, with the variability related to methods of ascertainment and the population sampled. Studies of at-risk individuals (e.g., combat veterans, victims of volcanic eruptions or criminal violence) have yielded prevalence rates ranging from 3% to 58% (American Psychiatric Association, 2000).

2.4.4. Course:

Posttraumatic Stress Disorder can occur at any age, including childhood. Symptoms usually begin within the first 3 months after the trauma, although there may be a delay of months, or even years, before symptoms appear. Frequently, the disturbance initially meets criteria for Acute Stress Disorder in the immediate aftermath of the trauma. The symptoms of the disorder and the relative predominance of reexperiencing, avoidance, and hyperarousal symptoms may vary over time. Duration of the symptoms varies, with complete recovery occurring within 3 months in approximately half of cases, with many others having persisting symptoms for longer than 12 months after the trauma (American Psychiatric Association, 2000).

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The severity, duration, and proximity of an individual's exposure to the traumatic event are the most important factors affecting the likelihood of developing this disorder. There is some evidence that social supports, family history, childhood experiences, personality variables, and preexisting mental disorders may influence the development of Posttraumatic Stress Disorder. This disorder can develop in individuals without any predisposing conditions, particularly if the stressor is especially extreme.

2.4.5. DSM-IV criteria for PTSD:

In 2000, the American Psychiatric Association revised the PTSD diagnostic criteria in the fourth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). The diagnostic criteria (Criterion A-F) are specified below.

Diagnostic criteria for PTSD include a history of exposure to a traumatic event meeting two criteria and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms. Fifth criterion concerns duration of symptoms and a sixth assesses functioning.

Criterion A: stressor

The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.

2. The person's response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behavior . (American Psychiatric Association, 2000).

Criterion B: intrusive recollection

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The traumatic event is persistently re-experienced in at least **one** of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

2. Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content

3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: in children, trauma-specific reenactment may occur.

4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event (American Psychiatric Association, 2000).

Criterion C: avoidant/numbing

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least **three** of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma

3. Inability to recall an important aspect of the trauma

4. Markedly diminished interest or participation in significant activities

5. Feeling of detachment or estrangement from others

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6. Restricted range of affect (e.g., unable to have loving feelings)

7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span) (American Psychiatric Association, 2000).

Criterion D: hyper-arousal

Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least **two** of the following:

1. Difficulty falling or staying asleep

2. Irritability or outbursts of anger

3. Difficulty concentrating

4. Hyper-vigilance

5. Exaggerated startle response (American Psychiatric Association, 2000).

Criterion E: duration

Duration of the disturbance (symptoms in B, C, and D) is more than one month (American Psychiatric Association, 2000).

Criterion F: functional significance

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 2000).

Specify if:

Acute: if duration of symptoms is less than three months

Chronic: if duration of symptoms is three months or more

Specify if:

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With or without delay onset: Onset of symptoms at least six months after the stressor (American Psychiatric Association, 2000).

2.5. Psychotherapeutic Interventions:

Psychotherapy is an intentional interpersonal relationship used by trained psychotherapists to aid a client in problems of living. It aims to increase the individual's well-being. Psychotherapists employ a range of techniques based on experiential relationship building, dialogue, communication and behavior change and that are designed to improve the mental health of a client or patient, or to improve group relationships (such as in a family). Psychotherapy may be performed by practitioners with a number of different qualifications, including psychologists, marriage and family therapists, occupational therapists, licensed clinical social workers, counselors, psychiatric nurses, psychoanalysts, and psychiatrists (Kalman & Matthew, 2004).

The word psychotherapy comes from the Ancient Greek words psychē, meaning breath, spirit, or soul and therapeia or therapeuein, to nurse or cure. Its use was first noted around 1890. It is defined as the relief of distress or disability in a one person by another, using an approach based on a particular theory or paradigm (Kalman & Matthew, 2004).

The treatment of mental and emotional disorders through the use of psychological techniques designed to encourage communication of conflicts and insight into problems, with the goal being relief of symptoms, changes in behavior leading to improved social and vocational functioning, and personality growth.

Most forms of psychotherapy use spoken conversation. Some also use various other forms of communication such as the written word, artwork, drama, narrative story or music. Psychotherapy occurs within a structured encounter between a trained therapist and client(s). Purposeful, theoretically based psychotherapy began in the 19th century with psychoanalysis; since then, scores of other approaches have been developed and continue to be created (Binstock, 1997).

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Whilst some psychotherapeutic interventions are designed to treat the patient employing the medical model, many psychotherapeutic approaches do not adhere to the symptom-based model of "illness/cure". Some practitioners, such as humanistic therapists, see themselves more in a facilitative/helper role. As sensitive and deeply personal topics are often discussed during psychotherapy, therapists are expected, and usually legally bound, to respect client or patient confidentiality. The critical importance of confidentiality is enshrined in the regulatory psychotherapeutic organizations' codes of ethical practice (Kalman & Matthew, 2004).

2.5.1. Systems of psychotherapy:

- **Psychoanalytic**: the first practice to be called psychotherapy. It encourages the verbalization of all the patient's thoughts, including free associations, fantasies, and dreams, from which the analyst formulates the nature of the unconscious conflicts which are causing the patient's symptoms and character problems(Binstock,1997).
- **Cognitive behavioral**: generally seeks by different methods to identify and transcend maladaptive cognitions, appraisal, beliefs and reactions with the aim of influencing destructive negative emotions and problematic dysfunctional behaviors. Cognitive behavioral therapy refers to a range of techniques which focus on the construction and re-construction of people's cognitions, emotions and behaviors. Generally in CBT the therapist, through a wide array of modalities, helps clients assess, recognize and deal with problematic and dysfunctional ways of thinking, emoting and behaving (Binstock, 1997).
- **Behavior:** focuses on modifying overt behavior and helping clients to achieve goals. This approach is built on the principles of learning theory including operant and respondent conditioning, which makes up the area of applied behavior analysis or behavior modification. This approach includes acceptance and commitment therapy, functional analytic psychotherapy, and dialectical behavior therapy. Sometimes it is integrated with cognitive therapy to make cognitive behavior therapy. By nature, behavioral therapies are empirical (data-driven), contextual (focused on the environment and context), functional (interested in the effect or consequence a behavior ultimately has), probabilistic (viewing behavior as statistically predictable), monistic (rejecting mind-body dualism and treating the person as a unit), and relational (analyzing bidirectional interactions) (Wilson & others, 1985).

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- **Psychodynamic**: is a form of depth psychology, the primary focus of which is to reveal the unconscious content of a client's psyche in an effort to alleviate psychic tension. Although it has its roots in psychoanalysis, psychodynamic therapy tends to be briefer and less intensive than traditional psychoanalysis (Binstock, 1997).
- **Existential** : is based on the existential belief that human beings are alone in the world. This aloneness leads to feelings of meaninglessness which can be overcome only by creating one's own values and meanings (Kalman & Matthew, 2004).
- **Humanistic :** emerged in reaction to both behaviorism and psychoanalysis and is therefore known as the Third Force in the development of psychology. It is explicitly concerned with the human context of the development of the individual with an emphasis on subjective meaning, a rejection of determinism, and a concern for positive growth rather than pathology. It posits an inherent human capacity to maximize potential, 'the self-actualing tendency'. The task of Humanistic therapy is to create a relational environment where this tendency might flourish (Binstock, 1997).
- **Brief**: "Brief therapy" is an umbrella term for a variety of approaches to psychotherapy. It differs from other schools of therapy in that it emphasizes a focus on a specific problem and direct intervention. It is solution-based rather than problem-oriented. It is less concerned with how a problem arose than with the current factors sustaining it and preventing change (Binstock, 1997).
- **Systemic**: seeks to address people not at an individual level, as is often the focus of other forms of therapy, but as people in relationship, dealing with the interactions of groups, their patterns and dynamics (includes family therapy & marriage counseling) (Binstock,1997) .

2.5.2. Some Types of Psychotherapy:

- **Cognitive Behavioral Therapy:**

Cognitive Behavioral therapy is one of the few forms of psychotherapy that has been scientifically tested and found to be effective in for many different disorders. In contrast to other forms of psychotherapy, cognitive behavioral therapy is usually more focused on the present, more time-limited, and more problem-solving oriented. Indeed, much of what the patient does is solve current problems. In addition, patients learn specific skills that they can use for the rest of

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their lives. These skills involve identifying distorted thinking, modifying beliefs, relating to others in different ways, and changing behaviors (Donohue, 1998).

CBT is an empirically supported treatment that focuses on patterns of thinking that are maladaptive and the beliefs that underlie such thinking. For example, a person who is depressed may have the belief, "I'm worthless," and a person with a phobia may have the belief, "I am in danger." While the person in distress likely holds such beliefs with great conviction, with a therapist's help, the individual is encouraged to view such beliefs as hypotheses rather than facts and to test out such beliefs by running experiments. Furthermore, those in distress are encouraged to monitor and log thoughts that pop into their minds (called "automatic thoughts") in order to enable them to determine what patterns of biases in thinking may exist and to develop more adaptive alternatives to their thoughts. People who seek CBT can expect their therapist to be active, problem-focused, and goal-directed (Donohue, 1998).

Studies of CBT have demonstrated its usefulness for a wide variety of problems, including mood disorders, anxiety disorders, personality disorders, eating disorders, substance abuse disorders, and psychotic disorders.

Cognitive Behavioral Therapy focused in three areas which are Cognitive, Behavior, and emotion as the following;

- **Cognitive:** It is the way of learning new methods and ways to change old thinking patterns and habits. If person always thinking and expecting the worst, then such this person will continue to suffer. CBT help in train or condition minds to think and respond differently than we have in the past. Or think of it this way – if mind can be conditioned to think and feel negatively, then person can be reconditioned to think healthfully (Kalman & Matthew, 2004).

- **Behavior:** The behavioral aspect of therapy is the part where actually put everything into place in everyday, real-life situations where bothered by anxiety and depression. This area is always handled at the same time or after cognitive therapy, because we need a strong foundation of cognitive and emotional skills/strategies so that begin living and acting differently before we confront real-life challenges. This stage is essential for people with some of the anxiety problems

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(such as social anxiety disorder and PTSD) and serves as a powerful adjunct to individual treatment for others (Donohue, 1998).

- **Emotion:** It is important to have some type of relaxation or "de-stress" strategy that is accessible whenever we need it. In this area, calmness and peace are the goals. The more your brain is quiet and relaxed, the easier therapeutic information can get into it and be processed. This is simply another way to let the therapy reach your brain and gently sink in (Kalman & Matthew, 2004).

- **Exposure Therapy:**

Over time, people with PTSD may develop fears of reminders of their traumatic event. These reminders may be in the environment. For example, certain pictures, smells, or sounds may bring about thoughts and feelings connected with the traumatic event. These reminders may also be in the form of memories, nightmares, or intrusive thoughts. Because these reminders often bring about considerable distress, a person may fear and avoid them (Spitzer, 1983).

The goal of exposure therapy is to help reduce the level of fear and anxiety connected with these reminders, thereby also reducing avoidance. This is usually done by having the client confront (or be exposed to) the reminders that he fears without avoiding them. This may be done by actively exposing someone to reminders (for example, showing someone a picture that reminds him of his traumatic event) or through the use of imagination (Spitzer, 1983).

By dealing with the fear and anxiety, the patient can learn that anxiety and fear will lessen on its own, eventually reducing the extent with which these reminders are viewed as threatening and fearful. Exposure therapy is usually paired with teaching the patient different relaxation skills. That way the patient can better manage his anxiety and fear when it occurs (instead of avoiding) (Spitzer, 1983).

- **Play Therapy:**

Children who have experienced considerable change in their lives or who have survived traumatic events need to express and understand their feelings. Through the therapeutic use of

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play, children are given the opportunity to express their feelings naturally, and safely, thus enabling the healing process to begin. When a child is helped in this way, a clear message is sent: receiving help is okay. Therapy allows children to internalize this nurturing message and learn healthy self-care skills that carry into adulthood (Livingston, 2000).

Play Therapy is a specific counseling approach in which games, toys and mediums such as clay, drawings and paint are used to help a child or adolescent to express their emotions, thoughts, wishes and needs. It helps them to understand muddled feelings and upsetting events that they have not had the chance or the skills to sort out properly. Rather than having to explain what is troubling them, as adult therapy usually expects, children use play to communicate at their own level and at their own pace, without feeling interrogated or threatened (Livingston, 2000).

Play Therapy is the systematic use of a theoretical model to establish an interpersonal process where in play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial challenges and achieve optimal growth and development (Livingston, 2000).

Play Therapy is often used as tool of diagnosis. A play therapist observes a client playing with toys (play-houses, pets, dolls, etc.) to determine the cause of the disturbed behavior. The objects and patterns of play, as well as the willingness to interact with the therapist, can be used to understand the underlying rationale for behavior both inside and outside the session (Spitzer, 1983).

According to the psychodynamic view, people (especially children) will engage in play behavior in order to work through their interior obfuscations and anxieties. In this way, play therapy can be used as a self-help mechanism, as long as children are allowed time for "free play" or "unstructured play." From a developmental point of view, play has been determined to be an essential component of healthy child development. Play has been directly linked to cognitive development (Livingston, 2000).

One approach to treatment is for play therapists use a type of systematic desensitization or relearning therapy to change disturbing behavior, either systematically or in less formal social settings.

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The initial focus of the therapy is on building a relationship between a child and the therapist. This relationship is a very important tool in the therapeutic process because a child or adolescent will more readily talk about their intimate feelings when they feel respected and accepted. In the sessions the therapist uses specific techniques to assess how a child or adolescent experience their world and how they communicate and react to the events and people in their world. Children are lead to become aware of what they are feeling and opportunities are given to express these feelings. Awareness is a very important process in play therapy, because without awareness change is not possible. Throughout the therapy the child or adolescent is empowered and supported to learn more about who they are, to talk about things that are frightening or painful, to be self supportive and to experiment with new behavior (Livingston, 2000).

Play Therapy can be useful to become aware of what feelings and how these feelings manifest in behavior or one's body. They can learn how to become better at regulating emotions and expressing them in constructive ways. They can discover who they are and what their strong and weak points, needs, wishes, thoughts and dreams are. The combination of this self-knowledge and training in social skills may help a child to become more assertive, self-confident and to have self-respect and respect for others (Spitzer, 1983).

Play therapy Helpful for;

- Children who are dealing with **parental conflict, separation or divorce**
- Children who have been **traumatized** (sexual, physical or emotional abuse)
- Children who have been **adopted** or are in **foster care**
- Children who are dealing with issues of **loss**, such as **illness or death** of a loved one
- Children who have been **hospitalized**
- Children who have **witnessed domestic violence**
- Children diagnosed with **Attention Deficit Disorder (ADD/ADHD)**
- Children who have experienced serious **accidents or disasters** (Livingston, 2000).

- **Stress-Inoculation Training:**

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The basic goal of Stress-Inoculation Training (SIT) is to help a patient gain confidence in his ability to cope with anxiety and fear stemming from trauma reminders.

In SIT, the therapist helps the client become more aware of what things are reminders (also referred to as "cues") for fear and anxiety. In addition, clients learn a variety of coping skills that are useful in managing anxiety, such as muscle relaxation and deep breathing.

The therapist helps the patient learn how to detect and identify cues as soon as they appear so that the patient can put the newly learned coping skills into immediate action. In doing so, the patient can tackle the anxiety and stress early on before it gets out of control (Spitzer, 1983).

- **Cognitive Processing Therapy:**

Cognitive-Processing Therapy (CPT) was developed by Resick and Schnicke to specifically treat PTSD among people who have experienced a sexual assault. CPT lasts 12 sessions. CPT can be viewed as a combination of cognitive therapy and exposure therapy.

CPT is like cognitive therapy in that it is based in the idea that PTSD symptoms stem from a conflict between pre-trauma beliefs about the self and world (for example, the belief that nothing bad will happen to me) and post-trauma information (for example, the trauma as evidence that the world is not a safe place). These conflicts are called "stuck points" and are addressed through the next component in CPT writing about the trauma (Spitzere, 1983).

Like exposure therapy, in CPT, the patient is asked to write about his traumatic event in detail. The patient is then instructed to read the story aloud repeatedly in and outside of session. The therapist helps the client identify and address stuck points and errors in thinking, sometimes called "cognitive restructuring." Errors in thinking may include, for example, "I am bad person" or "I did something to deserve this." The therapist may help the patient address these errors or stuck points by having the client gather evidence for and against those thoughts (Spitzer, 1983).

2.5.3 Pharmacological Therapy:

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Post-traumatic stress disorder (PTSD) causes significant distress and is often associated with markedly reduced functioning. Recent reviews have consistently recommended trauma-focused psychological therapies as a first-line treatment for PTSD. Pharmacological treatments have also been recommended but not as consistently (Pharmacological treatment, 2009).

In some cases, Therapist needs to prescribe psychotropic medications even before he or she has completed the medical and psychiatric evaluation. The acute use of medications may be necessary when the survivor is dangerous, extremely agitated, or psychotic.

After a disaster, some survivors experience extreme and persistent arousal in the form of anxiety, panic, hyper-vigilance, irritability, and insomnia. Empirical research has shown that hyper-arousal during the first few weeks following trauma is a risk factor for the development of PTSD. Techniques to reduce arousal include relaxation and breathing exercises, utilizing social supports, psychotherapy, and pharmacotherapy (Pharmacological treatment, 2009).

Pharmacological agents for the treatment of trauma-related arousal include antiadrenergic agents such as clonidine, guanfacine, prazosin, and propranolol. Pharmacological treatment for post traumatic stress reactions is generally reserved for individuals who already have received a brief individual or group intervention. If these approaches are ineffective, clinicians should consider pharmacotherapy (Pharmacological treatment, 2009).

2.5.4 Islam and Psychotherapeutic Treatment:

An understanding of Islamic beliefs and the teachings of Islam can provide invaluable resources for the treatment of Muslim clients who are experiencing depression, anxiety, stress, loss and grief, and posttraumatic stress symptoms. In such a model it is essential to support clients in their religious beliefs, to strengthen their faith, correct their thoughts and beliefs (cognitive re-structuring) and change their behaviors. Counseling' and 'psychotherapy' within Islamic belief has an ancient tradition of changing the behavior and manner of clients, sinners, evil doers and patients by cognitive and behavioral psycho-spiritual methods that extensively rely on the righteous and exalted personality of the therapist (Mehraby, 2003).

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Psychotherapy is in reality a form of education which directs the patient to recognize his behavior, to conform with prevailing standards. It helps in motivating the patient to adopt the alternate ways of behavior. Islamic principles which are based on Quran and Hadith are the best form of prevention and treatment of emotional disturbances. Muslims physicians and mental health professionals should incorporate the Islamic values and ethics in techniques of psychotherapy.

Religion plays a significant role in satisfying our physical as well as spiritual needs: Islam teaches us a code of behavior and gives us a meaning for our existence. Unfortunately, in today's western society the religious, moral and ethical values have been declining. The families are falling apart, divorce rate is increasing sharply, substance abuse and excessive sexual indulgence are common in adolescents and young adults. These factors lead to conflicts, resentment, loss of self-respect, loneliness, depression, anxiety and a host of psychological symptoms. Despite progress in the behavioral sciences, there remains the question of whether current technique of treatment and prevention of emotional disturbances are effective in making a significant impact on psychiatric problem (Ahmed, 2008).

. Our religion, Islam, plays a significant role in satisfying our physical as well as spiritual needs. Islam teaches us, a code of behavior, and conservation of social values and gives us a meaning for our existence. It helps in toleration and developing adaptive capacities for stressful events of life. It gives us a sense of self-respect and teaches us about the virtues of family life and a cohesive society with a sense of brotherhood. Shall Muslim psychiatrists and psychotherapists incorporate the Islamic values, ethics and code of behavior in techniques of psychotherapy? (Ahmed, 2008)

Person' s religious belief has a significant bearing on his personality and his viewpoint in life. When a Muslim puts trust in God he minimizes the stress on himself by reducing his responsibility and power to control his failure.

It is therefore important to take into account all religious matters and traditional values in the treatment of Muslim clients, notwithstanding that a person's religious beliefs are also a dynamic part of their personality, and at different stages in their lives they may be more reliant on their "Spirituality and religious faith (Mehraby, 2003).

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2. 6. Evaluation:

Is the process of determining significance or worth, usually by carefully appraisal and study? Evaluation is the analysis and comparison of actual progress vs. prior plans, oriented towered plans for future implementation .It is part of a continuing management process consisting of planning, implementation and evaluation ideally with each following the other in a continuous cycle until successful completion of the activity .Evaluation is the process of determining the worth or value of something (Marris and Braz, 2006).

Evaluation is about using monitoring and other information you collect to make judgments about your project. It is also about using the information to make changes and improvements (William, 2006).

William sees that evaluation aims to answer agreed questions and to make a judgment against specific criteria. Like other research, for a good evaluation, data must be collected and analyzed systematically, and its interpretation considered carefully. Assessing 'value' - or the worth of something - and then taking action makes evaluation distinctive. The results of an evaluation are intended to be used.

There are many different perspectives and approaches to evaluation. Answering questions such as 'Why are we doing it?' 'Who is the evaluation for?' and 'What are the key issues to address?' will help you decide whether you wish to self-evaluate or to have an external evaluation. The questions will help you to think about what you want to focus on (William, 2006).

Charities Evaluation Service (CES) approach is that monitoring and evaluation not only measure how well you are doing , but also help you to be more effective (Marris and Braz,2006)

Evaluation helping to ensure that objectives are met, identifying successes, problems , weakness, staff training and development needs so they can be rectified ,providing information to aid further development ,contributing to securing funding for further development and gaining the support of institutional managers (Thebridge, 2002) .

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Evaluation guiding future plans, providing information for stakeholders, developing guidelines which may be useful for other library services ,devising strategies to develop projects into services and positioning the library in relation to current learning and research environment (Marris and Braz,2006).

Evaluation has been defined as systematic investigation of the merit, worth, or significance of an object. During the past three decades, the practice of evaluation has evolved as a discipline with new definitions, methods, approaches, and applications to diverse subjects and settings. Despite these refinements, a basic organizational framework for program evaluation practice had not been developed. In May 1997, staff recognized the need for such a framework and the need to combine evaluation with program management. Further, the need for evaluation studies that demonstrate the relationship between program activities and prevention effectiveness was emphasized (Scutchfield. & Keck, 2002).

2.6.1 Health Program Evaluation:

Program evaluation is an essential organizational practice in health however, it is not practiced consistently across program areas, nor is it sufficiently well-integrated into the day-to-day management of most programs. Program evaluation is also necessary for fulfilling operating principles for guiding health activities, which include a) using science as a basis for decision-making and public health action; b) expanding the quest for social equity through public health action; c) performing effectively as a service agency; d) making efforts outcome oriented; and e) being accountable (2). These operating principles imply several ways to improve how health activities are planned and managed (CDC, 1999). They underscore the need for programs to develop clear plans, inclusive partnerships, and feedback systems that allow learning and ongoing improvement to occur. One way to ensure that new and existing programs honor these principles is for each program to conduct routine, practical evaluations that provide information for management and improve program effectiveness (CDC, 1999).

Effective program evaluation is a systematic way to improve and account for health actions by involving procedures that are useful, feasible, ethical, and accurate. The recommended framework was developed to guide public health professionals in using program evaluation. It is

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a practical, nonprescriptive tool, designed to summarize and organize the essential elements of program evaluation. The framework comprises steps in evaluation practice and standards for effective evaluation (CDC, 1999).

There is a framework for program evaluation. The framework is composed of six steps that must be taken in any evaluation. They are starting points for tailoring an evaluation to a particular health effort at a particular time. Because the steps are all interdependent, they might be encountered in a nonlinear sequence; however, an order exists for fulfilling each — earlier steps provide the foundation for subsequent progress. Thus, decisions regarding how to execute a step are iterative and should not be finalized until previous steps have been thoroughly addressed (CDC, 1999). The steps are as follows:

Step 1: Engage stakeholders.
Step 2: Describe the program.
Step 3: Focus the evaluation design.
Step 4: Gather credible evidence.
Step 5: Justify conclusions.
Step 6: Ensure use and share lessons learned.

Adhering to these six steps will facilitate an understanding of a program's context (e.g., the program's history, setting, and organization) and will improve how most evaluations are conceived and conducted.

2.6.2 Steps in Program Evaluation

Step 1: Engaging Stakeholders

The evaluation cycle begins by engaging stakeholders (i.e., the persons or organizations having an investment in what will be learned from an evaluation and what will be done with the knowledge). Public health work involves partnerships; therefore, any assessment of a public health program requires considering the value systems of the partners. Stakeholders must be engaged in the inquiry to ensure that their perspectives are understood (CDC, 1999). When stakeholders are not engaged, an evaluation might not address important elements of a program's objectives, operations, and outcomes. Therefore, evaluation findings might be ignored, criticized,

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or resisted because the evaluation did not address the stakeholders' concerns or values. After becoming involved, stakeholders help to execute the other steps (CDC, 1999).

Step 2: Describing the Program

Program descriptions convey the mission and objectives of the program being evaluated. Descriptions should be sufficiently detailed to ensure understanding of program goals and strategies. The description should discuss the program's capacity to effect change, its stage of development, and how it fits into the larger organization and community. Program descriptions set the frame of reference for all subsequent decisions in an evaluation. The description enables comparisons with similar programs and facilitates attempts to connect program components to their effects (CDC, 1999).

Moreover, stakeholders might have differing ideas regarding program goals and purposes. Evaluations done without agreement on the program definition are likely to be of limited use. Sometimes, negotiating with stakeholders to formulate a clear and logical description will bring benefits before data are available to evaluate program effectiveness. Aspects to include in a program description are need, expected effects, activities, resources, stage of development, context, and logic model (CDC, 1999).

Step 3: Focusing the Evaluation Design

The evaluation must be focused to assess the issues of greatest concern to stakeholders while using time and resources as efficiently as possible. Not all design options are equally well-suited to meeting the information needs of stakeholders. After data collection begins, changing procedures might be difficult or impossible, even if better methods become obvious. A thorough plan anticipates intended uses and creates an evaluation strategy with the greatest chance of being useful, feasible, ethical, and accurate. Among the items to consider when focusing an evaluation are purpose, users, uses, questions, methods, and agreements (CDC, 1999).

Step 4: Gathering Credible Evidence

An evaluation should strive to collect information that will convey a well-rounded picture of the program so that the information is seen as credible by the evaluation's primary users. Information should be perceived by stakeholders as believable and relevant for answering their

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questions. Such decisions depend on the evaluation questions being posed and the motives for asking them. For certain questions, a stake holder's standard for credibility might require having the results of a controlled experiment; whereas for another question, a set of systematic observations (e.g., interactions between an outreach worker and community residents) would be the most credible. Consulting specialists in evaluation methodology might be necessary in situations where concern for data quality is high or where serious consequences exist associated with making errors of inference (CDC, 1999).

The second element of the framework is a set of 30 standards for assessing the quality of evaluation activities (CDC, 1999), organized into the following four groups:

Standard 1: utility,

Standard 2: feasibility,

Standard 3: propriety, and

Standard 4: accuracy.

2.7. Conclusion;

In this chapter researcher tackled many different points like Gaza ongoing trauma that started on 1948 and still running over years, and how it effects different ages within Palestinian context. Second, effect of war on Gaza's children, which is the main important point in this research as we found it in many researches like (Baker & Kanan, 2003), (Vostain, 1999), (Thabet, 2002), & (Thabet, 2006). Third diagnostic criteria of PTSD. Forth different types of psychotherapeutic interventions that used in and out palestain. and last, evaluation system.

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Chapter 3

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Chapter 3
Literature Review

3.1 Introduction:

In this chapter the researcher presents related previous studies that related to children, trauma and war, PTSD and children during war,Effectivness of Play Therapy, Effectivness of Chemichal theraPsychotherapeutic interventions, Evaluating Psychotherapy, and psychotherapy (medication). Finally the researcher will present her own comments in previous literature review.

3.2 Studies related to Children, Trauma, & War

3.2.1. Emotional problem in Palestinian children living in war zone (Thabet, 2002).

In another study done by Thabet which aimed in identifying the emotional problems in Palestinian children who are living in the war zone . 91 children taken as a sample who suffered their homes demolished during the events of the Al-Aqsa Intifada in the Salah al-Din Gate, and the Tufah neighborhood in Khan Younis, and on settlements in Deir el-Balah and 89 children had been subjected to female sample types other painful events related to political violence, it has been shown that children whose homes bombed and Demolition showed symptoms of psychiatric disorders and post-traumatic symptoms. Also fear more members of the group and the law has been the results by 59.3% of the children of the group that their homes were demolished and 24.7 % of the group told the law on the reactions of post-traumatic disorders. There has been a direct correlation between exposure to traumatic experiences, such as the bombing of homes and the emergence of psychological reaction. In contrast, the children who had been subjected to traumatic experiences transferred from adults and the media showed concern and the expression aware anguish.

3.2.2. Psychological impact of military violence on children as a function of distance from traumatic event: the Palestinian case (Baker & Kanan, 2003).

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The psychological well-being of 114 Palestinian children aged 5-16 was assessed with questionnaires. Three groups of children were distinguished: children living at close proximity (500 meters or less) to a bombed target; children living within a distance of 500-1000 meters, and children living at a greater distance than 1000 meters. The results showed that the well-being of Palestinian children was negatively affected by the military and political violence to which they were subjected. The study also demonstrates that psychological security is as crucial as physical security to the wellbeing of children. It may not be sufficient to relate the impact of a traumatic event to the physical distance alone, psychological distance also has to be taken into account.

3.2.3. Effect of political violence on Palestinians in the Gaza Strip (Thabet, 2006)

The aim of the study was to determine the prevalence of PTSD, anxiety, behavioral, and emotional problems of Palestinian children in relation to traumatic events and other socioeconomic status. A sample of 409 children from the entire Gaza Strip aged 9-18 years was survey using self-report questionnaires. Children were interviewed using Gaza Trauma Checklist, Child Revised Impact of Event Scale-13, and Child Revised Manifest Anxiety Scale, and their parents reported about their children behavioral and emotional problems using Strength and Difficulties Questionnaire. The results estimated mean traumatic experiences were 7.7. There was significant relationship between number of traumatic events and PTSD of children, intrusion, avoidance, and arousal. No gender differences in PTSD symptom. Children coming from families with monthly income less than 271 $ reported more traumatic events. Total IES score of children was significantly associated with PTSD symptoms. No relationships between number of traumatic events SDQ total or subscales. Prevalence of PTSD in children was 65.5%. The result showed that there were no sex differences in PTSD symptoms. Children coming from families with 4 and less children had more PTSD symptoms. Prevalence of anxiety disorder was (33.9%). No gender differences in anxiety disorder. General mental health problems rated by parents SDQ was (52.2%); conduct disorder (42.2%); hyperactivity (28.1%), emotional problems (32.8%), peers problems (69.9%), and prosocial problems (14%).

3.2.4. Trauma exposure in pre-school children in a war zone (Thabet & others, 2006).

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Thabet investigate the relationship between exposure to war trauma and behavioral and emotional problems among pre-school children, and that b y taking a total of 309 children aged 3–6 years which were selected from kindergartens in the Gaza Strip, and were assessed by parental reports in regard to their exposure to war trauma, using the Gaza Traumatic Checklist, and their behavioral and emotional problems, using the Behavior Checklist (BCL) and SDQ. Thabet found that Pre-school children were exposed to a wide range of traumatic events. The total number of traumatic events independently predicted total BCL and SDQ scores. Exposure to day raids and shelling of the children's houses by tanks were significantly associated with total behavioral and emotional problems scores.

3.3 Studies related to PTSD & Children during War:

3.3.1. Post-traumatic stress reactions in children of war (Thabet & Vostanis, 1999).

The aims of this study were to estimate the rate of posttraumatic stress reactions in Palestinian children who experienced war traumas, and to investigate the relationship between trauma-related factors and PTSD reactions. The sample consisted of 239 children of 6 to 11 years of age. Measures included the Rutter A2 (parent) and B2 (teacher) scales, the Gaza Traumatic Event Checklist and the Child Post Traumatic Stress Reaction Index. 174 children (72.8%) reported PTSD reactions of at least mild intensity, while 98 (41%) reported moderate/severe PTSD reactions. Caseness on the Rutter A2 scale was detected in 64 children (26.8%), which correlated well with detection of PTSD reactions, but not with teacher-detected caseness. The total number of experienced traumas was the best predictor of presence and severity of PTSD.

3.3.2. Child Development And Post-traumatic Stress Disorder After Hurricane Exposure (Delamater & Applegate, 2000).

This study examined child development in relation to post-traumatic stress disorder (PTSD) after hurricane exposure. The study subjects were 175 3 to 5-year old minority children enrolled in Head Start programs. Children were evaluated 12 and 18 months after Hurricane Andrew struck south Florida. Mothers were interviewed concerning symptoms of PTSD and

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completed a questionnaire regarding their children's development. Results indicated that 16.5% of exposed children met DSM-IV diagnostic criteria for PTSD at 12 months, and 11.6% had PTSD at 18 months post-hurricane. Children who had PTSD at 12 months were more likely to be delayed in their development at 18 months, and those with PTSD at 18 months similarly were more likely to be delayed. These findings indicate that children with PTSD are at risk for delays in their overall development.

3.3.3. Prevalence and determinants of PTSD among Palestinian children exposed to military violence (Quota, 2003).

Quota study aimed to show the prevalence of PTSD among Palestinian children who exposed to military violence. The prevalence and determinants of PTSD were assessed Among 121 Palestinian children (6–16 years; 45% girls and 55% boys) living in the area of bombardment. The mothers (21–55 years) and the children themselves reported their exposure to military violence (being personally the target of violence or witnessing it towards others) and symptoms of posttraumatic stress disorders (PTSD: intrusion, avoidance and hyper vigilance). The results showed that 54% of the children suffered from severe, 33.5 % from moderate and 11 % from mild and doubtful levels of PTSD. Girls were more vulnerable; 58% of them suffered from severe PTSD, and none Scored on the mild or doubtful levels of PTSD. The child's gender and age, mother's education and PTSD symptoms were significant, and the exposure to traumatic experiences marginally significant determinants of children's PTSD symptoms. The most vulnerable to intrusion symptoms were younger girls whose mothers showed a high level of PTSD symptoms, whereas those most vulnerable to avoidance symptoms were children who had personally been targets of military violence and whose mothers were better educated and showed a high level of PTSD symptoms.

3.3.4. Prevalence of PTSD among Palestinian children in Gaza Strip (Qouta, 2004)

This research study aimed to get acquainted with the prevalence of PTSD, and other psychological suffering among Palestinian children living under severe conditions during the last

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two and half years of the Al-Aqsa Intifada. The sample consists of 944 children whom age ranged between 10-19 years. The group excluded those with previous mental health problems. In this research, trauma scale, PTSD scale, the Child Posttraumatic Stress Index, the Children's PTSD-symptoms, *The* Posttraumatic Stress Disorder Reaction Index *(CPTS-RI)* and open questions had been used as tools. The results indicated that 32.7% of the children started to develop acute PTSD symptoms that need psychological intervention, while 49.2% of them suffered from moderate level of PTSD symptoms. Also the results 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 who were not relatives (66.9%), and saw family members injured or killed (61.6%).

3.3.5. Risk of Posttraumatic Stress Symptoms: A Comparison of Child Survivors of Pediatric Cancer and Parental Bereavement (Stoppelbei & Greening, 2005).

This study done to compare the risk of posttraumatic stress (PTS) symptoms and the mediating effect of perceived future threat on the risk of PTS symptoms among survivors of pediatric cancer and children who had a parent die. Seventy-eight children (39 survivors of cancer, 39 bereaved) completed self-report measures of PTS symptoms, depression, anxiety, and perceived risk of future threat for the event they experienced. The children who lost a parent reported significantly more PTS symptoms than the survivors of cancer. The effect of group status (survivor of cancer vs. bereaved) on PTS symptomatology was partly mediated by the children's perceived risk of future threat. The rate of PTS symptoms was found to be higher among children who had lost a parent than among survivors of pediatric cancer. This difference may partly be explained by their perceived risk of a future threat.

3.3.6. Posttraumatic Stress and Depressive Reactions among Nicaraguan Adolescents after Hurricane Mitch (Goenjian & others, 2005).

This study determined the severity of posttraumatic stress and depressive reactions among Nicaraguan adolescents after Hurricane Mitch and the relationship of these reactions to objective and subjective features of hurricane exposure, death of a family member, forced relocation, and

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thoughts of revenge. Six months after the hurricane, 158 adolescents from three differentially exposed cities were evaluated by using a hurricane exposure questionnaire, the Child Posttraumatic Stress Disorder Reaction Index, and the Depression Self-Rating Scale. Severe levels of posttraumatic stress and depressive reactions were found among adolescents in the two most heavily affected cities. Severity of posttraumatic stress and depressive reactions and features of objective hurricane-related experiences followed a "dose-of-exposure" pattern that was congruent with the rates of death and destruction across cities. Level of impact (city), objective and subjective features, and thoughts of revenge accounted for 68% of the variance in severity of posttraumatic stress reaction. Severity of posttraumatic stress reaction, death of a family member, and sex accounted for 59% of the variance in severity of depression. Adolescents in heavily affected areas with extreme objective and subjective hurricane-related traumatic features of exposure experience severe and chronic posttraumatic stress and co morbid depressive reactions. The recovery of the severely affected Nicaraguan adolescents is vital to the social and economic recovery of a country ravaged by years of political violence and poverty. These findings strongly indicate the need to incorporate public mental health approaches, including systematic screening and trauma/grief-focused interventions, within a comprehensive disaster recovery program.

3.4. Studies related to Pharmacological & Play therapy:

3.4.1. The Effectiveness of Interventions to Reduce Psychological Harm from Traumatic Events among Children and Adolescents: A Systematic Review (Wethington, 2008),

This research review evaluated interventions commonly used to reduce psychological harm among children and adolescents exposed to traumatic events. *Guide to Community Preventive Services* (*Community Guide*) criteria were used to assess study design and execution. Meta-analyses were conducted, stratifying by traumatic exposures. Evaluated interventions were conducted in high-income economies, Subjects in studies were ≤21 years of age, exposed to individual/mass, intentional/unintentional, or manmade/natural traumatic events. The seven evaluated interventions were individual cognitive–behavioral therapy, group cognitive behavioral therapy, play therapy, art therapy, psychodynamic therapy, and pharmacologic therapy for symptomatic children and adolescents, and

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psychological debriefing, regardless of symptoms. The main outcome measures were indices of depressive disorders, anxiety and posttraumatic stress disorder, internalizing and externalizing disorders, and suicidal behavior.

Strong evidence (according to *Community Guide* rules) showed that individual and group cognitive–behavioral therapy can decrease psychological harm among symptomatic children and adolescents exposed to trauma. Evidence was insufficient to determine the effectiveness of play therapy, art therapy, pharmacologic therapy, psychodynamic therapy, or psychological debriefing in reducing psychological harm.

Personnel treating children and adolescents exposed to traumatic events should use interventions for which evidence of effectiveness is available, such as individual and group cognitive–behavior therapy.

3.4.2. A meta-analysis of play therapy outcomes (Ritchie, 2010).

A meta-analysis of play therapy outcomes with children was conducted to determine the overall effectiveness of play therapy and the variables related to effectiveness. Hierarchical linear modeling was used to analyze the data. The analysis showed an average treatment effect of 0.66 standard deviations. A strong relationship between treatment effectiveness and the inclusion of parents in the therapeutic process was reported. The duration of therapy also appeared to be related to treatment outcomes, with maximum effect sizes occurring after approximately 30 treatment sessions. Play therapy appeared to be as effective as non-play therapies in treating children experiencing.

3.4.3. A Multi-Site, Randomized Controlled Trial for Children With Abuse-Related PTSD Symptoms (Cohean, 2002).

This study used to examine the differential efficacy of trauma-focused, cognitive behavioral therapy (TF-CBT) and play therapy for treating posttraumatic stress disorder (PTSD) and related emotional and behavioral problems in children who have suffered sexual abuse. Two hundred and twenty-nine 8–14 year old children and their primary caretakers were randomly assigned to the above alternative treatments. These children

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had significant symptoms of Posttraumatic Stress Disorder (PTSD) with 89% meeting full DSM-IV PTSD diagnostic criteria.

A series analyses of covariance indicated that children assigned to TF-CBT, as compared to those assigned to play therapy, demonstrated significantly more improvement with regard to PTSD, depression, behavior problems, shame and abuse-related attributions.

3.4.4. Treatment practices for childhood posttraumatic stress disorder (Jaudith, 2001).

This study surveyed practices in treating childhood PTSD among child psychiatrists and non-M.D. therapists with self-identified interest in treating traumatized children. An anonymous survey was mailed to 207 child psychiatrists ("medical") and 460 nonphysician ("non-medical") therapists inquiring about current interventions used to treat children with PTSD. Results showed that two hundred and forty-seven responses were received: of 77 medical and 82 nonmedical respondents who currently treat children with PTSD, a wide variety of modalities are used. Most preferred modalities among medical responders were pharmacotherapy, psychodynamic, and cognitive-behavioral therapy. Most preferred modalities among nonmedical respondents were cognitive-behavioral, family, and nondirective play therapy. Ninety-five percent of medical respondents used pharmacotherapy for this disorder; most preferred medications to treat childhood PTSD were selective serotonin reuptake inhibitors and alpha-adrenergic agonists. Several significant differences between medical and nonmedical practices were identified.

3.4.5. Patient Predictors of Response to Psychotherapy and Pharmacotherapy (Stosky, 2006).

The authors investigated patient characteristics predictive of treatment response in the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program. Two hundred thirty-nine outpatients with major depressive disorder according to the Research Diagnostic Criteria entered a 16-week multicenter clinical trial and were randomly assigned to interpersonal psychotherapy, cognitive-behavior therapy, imipramine with clinical

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management, or placebo with clinical management. Pretreatment sociodemographic features, diagnosis, course of illness, function, personality, and symptoms were studied to identify patient predictors of depression severity (measured with the Hamilton Rating Scale for Depression) and complete response (measured with the Hamilton scale and the Beck Depression Inventory). One hundred sixty-two patients completed the entire 16-week trial. Six patient characteristics, in addition to depression severity previously reported, predicted outcome across all treatments: social dysfunction, cognitive dysfunction, expectation of improvement, endogenous depression, double depression, and duration of current episode. Significant patient predictors of differential treatment outcome were identified. Low social dysfunction predicted superior response to interpersonal psychotherapy. Low cognitive dysfunction predicted superior response to cognitive-behavior therapy and to imipraminte. High work dysfunction predicted superior response to imipramine. High depression severity and impairment of function predicted superior response to imipramine and to interpersonal psychotherapy. The results demonstrate the relevance of patient characteristics, including social, cognitive, and work function, for prediction of the outcome of major depressive disorder. They provide indirect evidence of treatment specificity by identifying characteristics responsive to different modalities, which may be of value in the selection of patients for alternative treatments.

3.5 Studies related to Psychotherapeutic Interventions:

3.5.1. Resiliency factors predicting psychological adjustment after political violence among Palestinian children (Qouta & others, 1996).

In another study for Qouta, punamaki, and alsaraj which showed the effects of cognitive capacity, perceived parenting, traumatic events, and activity, which were measured in the midst of the political violence of the Intifada in 1993, were examined on post-traumatic stress disorder (PTSD), emotional disorders, school performance, and neuroticism three years later in more peaceful conditions among 86 Palestinian of school aged children. The results showed, that PTSD was high among the children who had been exposed to a high level of traumatic events and had responded passively (not actively) to Intifada violence. Discrepant perceived parenting

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was also decisive for adjustment: Children who perceived their mothers as highly loving and caring but their fathers as not so showed a high level of PTSD. High intellectual but low creative performance was also characteristic of the children suffering from emotional disorders. Second, the hypothesis that cognitive capacity and activity serve a resiliency function if children feel loved and nonrejected at home was confirmed. Third, neuroticism decreased significantly over the three years, especially among the children who had been exposed to a high number of traumatic events.

3.5.2 The impact of extracurricular activities in the summer camps on mental health of children in the Gaza Strip (Thabet, 2003).

The aims of the study were to examine the types and severity of traumatic experiences and reaction to trauma such as anxiety, depression, and PTSD. also, to investigate the effectiveness of extracurricular activities in the summer camps on children mental health problems such as anxiety, depression, and PTSD. A total number of 221 children aged 6-16 years were selected from 3 summer camps in the Gaza Strip. Children were interviewed before the activities in the summer camps which include: drawing, story telling, cultural activities, and role play. The scales were sociodemographic, Gaza Traumatic Events Checklist, Impact of Event Scale (IES). The results showed that there are no changes in any psychological reactions due to traumatic events such as depression, anxiety, PTSD, avoidance and intrusion after finishing 5 days of activities in the summer camps.

3.5.3 Outcome of Psychotherapy among Early Adolescents after Trauma (Armen & others, 2003).

The authors evaluated the effectiveness of brief trauma/grief-focused psychotherapy among early adolescents exposed to the 1988 earthquake in Armenia. Posttraumatic stress and depressive reactions among treated and not treated subjects were evaluated pre- and postintervention, at 11 years after the earthquake. Posttraumatic stress symptoms significantly decreased among the subjects given psychotherapy, while severity of these symptoms increased significantly among the subjects not treated with psychotherapy. The improvement in

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posttraumatic stress symptoms was attributable to improvement in all three symptom categories (intrusion, avoidance, and arousal) of PTSD. There was no change in severity of depressive symptoms among subjects given psychotherapy. However, depressive symptoms among subjects not treated with psychotherapy significantly worsened over time. The changes in severity of posttraumatic stress and depressive symptoms were positively correlated within both groups. The findings demonstrate the efficacy of trauma/grief-focused brief psychotherapy in alleviating PTSD symptoms and preventing the worsening of co morbid depression among early adolescents after a catastrophic disaster. The results support the broad use of such school based interventions after major disasters and demonstrate the cross-cultural applicability of Western psychotherapeutic approaches.

3.5.4 An Examination of the Effectiveness of Periodic Stress Debriefings with Law Enforcement Personnel (Young & Parr, 2003).

This study was conducted in an effort to address issues associated with police officers' levels of critical incident-related stress, cumulative stress, and their subsequent effects (e.g., divorce, alcohol use, and job dissatisfaction) and to now the effectiveness of Critical Incident Stress Debriefing (CISD) and Critical Incident Stress Management (CIS) . Another component of the treatment intervention was to educate officers in stress management. Police cadet training briefly covers posttraumatic stress, basic coping skills , and how to identify stress reactions in others and as a result the stress reduced for the officers .

3.5.5 Psychological Debriefing for Road Traffic Accident Victims: Three-Year Follow-Up of a Randomized Controlled Trial (Mayou, 2003).

The aims of this study are to evaluate the 3-year outcome in a randomized controlled trial of debriefing for consecutive subjects admitted to hospital following a road traffic accident. Patients were assessed in hospital by the IES, Brief Symptom Inventory (BSI) and questionnaire and re-assessed at 3 months and 3 years. The intervention was psychological debriefing as recommended and described in the literature. The intervention group had a significantly worse outcome at 3 years in terms of general psychiatric symptoms Brief Symptom Inventory (BSI),

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travel anxiety when being a passenger, pain, physical problems, overall level of functioning, and financial problems. Patients who initially had high intrusion and avoidance symptoms IES remained symptomatic if they had received the intervention, but recovered if they did not receive the intervention. Psychological debriefing is ineffective and has adverse long-term effects. It is not an appropriate treatment for trauma victims . Brief Symptom Inventory

3.5.6 Effectiveness of school-based debriefing sessions for Palestinian children affected by war and trauma in the Gaza Strip (Thabet & others, 2005).

Aim of the study is to evaluate the school-based debriefing sessions for children living in a zone of ongoing war conflict. A randomly selected sample of 240 children aged 10-16 years who were affected by the current conflict in the Gaza Strip were interviewed about their war experiences and reactions to the violence before and after participating in the 2-week intervention in schools for 8 sessions. Children themselves reported decrease in all mental health problems after the intervention. However parents disagreed with their children and reported no change in behavioral and emotional problems of their children after the intervention.

3.5.7 A Prospective Study of Posttraumatic Stress and Depressive Reactions among Treated and Untreated Adolescents 5 Years After a Catastrophic Disaster (Goenjian & others, 2005)

This study evaluated the natural course of posttraumatic stress and depressive reactions among untreated adolescents from two cities in an earthquake zone and one at the periphery that were differentially exposed to the 1988 Spitak earthquake in Armenia and the effectiveness of brief trauma/grief-focused psychotherapy among adolescents from Gumri. One hundred twenty-five adolescents were assessed with the Child Posttraumatic Stress Disorder Reaction and the Depression Self-Rating Scale (DSRS) at 1.5 and 5 years postearthquake. At 1.5 years, trauma/grief-focused group and individual psychotherapy was provided over 6 weeks to a group of students in Gumri. CPTSD-RI scores among untreated adolescents from Gumri and Spitak subsided significantly but mildly at follow-up, with scores from Spitak, the city at the epicenter, remaining above the cutoff for a diagnosis of PTSD. DSRS scores increased mildly in both earthquake cities but only significantly in Gumri. Among treated adolescents in Gumri,

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improvement in CPTSD-RI scores was three times that of the untreated Gumri comparison group. The treated group also tended to improve on their DSRS scores, whereas these scores worsened significantly among untreated subjects. Untreated adolescents exposed to severe trauma are at risk for chronic PTSD and depressive symptoms. Brief trauma/grief-focused psychotherapy is effective in reducing PTSD symptoms and halting the progression of depression. This study supports the implementation of mental health intervention programs in schools after disasters to reduce trauma-related psychopathology.

3.5.8 Cognitive-behavioral Group Intervention for PTSD Symptoms in Children Following the Athens 1999 Earthquake: A Pilot Study (Yule, 2006)

This study examined the effects of a short-term group cognitive-behavioral intervention in children who were experiencing PTSD symptoms following the Athens 1999 earthquake. Twenty children, aged 8-12 years, referred for treatment to a local child mental health team were assigned, depending on timing of referral to two groups - Group 1 (N = 10), which started treatment 2 months after the earthquake and Group 2 (N = 10), which started treatment at 4 months post earthquake. A statistically significant reduction in overall PTSD symptoms across the three PTSD symptom clusters - intrusion, avoidance, and arousal - as well as in depressive symptoms was reported immediately after the intervention. The treatment also produced a statistically significant improvement in children's psychosocial functioning. Further significant improvement was reported in children at an 18-month follow-up. Treatment gains were maintained at a 4-year follow-up. Despite several limitations to this study, short-term group CBT was found to be a useful treatment approach, which can be offered in clinical settings, particularly if resources are limited.

3.5.9 Psychosocial intervention for war-affected children in Sierra Leone.(Gupta & Zimmer, 2008).

Aims of this study are to assess the psychosocial status of displaced children enrolled in the Rapid-Ed intervention; and to determine whether the Rapid-Ed intervention alleviated traumatic stress symptoms that interfere with learning among war-affected children in Sierra Leone. A randomly selected sample of 315 children aged 8–18 years who were displaced by war were interviewed about their war experiences and reactions to the violence before and after

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participating in the 4-week Rapid-Ed intervention combining basic education with trauma healing activities. High levels of intrusion, arousal and avoidance symptoms were reported at the pre-test interviews conducted 9–12 months after the war. Post-test findings showed statistically significant decreases in intrusion and arousal symptoms ($P<0.0001$), a slight increase in avoidance reactions ($P<0.0001$) and greater optimism about the future.

3.5.10 Effectiveness of Student Mediation Program to decrease behavioral and emotional problems in Palestinian children affected by war and trauma in the Gaza Strip (Thabet & others, 2008).

The aim of the study was to evaluate the effectiveness of student mediation program in improving mental health status of Palestinian children in the Gaza Strip. Participants of the study were 304 schoolchildren aged 6-16 (Mean age = 10.62 years) from grades one tenth from three schools selected randomly from schools registration lists provided by the Ministry of Education. From each school, classes were randomly assigned to the prevention. Pre-test and assessment scales (Sociodemographic scale and Gaza Child Mental Health Scale) were applied to children one week before starting the student mediation sessions on Sep 2007 by 8 psychologists and psychiatric nurses working the field of children victims of trauma and war and at the end of scholastic year on May 2008. According to children report, the results showed that there was statistically significant decrease in total scores of child mental health and hyperactivity symptoms after student school mediation program. According to parents, the results showed that there was statistically significant decrease in obsessive and overanxious symptoms after student mediation program.

3.6 Studies related to Evaluation of Psychotherapy:

3.6.1 Evaluation of a short-term group therapy program for children with behavior problems and their parents (Hemphill & Littlefield, 2000).

The current study investigated the effectiveness of a short-term, cognitive behavioral program for 106 primary school-aged children referred with externalizing behavior problems and their parents, compared with 39 children and their parents on a waiting-list to be treated. Comprised a children's group (anger management, problem-solving and social skills training), a

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parents' group (parenting skills training and dealing with parents' own issues), and a combined children's and parents' group (to target parent-child interactions). The program reduced children's behavior problems and improved their social skills at home. Changes in children's behaviors and social skills at home were generally maintained at 6- and 12-month follow-up. Implications of the findings for improving interventions for childhood.

3.6.2 Evaluation of psychological therapy in patients with testicular cancer: randomized controlled trial (Moynihan, 1998).

The aim of this study is to determine the efficacy of psychological therapy in patients with testicular cancer and to compare the characteristics and psychosocial outcomes of men who agreed to participate with those who declined to participate in a randomized trial of psychological intervention. Newly diagnosed patients were asked to participate in a randomized trial of psychological support compared with standard medical care. Participants and non-participants completed self assessment questionnaires at baseline and at 2, 4 and 12 months. Testicular Tumor Unit of the Royal Marsden Hospital, 73 of 184 (40%) eligible patients agreed to enter the randomized trial (participants) and 81 (44%) declined to participate but agreed to complete further assessments (non-participants). 30 patients wanted no further contact with the researchers. Hospital anxiety and depression scale, psychosocial adjustment to illness scale, Rotterdam symptom checklist, mental adjustment to cancer scale. Only scores on the hospital anxiety and depression scale are reported for evaluating treatment efficacy.

111 of 184 (60%) eligible men declined to participate in the trial. Patients with stage I disease were most likely to refuse to participate. A patient was less likely to participate if he had low volume disease and was receiving no further treatment. Likelihood of participation was associated with stage of disease and with type of primary treatment . Patients with early stage disease and fewer physical symptoms were less likely to participate. Psychosocial factors associated with participation included anxious preoccupation regarding disease. There were no differences in outcome between participants and non-participants during follow up. Patients seemed to gain little benefit from psychological therapy. Patients with testicular cancer seem to have considerable coping abilities. Those who declined to participate in the trial differed from those who participated. Those who agreed to participate may

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comprise the clinical group who perceive a need for psychological support. No evidence was found to indicate a need for routinely offering psychological therapy.

3.7 Summary of Literature Review:

After reviewing the literatures, the author found that there are different studies that talk about the trauma and PTSD among children , and evaluate the implementation of psychotherapeutic interventions among Gaza's children, most of the available studies are new studies from different researchers, the author tends to high light on these studies in the following points;

3.7.1 Studies related to Children, Trauma, & War .

- **Objectives of the studies:**

Most of the previous studies (Thabet, 2002), (Thabet, 2006), & (Baker & Khanan, 2003) were assessing similar goals. Studies of (Thabet, 2002) showed clearly the strong relation between traumatic events and behavioral and psychological problems among children from different age group in Gaza strip.

- **Population of the studies:**

All of the literature reviewed was focused on the children; most studies consisted from more then 60 children who exposed to at least one traumatic event in their life. Some studies used parents to collect information about their children behaviors like (Thabet, 2006) study that studied the effect of political violence on Palestinians in the Gaza Strip.

- **Instruments of the Studies:**

Studies used PTSD tool, Gaza Trauma Checklist, Child Revised Impact of Event Scale-13, Child Revised Manifest Anxiety Scale, and Strength and Difficulties Questionnaire. Literature showed that different tools were used to study the effect of trauma on children.

- **The Results of the Studies:**

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Results were similar to each other in all studies (Thabet, 2006), (Thabet, 2002), & (Baker & Khanan, 2003) which showed that children who experienced traumatic events complaints from many problems like behavioral problem, recalling dreams, PTSD, low self esteem, and others.

3.7.2 PTSD & Children during War

- **Objectives of the studies:**

Most of the previous studies (Thabet & Vostains, 1999), (Delamate & Applegante, 2000), (Qouta, 2003), (Stoppelbei & Greening, 2005) & (Goenjian, 2005) were assessing similar goals. Studies of (Thabet, 1999) and (Qouta, 2003) showed clearly the strong relation between traumatic events and the present of PTSD, while in other study like (Delamater & Applegate, 2000) talk about the relation between PTSD and child development.

- **Population of the studies:**

All of the literature reviewed was focused on children; most studies consisted from more then 80 children who exposed to different kinds of trauma in their life. Some studies used parents and teacher to collect information about their children behaviors like (Thabet & Vostan, 1999) study that studied Post-traumatic stress reactions in children of war zone.

- **Instruments of the Studies:**

Most of the studies, which studied the effect of the trauma and PTSD used PTSD index, , Child Revised Impact of Event Scale-13, Child Revised Manifest Anxiety Scale, Strength and Difficulties Questionnaire, teacher questioners, open questions, and focus group for parents.

- **The Results of the Studies:**

Results were similar to each other in most of the studies. Studies of (Thabet, 1999), (Qouta, 2002 & 2003), & (Goenjian, 2005) showed clearly the strong relation between traumatic

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events and developing Posttraumatic Stress Disorder PTSD. Other studies like Delamater & Applegate 2000 showed that PTSD can lead to delay child development.

3.7.3. **Pharmacological & Play therapy**

- **Objectives of the studies:**

Most of the previous studies (Wethington, 2008), (Ritchie, 2010), (Cohean, 2002), (Jaudith, 2001), & (Stosky, 2006) assessing similar goals. Studies showed clearly the relation between psychotherapeutic interventions and decrease psychological symptoms, some studies showed the effectiveness of play therapy, or medication, others compared between different types of psychotherapies.

- **Population of the studies:**

Researchers used different population, some of them used adults, other used children. Most studies consisted from more then 100 samples that exposed to different kinds of interventions after trauma.

- **Instruments of the Studies:**

Most of the studies, which studied the effect of play therapy and medication after trauma used PTSD index. Others used meta analysis.

- **The Results of the Studies:**

Results were similar to each other in most of the studies. Studies which showed the both medication and play therapy are effective, and other showed that play therapy is more effective then pharmacological therapy.

3.7.3 Psychotherapeutic Interventions, Evaluation of Psychotherapy.

- **Objectives of the studies:**

Most of the previous studies (Qouta, 1996), (Thabet, 2003), (Armen, 2003), (Young & Parr, 2003), (Mayou, 2003), (Goenjian, 2005), (Yule, 2006), (Gupta, & Zimmer, 2008) were assessing similar goals. Studies showed clearly the relation between psychotherapeutic interventions and decrease or increase psychological symptoms after trauma. Some studies like

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(Mayou, 2003) and (Yule, 2006) talk about debriefing, while other studies used special types of psychotherapeutic interventions. (Stosky, 2006) explained the way in selecting the best treatment for the client (either psychotherapy or pharmacotherapy).

- **Population of the studies:**

Researchers used different population, some of them used adults, other used children, and many of them used adolescents. Most studies consisted from more then 100 samples that exposed to different kinds of interventions after trauma. Some studies used clients who faced natural disasters, while others used patients of chronic illness (cancer). (Mayou, 1998) used sample of adult after road traffic accident.

- **Instruments of the Studies:**

Most of the studies, which studied the effect of psychotherapeutic interventions after trauma used PTSD index. Others used sociodemographic, Gaza Traumatic Events Checklist, IES, CRMAS, and CDI.

- **The Results of the Studies:**

Results were similar to each other in most of the studies. Studies which showed the improving psychological status after psychotherapeutic interventions for different age group and due to different reasons. All results summarized in annex 14.

From the previous review of the literature, the author came to the conclusion that there is a need to conduct this study which aimed to evaluate the effectiveness of selected therapeutic interventions implemented in the mental health clinic of the Palestinian Ministry of Health for Gaza children after Crisis.

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Chapter 4

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Chapter 4
Methodology

4.1 Introduction

In this chapter the researcher presents the study methodology which includes: study design, study populations and samples, period of study, Inclusion and exclusion criteria, period of study, sample size, sampling process, inclusion criteria, exclusion criteria, reason for selecting sample, sampling process, description of the treatment program at the MOH mental health clinic, research tools, data collection, validity and reliability of instruments data entry process, and finally limitation of the study and ethical consideration.

4.2 Study Design

The design of this study is an evaluation case of study as it evaluates the psychological interventions that were used for children after crisis, as well as it measures specific indicators that reflect the factors that influence the psychological interventions. The study design was chosen because, it enables the researcher to meet the study objectives.

4.3 Study samples

There are 3 samples in this study. They are:

1- **Children** who came to "MOH" mental health clinic with their families, or attracted by it through community and complaints of PTSD due to war. The sample of the study is about 30 children aged from "6- 16" with their parents, (15 of them received psychological interventions, while the other 15 received pharmacological interventions) in Governmental mental health hospital after Gaza crisis.

2- Children 'parents: He or she could be either mother or father who lived the symptoms of children, and come to seek treatment from mental health clinic _Ministry of health.

3- **Health care providers** in the MOH mental health clinic, 6 of them participated in the treatment using either play therapy or medication.

4.4 Period of study

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The study was conducted on May 2009 after the researcher has the approval from the director of governmental mental health hospital in Gaza city. Data collection started on October 2009 and be continued to December 2009. Data entry, data cleaning and analysis, and writing of the final report continued till the beginning of January 2010.

4.5 Eligibility Criteria

4.5.1 Inclusion Criteria

- All children who complained from psychological trauma after Gaza war , developed PTSD, and got treatment in governmental mental health hospital for at least 4 sessions, male and female, from (6-16) years old
- All of them were included in the study by filling the researcher questioners with one of their parents.
- In addition to 6 community mental health clinicians.

4.5.2 Exclusion Criteria

- Mother's of a child who refuses to participate.
- Children who are not related to the previous criteria

4.6 Reasons for selecting the sample

As the researcher mentioned before that the total sample was 30 cases in governmental mental health hospital during limited period, from children who faced Gaza war and complaints of PTSD, and treated either by medication or play therapy. The researcher tried her best to contact this number of cases in the clinic, by phone, and reaching to their houses, however it was so difficult.

4.7 Sampling Process

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The researcher selected the study sample according to her inclusion criteria by covering all the study population conveniently.

4.8 Description of the treatment program at the MOH mental health clinic

There are different types of psychotherapy that are used in mental health clinic like cognitive behavioral therapy, medication, play therapy, and family therapy. The researcher used two types of psychotherapeutic interventions which are play therapy and medication.

The researcher conducted at least four sessions for the 30 cases. Fifteen were treated by medication from the first visit, and were not treated by any type of psychotherapy. The other 15 were treated by play therapy (free play, reading story, and drawing) with presence of their parents.

The researcher discussed with the psychotherapists the treatment process to ensure the principles are clear in their minds. The psychotherapist starts the treatment process once the child is diagnosed with PTSD. She gives the child a chance to have free playing for the first session. The psychotherapist has the right to guide the session if the child feels isolated or needs any help. The researcher closely monitored the psychotherapists.

4.9 Research tools:

The researcher has used 6 research tools to answer study questions. They are:

1. Document analysis for children files at the MOH mental health clinic, which described child age, name, diagnosis, type of psychotherapy or medication, name of psychotherapist, and follow up.
2. **Socio demographical questionnaires**: as it developed by Gaza community mental health team in 1999, which has 10 questions about social status for the client. It contains the following questions like age, name, socioeconomical status, ---etc (see annex11).
3. **PTSD questionnaires** which developed by Prof. Edua Fao in 2002 and has a scale of 17 questions to check the degree of PTSD for child, and that by checking reexperince, Hypervigillence, and avoidance of the traumatic experience. It contains the following questions (See annex 13).
4. **SDQ questionnaire**, which contains 25 questions designed for parents to talk about the personality manner for their child, and that through observations that done by parents. It

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is taken also from Gaza Community Mental Health program. It contains the following questions (see annex 8).

5. **Questionnaires to evaluate the service** in governmental mental health hospital from the parents' perspective. It contains 6 domains, the First domain is about general satisfaction for parents, the Second is about satisfaction of performance among community mental health worker, the Third one is about the psychotherapeutic service, the Fourth one is about hospital service, the Fifth one is about psychotherapeutic guidance, and the Last one is about the accessibility to reach to service (see annex 12).
6. **Focus group** which involves encouraging an invited group of participants from the MOH to share their thoughts, feelings, attitudes and ideas on certain subject related to this research. The researcher Invited around 6 community mental health worker to participate for a session to last for about an hour. Participants introduced themselves; open questions were used, which focused on the factors that affected psychological interventions from mental health care providers' perspectives.

4.10 Data Collection

The research used study tools in the following order: document analysis, socio demographic questionnaires, PTSD questionnaires, evaluation of service in governmental mental health hospital, and SDQ at the first visit. Evaluation of the service used at the end of the study with SDQ and PTSD questionnaires, as the questionnaires collected pre and post treatment. Focus group done for community mental health worker, who are working in mental clinic

With regard to questionnaires, the researcher prepared 30 folders of questionnaires, organized and numbered serially, in addition to, a consent form attached with each questionnaires encouraging mother to participate in the study for research benefits only with complete confidentiality. The answer period for each package was estimated to be around 30 minutes. The researcher checked all the questionnaires before data entry process.

4. 11 Psychometric Properties of research instruments

4.11.1 Validity

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Validity in general means the degree to which an instrument measures what is supposed to measure (Polit, 2004). There are different types of evidences that could be collected to include: contented related evidence, criterion–related evidence and construct related evidence. Content validity is concerned with sample adequacy of the content area being measured (Polit, 2004). It is also defined as the extent to which a test reflects the variables it seek to measure (Holm & Liwelly, 1986). In this study the researcher consulted four experts in the field who reviewed the instruments and as a result they indicated that the study tools are suitable for study purposes as they all had been used in the Palestinian context with high validity estimates.

4.11.2 Reliability

The reliability of an instrument is the degree of consistency with which the instruments measure the attribute. The less variation an instrument produced in repeated measurements of an attribute, the higher is its reliability (Polit, 2004). Another way to define reliability is in terms of accuracy; an instrument is reliable to the extent that errors of measurement are absent from obtained scores, the maximum true score and minimize error component.

Accuracy was insured for all questionnaires thought collecting data by recording inform from clients file, training mental health workers, collecting data, data entry, cleaning data, and analyzing it.

The researcher calculated reliability coefficients for study tools using Cronbach's alpha estimate. The coefficients were for PTSD questionnaire (0. 876), PTSD questionnaires (0.789) parents' satisfaction questionnaire domains (0.763), (0.943), (0.754), (0.909), (0.860), (0.715). With regard to focus groups questions, the researcher besides experts in the field agreed that the questions were clear and related to study questions.

4.12 Ethical consideration and procedures:

For completing this study scientifically, the researcher has assured having the ethical approval letters. The first one is to the director of governmental mental health clinic to get agreement to conduct this study in their society (see annex 9). The second letter was the explanatory letter for a mother for a child to explain for her the purpose and objective of the study (see annex 10).

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4.13 Variables of the study

The study included the following variables:

The Independent variable is:

- Group (medication, play therapy)

The dependent variables included:

- PTSD total score
- SDQ total score
- Parents satisfaction in addition total scores for each dimension.

4.13.1 Controlling the variables

To ensure the results accuracy and avoid unrelated inferences the researcher tried to control the study variables before the study. Mann Whitney test was conducted to see if there are differences between the two groups. Results were as follows:

Table (4-1): PTSD total scores for both groups (medication & play therapy) (Mann-Whitney) test.

Before treatment (PTSD)	N	Mean Rank	Sum Rank	Z value	Significance
Medication	15	7.06	56.50	1.104	0.270
Play therapy	15	9.07	63.50		

Table (4-1) showed that children who came to mental health clinic for treatment having PTSD symptoms as mean rank (7.06) for medication group and, mean rank (9.07) for play therapy group. Mann Whitney test showed that **no statistical significant differences** between groups (medication & play therapy) as a result showed that asymp. Sig=(0.270) , and that mean both groups came with the same severity of PTSD.

Table (4-2): SDQ total score for both groups (medication & play therapy) (Mann-Whitney) test.

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After treatment (PTSD)	N	Mean Rank	Sum Rank	Z value	Significance
Medication	15	8.52	99.00	2.921	.003
Play therapy	15	3.00	6.00		

Table (4-3) showed that children who came to mental health clinic for treatment having PTSD symptoms with a mean rank score (8.25) for medication group and mean rank score (3.00) for play therapy group from parents. Mann-Whitney test showed that there are **statistical significant differences** between both groups (medication & play therapy) as a result showed that asymp. Sig=(0.003), and that mean medication group's families found that there children have more symptoms.

4.14. Data entry and analysis:

The researcher completes entering all 30 packages of questionnaires using SPSS version under supervision of academic c supervisors.

Steps of data entry consist of;

- Reviewing the field questionnaires.
- Coding questionnaires.
- Identify data entry model
- Identifying variables.
- Coding variables.
- Cleaning data.
- Running frequency tables for study variables.
- Running descriptive statistics.
- Running Mann Whittney test.

4.15. Difficulties that faced the researcher

- Hard and unstable political situation especially after war on Gaza.
- Lack of experience about psychosocial interventions among staff who are working in the mental field.

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- Poor preparation of the place for psychological interventions due to poor economical status among governmental hospitals.

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Chapter 5

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Chapter 5

Results and Discussion

5.1 Introduction:

In this chapter the researcher presented and discussed the results of the statistical analysis of the data, including a descriptive analysis for demographic variables. In addition, the relationship between service provided and therapeutic interventions that given for the child were presented. Finally the researcher discussed the results in the light of study literature review, conceptual framework, researcher point of view, and results in Palestinian context..

5.2 Descriptive analysis for the study variables:

5.2.1.1 Demographic Characteristics

The following graphics describe the main socioeconomic and demographic characteristics of the study participants which consist of 30 subjects. The variables include: age, sex, parent's education, and occupation , salary, place and type of living area.

5.2.1.2 Child Age

The high percentage of children age was in a group their age up to 10 years old with the percentage of 60%, then age group less than 10y with percentage of 40% among children who are using play therapy as shown in figure (5.1), while (100%) of the children who are using medication above 10 years old.

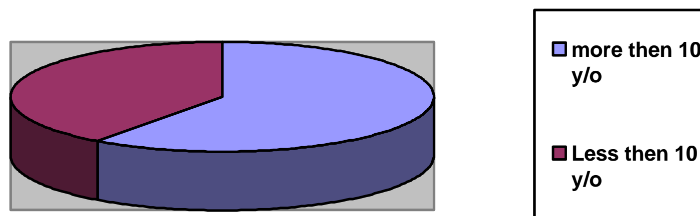

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Figure (5-1): Distribution of the study population by age for play therapy group

5.2.1.3 Gender of child

The highest percentage of PTSD children in this study was female with percent 53.3%, while male percentage 46.7% for group who are using play therapy as shown in figure (5.2)

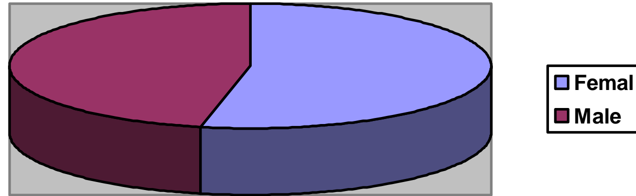

Figure (5-2): Distribution of the study population by gender (play therapy group)

The highest percentage of PTSD children in this study was for male with percent 60%, while female percentage 40% for group who are using medication as shown in figure (5.3).

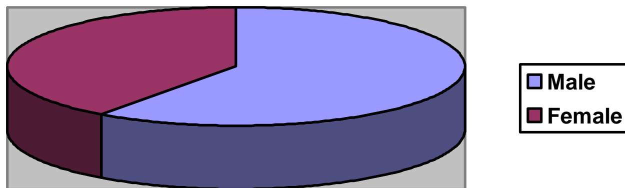

Figure (5-3): Distribution of the study population by gender (medication group).

5.2.1.4 Mother's education level;

With regard to child's mother education level, results showed that most of the children's mothers were at the preparatory level and secondary level equally with (33.3%) for both, after that non educated mothers come with (26.7%), and then come

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those with university level (6.7%) for a group of children who are treated by play therapy as in figure (5-4).

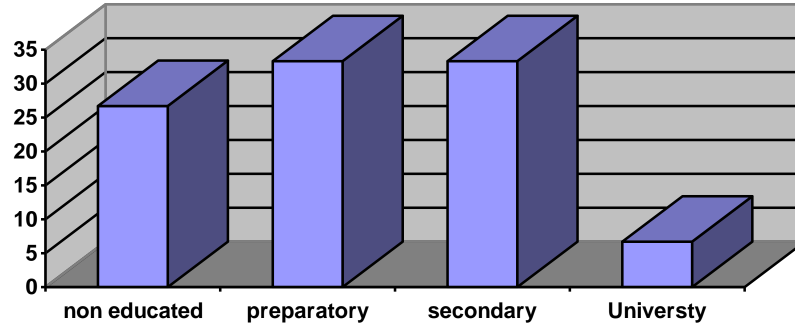

Figure (5-4): Distribution of the study population by mother's education (play therapy group)

Regarding to the group who used medication, researcher found that (53.7%) of mothers are non educated, while (20%) finished preparatory school, (26.7%) reach to secondary level, and no one continued university education as shown in figure (5-5).

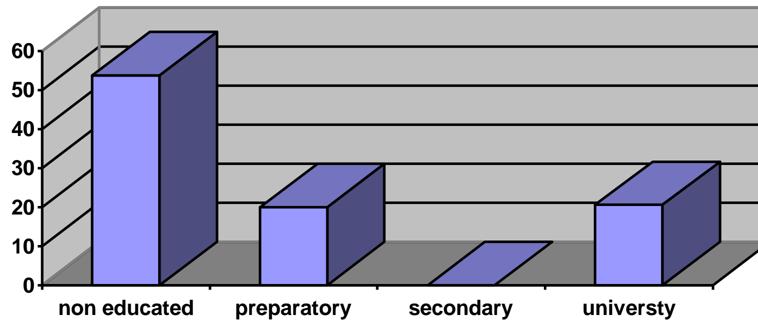

Figure (5-5): Distribution of the study population by mother's education (medication group)

5.2.1.5 Father's Education level;

Regarding to the group who used play therapy, researcher found that (40%) of fathers reach to secondary level, while (33%) finished preparatory school, (20%) are non

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educated, and the lowest level among university level, which reach to (6.7%) as shown in figure (5-6).

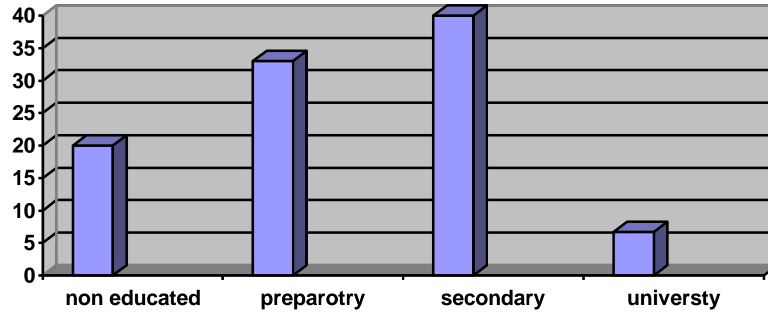

Figure (5-6): Distribution of the study population by father's education (play therapy group).

With regard to child's father education level, results showed that most of the children's father who are using medication were non educated (40%), then come those with secondary level (26.7%), (20%) with preparatory level, while the lowest percentage were those who had a university certificate 13.3% as in figure (5-7).

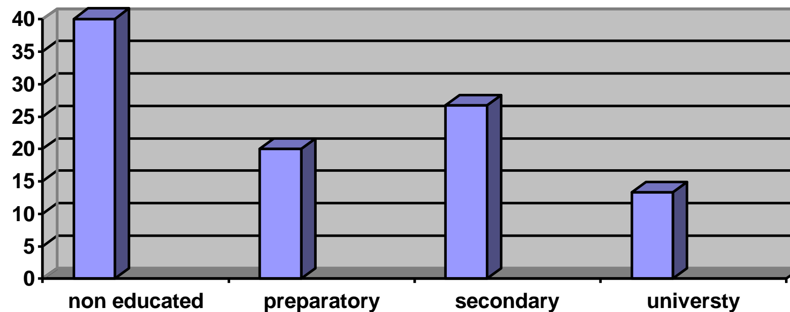

Figure (5-7): Distribution of the study population by father's education (medication group).

5.2.1.6 Mother's employment status;

The highest percentage with regard to mothers employment status showed that mothers were not employed with percentage (93.3%) for children who are treated by play

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therapy as shown in figure (5.8). (100%) of mothers are unemployment among children who are using medication.

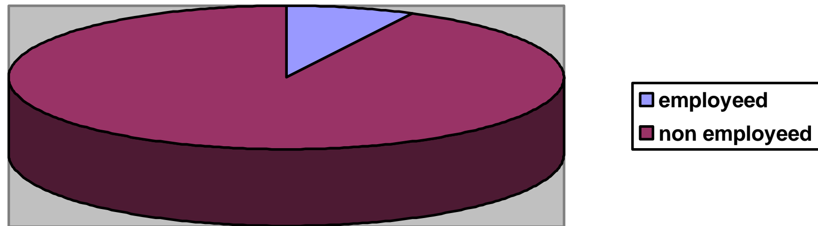

Figure (5-8): Distribution of the study population by mother's employment (play therapy group).

5.2.1.7 Father's employment status;

(80%) of fathers are working, while (20%) are not working among children who are using play therapy as shown in figure (5-9).

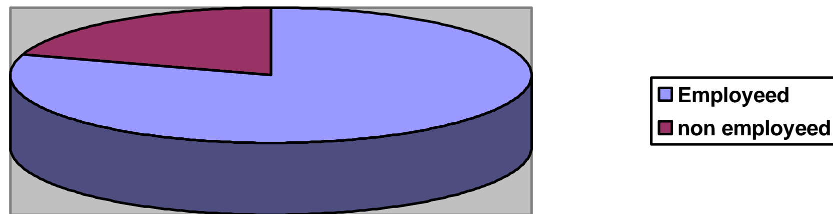

Figure (5-9): Distribution of the study population by father's employment (play therapy group).

Results show that 60 % of fathers working, while 40% are not working among children who used medication as shown in figure (5-10).

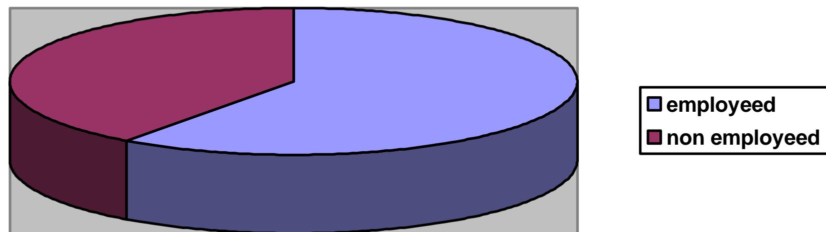

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Figure (5-10): Distribution of the study population by father's employment (medication group).

5.2.1.8 Socioeconomic status;

The highest percentage of children in this study was children with low socioeconomic status with percent 80% among children who are using play therapy, see figure (5-11).

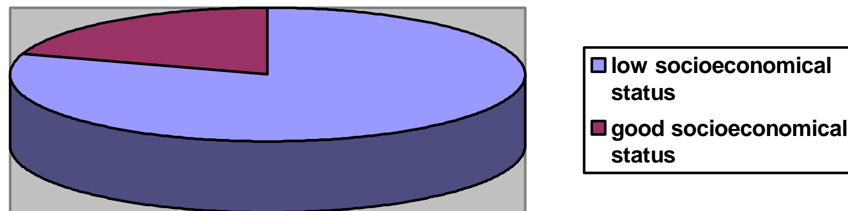

Figure (5-11): Distribution of the study population by socioeconomic status (play therapy group).

While the highest percentage of children in this study was children with low socioeconomic status with percent 73.3% among children who are using medication, see figure (5-12).

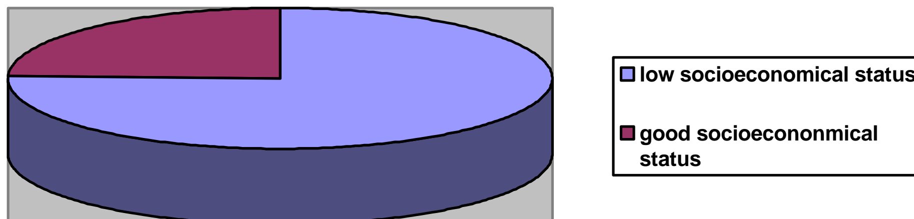

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Figure (5-12): Distribution of the study population by socioeconomic status (medication group).

5.2.1.9 Governorate:

The most of the study participants were from north area with percentage of 66.7, then Khanyouns and Rafah with percentage of 13.3, and the less one is Gaza with percentage 6.7% for groups who are using play therapy, see figure (5-13).

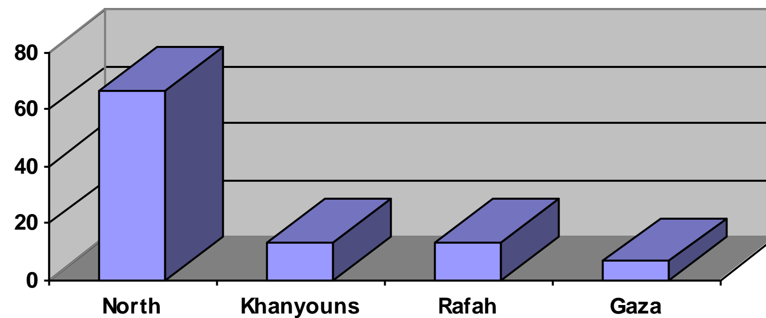

Figure (5-13): Distribution of the study population by governorate (play therapy).

While the most of the study participants were from the north area with percentage of 53.3%, then comes Gaza with percentage of 40%, and 6.7% for Kanyouns among children who are taking medication, see figure (5-14).

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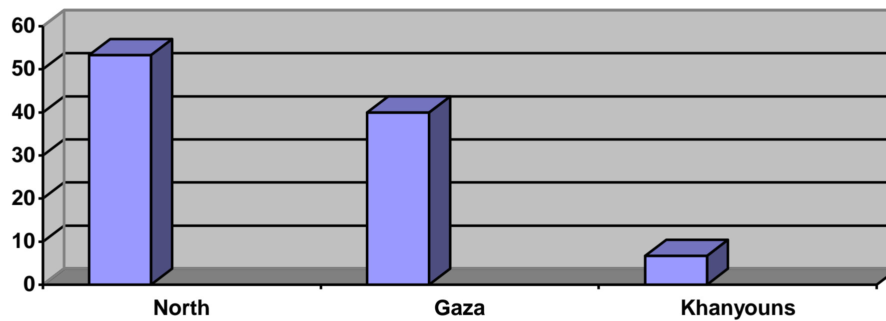

Figure (5-14): Distribution of the study population by governorate (medication group).

5.3 Results and interpretations:

5.3.1 Result of the first research questions:

First Question: What are the types of psychological interventions that were used with children in the mental health clinic in Ministry of Health?

Gaza war affected children severely; mental health clinic (MOH) received around 325 cases of traumatic children after war, 148 diagnosed as PTSD and the remaining numbers diagnosed with different types of psychological disorders. 100 children received different types of psychotherapeutic interventions, 30 of them were between 6-14 years old who treated either by play therapy or medication.

Focus group results with community mental health workers in addition to checking files for children who complaining of PTSD in mental health clinic- ministry of health, and between the periods of April till October, researcher showed the following;

Table (5-1): Types of psychotherapeutic interventions used MOH clinic

Types of psychotherapy	Age	Frequencies	Percentage
Cognitive behavioral	12-18	26	40%
Play therapy	6-16	17	26.1%

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Medication	12-18	17	26.1%
Family therapy	6-18	5	7.8%
Total	6-18	6 5	100%

The previous table showed that the most type used is cognitive Behavioral therapy with 40% in mental health clinic, Ministry of health, which also used by (Yule, 2006) in his research and showed the effectiveness of using CBT among traumatized patients.

Play therapy & medication are the second techniques that used with the same percent 26.1%, (Stosky, 2006), (Wethington, 2008), ((Ritchie, 2010), (Cohean, 2002), & (Jaudith, 2001) showed the effectiveness of using both medication & play therapy among depressed patients and after exposing to traumatic experience. Less percent are 7.8% among family therapy, and no studies showed the effectiveness or evaluation of family therapy.

(Thabet, 2003), (Young & Parr, 2003), (Mayou, 2003), (Thabet, 2005), (Gupta, & Zimmer, 2008) preferred to use short debriefing sessions instead of using a techniques with traumatized children.

5.3.1.1 Interpretation the result for the first question;

Researcher found that there are four types of psychotherapeutic interventions used and explained as it used in mental health clinic- Ministry of health. Collected data from community mental health workers showed that cognitive behavioral therapy is still not used as it should be used.

Cognitive-behavioral therapy for PTSD and trauma involves carefully and gradually “exposing” child to thoughts, feelings, and situations that remind him/her of the trauma. Therapy also involves identifying upsetting thoughts about the traumatic event, particularly thoughts that are distorted and irrational, and replacing them with more balanced picture. (Dohounus, 1988) said that Cognitive Behavioral therapy is one of the few forms of psychotherapy that has been scientifically tested and found to be effective in for many different disorders. In contrast to other forms of psychotherapy, cognitive

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behavioral therapy is usually more focused on the present, more time-limited, and more problem-solving oriented. Indeed, much of what the patient does is solve current problems. In addition, patients learn specific skills that they can use for the rest of their lives. These skills involve identifying distorted thinking, modifying beliefs, relating to others in different ways, and changing behaviors (Donohue, 1998). This result is congruous with (Yule, 2006) result, which showed the effectiveness of using CBT among traumatized patients.

Cognitive behavioral therapy is one of the difficult techniques to be used among community mental health workers especially in Gaza, and that due to many reasons ; First: staff in Gaza are not trained well to use cognitive behavioral therapy for PTSD patients as it supposed to be. Second: there is less professionals in this field, which can affect training process. Third; political situation in Gaza is very difficult due to the closure of border since 4 years, which make traveling in and out Gaza very difficult which affect staff capacity building, Finally to use cognitive behavioral therapy professionals need to have right diagnosis among PTSD patients.

Researcher has found that exposure techniques were used in clinic mostly under the name of cognitive behavioral therapy.

Play Therapy usually is used when children can't express their inner feeling only through playing. Community mental health workers used many types of play therapy depending on child age. Play Therapy is a specific counseling approach in which games, toys and mediums such as clay, drawings and paint are used to help a child or adolescent to express their emotions, thoughts, wishes and needs. It helps them to understand muddled feelings and upsetting events that they have not had the chance or the skills to sort out properly. Rather than having to explain what is troubling them, as adult therapy usually expects, children use play to communicate at their own level and at their own pace, without feeling interrogated or threatened (Livingston, 2000).

Medication is sometimes prescribed to people with PTSD to relieve secondary symptoms of depression or anxiety, but it does not treat the causes of PTSD, as showed by (Stosky, 2006) when he used medication for depressed patients after having traumatic experience. Most used medication in mental health clinic- Ministry of health is elatrol with anti hypnotic drugs.

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Play therapy with medication used equally for children with respect to age in ministry of health; as we found that regarding to medication, it used for children who are more then 12 years old while play therapy used mainly for children who are less then 16 years old.

Family therapy is the least one used due to shortage in community workers in Gaza. Since PTSD affects both child and those who close to him/her, family therapy can be especially productive. Family therapy can help family members understand what child going through. It can also help everyone in the family communicate better and work through relationship problems; unfortunately, researcher could not found any research about using or evaluating family therapy.

5.3.2 Result of the second question;

Second Question: To what extent the psychological interventions that were provided for children in mental health clinic of Ministry of Health were effective?

To answer the question, the researcher evaluated cases after using two different methods in treatment for the total PTSD scores and SDQ. Several hypotheses were tested.

Hypothesis one: There are no statistical significant differences in PTSD total score between medication and play therapy group after treatment.

Table (5-2): PTSD total score statistics for both groups (medication & play therapy) after treatment (Mann-Whitney) test.

After treatment (PTSD)	N	Mean Rank	Sum Rank	Z value	Significance

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Medication	15	17.27	259.00	-1.104	0.270
Play therapy	15	13.73	206.00		

Previous table showed that children who came to mental health clinic and received medication improved and that by decreasing symptoms of PTSD as mean rank score 17.27 for a grade of PTSD questionnaires , and improved also with play therapy as mean rank score 13.73 .

Mann-Whitney showed that **no statistical significant differences** between both groups (medication & play therapy). Null hypothesis is not rejected. Results showed that assumption sig = 0.270, and that mean both groups benefited from the treatment in the same manner and no difference between play therapy and medication group.

Researcher showed the effectiveness of using medication for traumatized children for reliving their symptoms, which was congruent with (Stosky, 2006) research when he wrote about the effectiveness of using medication for patients. (Wethington, 2008) In his study showed that people prefer to use non medical treatment more then pharmacological one, and children improved more with play therapy then with pharmacological treatment.

(Thabet, 2003), (Young & Parr, 2003), (Mayou, 2003), (Yule, 2006), (Thabet, 2005), (Gupta, & Zimmer, 2008) showed the effectiveness of using different types of psychotherapeutic interventions among traumatized children

(Thabet, 2003) result come incongruent with researcher results as he showed that there is no effectiveness of using extracurricular activities among schools children in Gaza.

The researcher's result is consist of the result of research studies for (Armen & others, 2003), (Young & Parr, 2003), (Mayou, 2003), (Yule, 2006), (Goenjian & others, 2005), (Thabet, 2005)& (Gupta & Zimmer, 2008), (Thabet, 2008) all of them reported that there was statistical significant between different types of psychotherapeutic interventions and decrease symptoms of PTSD among different age groups, especially children. Play therapy group and medication group improved, but play therapy group improved more.

The researcher interpreted this data using descriptive statistics with Mann-Whitney test after receiving both medication and play therapy treatment, so no statistical significant for both groups.

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Hypothesis two: There are no statistical significant differences in SDQ in medication group before and after treatment

To answer this question researcher used Wilcoxon test as showed in the following table;

Table (5-3): SDQ score statistics for medication group before & after treatment (Wilcoxon) test.

Dimension		N	Mean Rank	Sum of Ranks	Z value	Significance
1. General Difficulties	Negative Ranks	9a	7.61	68.50	-1.006a	.314
	Positive Ranks	5b				
	Ties	1c	7.30	36.50		
	Total	15				
2. Social Balance	Negative Ranks	4a	6.62	26.50	-1.342a	.180
	Positive Ranks	9b				
	Ties	2c	7.17	64.50		
	Total	15				
3. Hyperactivity balance	Negative Ranks	5a	5.50	27.50	.000a	1.000
	Positive Ranks	5b				
	Ties	5c	5.50	27.50		
	Total	15				
4. Emotional symptoms	Negative Ranks	9a	7.89	71.00	-1.790a	.073

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balance	Positive Ranks	4b				
	Ties	2c	5.00	20.00		
	Total	15				
5. Behavioral problem balance	Negative Ranks	6a	6.00	36.00	-.878a	.380
	Positive Ranks	4b				
	Ties	5c	4.75	19.00		
	Total	15				
6. Friends problems balance	Negative Ranks	7a	6.71	47.00	-.109a	.913
	Positive Ranks	6b				
	Ties	2c	7.33	44.00		
	Total	15				

Children who came to mental health clinic and received medication did not improved as mean rank score 7.61 before treatment and mean rank score 7.30 after treatment from family perspective. Wilcoxon results showed that there are **no statistical significant differences** between SDQ pre-test total score & SDQ post-test total score in medication group. Null hypothesis is rejected. Results showed that asymp. Sig= (0.314) and that mean, families who received medication for their children are not satisfied with treatment, and seeing that there children did not improved.

Wilcoxon results showed that there are **statistical significant differences** between SDQ pre-test score & SDQ post-test score for emotional balance in medication group. Results showed that asymp. Sig= (0.073) ,which mean families felt that Emotional balance for there children improved after receiving medications as mean rank 7.89 before treatment and 5.00 after treatment.

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(Jaudith, 2001) examined pharmacological and psychological treatment, he found that both groups improved from tow interventions, but they are improved from psychotherapeutic interventions more then that of pharmacological interventions.

(Stosky, 2006) wrote about the effectiveness of pharmacological therapy in treating depression and PTSD cases among patients. (Thabet & others, 2008) in his study showed that students improved after using psychotherapeutic interventions, while parents said that their children still have some behavioral problems . Researcher found the same result with parents, especially when they said that (Our children did not improved with medication).

All researcher results come with research result, as pharmacological treatment is effective, but not from family perspective, people in Gaza don't like to use medication and they prefer non pharmacological interventions.

Hypothesis three: There are no statistical significant differences in PTSD total score in medication group before and after treatment.

To answer this question researcher used Wilcoxon test as showed in the following table;

Table (5-4) PTSD total score statistics for both medication group before and after treatment (Wilcoxon) test.

Medication (PTSD), Before & After treatment	N	Mean Rank	Sum Rank	Z value	Significance
Negative	12	8.25	99.00	-2.921	0.003
Positive	2	3.00	6.00		
Ties	1				
Total	15				

Children who came to mental health clinic and received medication improved as mean rank score 8.25 before treatment and mean rank score 3.00 after treatment using PTSD questionnaires. Wilcoxon results showed that there are **statistical significant differences** between PTSD pre-test total score & PTSD post-test total score in

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medication group. Results showed that asymp. Sig= (0.003). Researcher showed the effectiveness of using medication for traumatized children for reliving their symptoms, which was congruent with (Wethington, 2008) discussed the effectiveness of using medication for traumatized children, which was consistent with researcher result, that children improved after using medication from mental health worker perspective. (Stosky, 2006) when he wrote about the positive effect of using medication for patients, and that mean child improved after taking the medication.

The researcher interpreted this data using descriptive statistics with wilcoxon test after receiving medication, and found that families felt that their children still having the symptoms of PTSD in the medication group. (Thabet & others, 2008) in his study showed that students improved after using psychotherapeutic interventions, while parents said that there children still have some behavioral problems . Researcher found the same result with parents, especially for medication group, which mean that they less satisfied with treatment.

Hypothesis four: There are no statistical significant differences in SDQ total score between medication and play therapy group after treatment

Table (5-5): SDQ total score statistics for both groups (medication & play therapy) after treatment (Mann-Whitney) test.

Dimension		N	Mean Rank	Sum of Ranks	Z value	Significance
1. General Difficulties	Medication	15	10.23	168.50	-2.662	.007
	Play therapy	15	19.77	296.50		
2. Social Balance	Medication	15	11.10	160.00	-1.611	0.005

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	Play therapy	15	18.90	280.00		
3. Hyperactivity balance	Medication	15	13.37	200.50	-1.333	0.183
	Play therapy	15	16.63	264.50		
4. Emotional symptoms balance	Medication	15	15.00	275	.000	1.000
	Play therapy	15	15.00	275		
5. Behavioral problem balance	Medication	15	13.5	200.00	-0.659	0.400
	Play therapy	15	16.50	257.00		
6. Friends problems balance	Medication	15	9.50	160.50	-1.342a	.006
	Play therapy	15	20.50	301.00		

Previous table showed that children who came to mental health clinic and received medication did not improved from family perspective as mean rank score (11.23) for a grade of SDQ questionnaires , and children who received play therapy improved from family perspective as mean rank score (19.77) .

Mann-Whitney showed that **there are statistical significant differences** between both groups (medication & play therapy). Results showed that asymp. Sig = (0.007).

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Mann-Whitney showed also that **there are statistical significant differences** between both groups (medication & play therapy) for social balance and friends problem balance with asymp sig = (0.005) & (0.006) for tow dimensions. Results showed that asymp. Sig = (0.007).

(Wethington, 2008) & (Ritchie, 2010) examined different types of psychotherapeutic interventions and talk about the effectiveness of psychotherapeutic interventions (especially; play therapy).). Study of (Cohean, 2002) was incongruent with researcher study, as he talk about the ineffectiveness of play therapy.

(Stosky, 2006) showed the effectiveness of using the medication, while (Thabet & others, 2008) in his study showed that students improved after using psychotherapeutic interventions, while parents said that there children still have some behavioral problems . Researcher found the same result with parents as they are not satisfied with pharmacological treatment.

Researcher result was consistent with other researchers result, especially for (jaudith, 2001),who showed that patients with PTSD improved with play therapy and other psychotherapeutic interventions more then that of pharmacological therapy, however (Cohean, 2007) showed that play therapy is not effective like CBT. All in all this study found that both medication and play therapy are effective, but play therapy is more effective then pharmacological therapy from family perspective.

5.3.2.3 Evaluating cases of the play therapy group:

Hypothesis five: There are no statistical significant differences in PTSD total score in play therapy group before and after treatment.

To answer this question researcher used Wilcoxon test as showed in the following table;

Table (5-6) PTSD total score statistics for play therapy group before & after treatment (Wilcoxon) test.

Play therapy (PTSD), Before & After treatment	N	Mean Rank	Sum Rank	Z value	Significance

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Negative	11	8.59	94.50	-2.639	0.008
Positive	3	3.50	10.50		
Ties	1				
Total	15				

Children who came to mental health clinic and received play therapy improved as mean rank score 8.59 before treatment and mean rank score 3.50 after treatment using PTSD questionnaires. Wilcoxon results showed that there are **statistical significant differences** between PTSD pre-test total score & PTSD post-test total score in play therapy group. Results showed that asymp. Sig = (0.008). Researcher showed the effectiveness of using play therapy for traumatized children for decreasing their symptoms, which was congruent with (Thabet, 2003), (Young & Parr, 2003), (Mayou, 2003), (Yule, 2006), (Thabet, 2005), (Gupta, & Zimmer, 2008) who showed the effectiveness of using different types of psychotherapeutic interventions among traumatized children

Hypothesis six: There are no statistical significant differences in SDQ total score in play therapy group before and after treatment

To answer this question researcher used Wilcoxon test as showed in the following table;

Table (5-7) SDQ total score statistics for play therapy group before & after treatment (Wilcoxon) test.

Dimension		N	Mean Rank	Sum of Ranks	Z value	Significance
1. General Difficulties	Negative Ranks	9a	7.31	65.50	-1.050a	.213
	Positive Ranks	5b				
	Ties	1c	7.30	36.50		
	Total	15				

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2. Social Balance	Negative Ranks	9a	7.25	89.00	-1.921	0.003
	Positive Ranks	2b				
	Ties	1c	3.00	5.00		
	Total	15				
3. Hyperactivity balance	Negative Ranks	6a	6.00	36.00	-.878a	.380
	Positive Ranks	4b				
	Ties	5c	4.75	19.00		
	Total	15				
4. Emotional symptoms balance	Negative Ranks	9a	7.89	71.00	-1.790a	.073
	Positive Ranks	4b				
	Ties	2c	5.00	20.00		
	Total	15				
5. Behavioral problem balance	Negative Ranks	6a	7.08	42.50	-0.629	0.530
	Positive Ranks	8b				
	Ties	1c	7.81	62.50		
	Total	15				
6. Friends problems balance	Negative Ranks	7a	7.00	60.00	-1.680a	.498
	Positive Ranks	3b				
	Ties	1c	8.00	40.00		
	Total	15				

Children who came to mental health clinic and received play therapy improved as mean rank score 7.30 before treatment and mean rank score 7.31 after treatment from

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family perspective using SDQ questionnaires. Wilcoxon results showed that there are no **statistical significant differences** between SDQ pre-test total score & SDQ post-test total score in play therapy group. Results showed that asymp. Sig= (0.213).

Table showed that there is statistical significant in social balance, and emotional symptoms balance which improved after treatment among children who are receiving play therapy from families perspective as asymp significance = (0.03) for social balance and (0.073) for emotional symptoms balance.

This result was different then others because it showed that there is no differences in traumatic symptoms before and after treatment from family perspective, and we can found that families who received play therapy was satisfied with their children situation before treatment, and bring them to the clinic for few symptoms. Researcher could not found other researches which support the same result.

(Ritchie, 2010) talk about the ineffectiveness of play therapy for traumatic children and found that CBT is more effective, while other researchers like (Wethington, 2008), (Cohean, 2002) & (Jaudith, 2001) talk about the effectiveness of play therapy.

5.3.2.4 Interpretation the result for evaluating cases between groups

The researcher's result is consist of the result of research studies for (Armen & others, 2003), (Young & Parr, 2003), (Mayou, 2003), (Yule, 2006), (Goenjian & others, 2005), (Thabet, 2005)& (Gupta & Zimmer, 2008), (Thabet, 2008) all of them reported that there was statistical significant between different types of psychotherapeutic interventions and decrease symptoms of PTSD among different age groups, especially children.

(Wethington, 2008) & (Ritchie, 2010) examined different types of psychotherapeutic interventions and talk about the effectiveness of psychotherapeutic interventions (especially; play therapy).). Study of (Cohean, 2002) wascongruent with researcher study, as he talk about the ineffectiveness of play therapy.

(Stosky, 2006) showed the effectiveness of using the medication.

Researcher result was consistent with other researchers result, especially for (jaudith, 2001),who showed that patients with PTSD improved with play therapy and other

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psychotherapeutic interventions more then that of pharmacological therapy, however (Cohean, 2007) showed that play therapy is not effective like CBT. All in all this study found that both medication and play therapy are effective, but play therapy is more effective then pharmacological therapy

The researcher interpreted this data using descriptive statistics with Mann-Whitney test and wilcoxon after receiving both medication and play therapy treatment, and found that families felt that their children still having the symptoms of PTSD in the medication group, and they need more intervention, while families who are using play therapy for their children are more satisfied before and after treatment. (Thabet & others, 2008) in his study showed that students improved after using psychotherapeutic interventions, while parents said that there children still have some behavioral problems . Researcher found the same result with parents, especially for medication group, which mean that they less satisfied with treatment

5.3.3 Result of the third question

Third Question: To what extent parents were satisfied with psychological interventions that provided for their children after crisis.

To answer this question, the researcher studied services in mental health clinic-ministry of health in Gaza from parents' perspectives. Mann- Whitney test was used after dividing provided services to six domains, for both families who are using medication and families who are using play therapy for their children.

5.3.3.1 First domain: General satisfaction for parents;

Hypothesis seven: There are no statistical significant in parents' general satisfaction total score between medication and play therapy group.

Table (5-8): General satisfaction total score statistics for both groups (medication & play therapy) (Mann-Whitney) test.

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General satisfaction	N	Mean Rank	Sum Rank	Z value	Significance
Medication	15	14.33	215.00	-0.729	0.466
Play therapy	15	16.67	250.00		

Previous table showed that children who came to mental health clinic and received treatment from both groups (medication & play therapy) are satisfied with service from family perspective as mean rank score (14.33) for medication group and mean rank sore (16.67) for play therapy group.

Mann-Whitney showed that **no statistical significant differences** between both groups (medication & play therapy). Null hypothesis is not rejected. Results showed that asymp. Sig=(0.466), and that mean both groups are satisfied with the services and no difference between them. Research studies for (Armen & others, 2003), (Young & Parr, 2003), (Mayou, 2003), (Yule, 2006), (Goenjian & others, 2005), (Thabet, 2005)& (Gupta & Zimmer, 2008), (Thabet, 2008) showed that children benefit from psychotherapeutic intervention which is one of the main important points of the service.

5.3.3.2 Second Domain: Satisfaction of the performance among community mental health clinic.

Hypothesis eight: There are no statistical significant in satisfaction performance among community mental health worker total score between medication and play therapy group.

Table (5-9): Performance total score statistics for both groups (medication & play therapy) (Mann-Whitney) test.

Performance	N	Mean Rank	Sum Rank	Z value	Significance
Medication	15	14.27	214.00	-0.768	0.461
Play therapy	15	16.73	251.00		

Previous table showed that children who came to mental health clinic and received treatment from both groups (medication & play therapy) are satisfied with

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performance among community mental health worker as mean rank score 14.27 for medication group and mean rank sore 16.73 for play therapy group.

Mann-Whitney showed that **no statistical significant differences** between both groups (medication & play therapy). Null hypothesis is not rejected. Results showed that asymp. Sig = (0.461), and that mean both groups are satisfied with community health workers performance. (Shalah, 2008) study showed that families for Down syndrome children are satisfied with worker performance for the workers.

5.3.3.3 Third Domain: Satisfaction with Benefits from psychotherapy:

Hypothesis nine: There are no statistical significant in benefits from psychotherapy total score between medication and play therapy group.

Table (5-10): Psychotherapy total score statistics for both groups (medication & play therapy) (Mann-Whitney) test.

Psychotherapy	N	Mean Rank	Sum Rank	Z value	Significance
Medication	15	13.37	200.50	-1.333	0.183
Play therapy	15	17.63	264.50		

Previous table showed that children who came to mental health clinic and received treatment from both groups (medication & play therapy) are satisfied with psychotherapeutic intervention as mean rank score (13.37) for medication group and mean rank sore (17.963) for play therapy group.

Mann-Whitney showed that **no statistical significant differences** between both groups (medication & play therapy). Null hypothesis is not rejected. Results showed that asymp. Sig=(0.183), and that mean both groups are satisfied with the psychotherapeutic interventions and no difference between them. Research studies for (Armen & others, 2003), (Young & Parr, 2003), (Mayou, 2003), (Yule, 2006), (Goenjian & others, 2005), (Thabet, 2005)& (Gupta & Zimmer, 2008), (Thabet, 2008) showed that children benefit from psychotherapeutic intervention which is one of the main important points of the service.

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5.3.3.4 Forth Domain: Satisfaction with hospital services:

Hypothesis ten: There are no statistical significant in satisfaction in hospital services total score between medication and play therapy group.

Table (5-11): Hospital services total score statistics for both groups (medication & play therapy) (Mann-Whitney) test.

Hospital services	N	Mean Rank	Sum Rank	Z value	Significance
Medication	15	11.13	167.00	-2.721	0,006
Play therapy	15	19.87	298.00		

Previous table showed that children who came to mental health clinic and received treatment from both groups (medication & play therapy) are satisfied with service from family perspective as mean rank score (11.13) for medication group and mean rank sore (19.87) for play therapy group.

Mann-Whitney showed that **there are statistical significant differences** between both groups (medication & play therapy). Results showed that asymp. Sig=(0.006) , Table showed that play therapy group are more satisfied with hospital services then that of medication group, which come congruent with researcher outcome in this study (Family for medication group not satisfied with treatment , while play therapy group satisfied more), and it comes congruent also with (Thabet & others, 2008) study which showed that students improved after using psychotherapeutic interventions, while parents said that there children still have some behavioral problems . .

5.3.3.5 Fifth Domain: Satisfaction with Psychotherapeutic guidance:

Hypothesis eleven: There are no statistical significant in satisfaction with psychotherapeutic guidance total score between medication and play therapy group.

Table (5-12): Psychotherapeutic guidance total score statistics for both groups (medication & play therapy) (Mann-Whitney) test.

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After treatment (PTSD)	N	Mean Rank	Sum Rank	Z value	Significance
Medication	15	13.37	200.50	-1.333	0.183
Play therapy	15	17.63	264.50		

Previous table showed that children who came to mental health clinic and received treatment from both groups (medication & play therapy) are satisfied with psychotherapeutic guidance as mean rank score 13.37 for medication group and mean rank sore 17.63 for play therapy group.

Mann-Whitney showed that **no statistical significant differences** between both groups (medication & play therapy). Null hypothesis is not rejected. Results showed that asymp. Sig=(0.183), and that mean both groups are satisfied with psychotherapeutic guidance. Research studies for (Armen & others, 2003), (Young & Parr, 2003), (Mayou, 2003), (Yule, 2006), (Goenjian & others, 2005), (Thabet, 2005)& (Gupta & Zimmer, 2008), (Thabet, 2008) showed that children benefit from psychotherapeutic guidance which is one of the main important points of the service.

5.3.3.6 Sixth domain: Satisfaction with Place of service;

Hypothesis twelve: There are no statistical significant in satisfaction with place of service total score between medication and play therapy group.

Table (5-13): Place of service total score statistics for both groups (medication & play therapy) (Mann-Whitney) test.

After treatment (PTSD)	N	Mean Rank	Sum Rank	Mean	Std. Deviation	Z value	Significance
Medication	15	14.77	221.50			-0.460	0.653
Play therapy	15	16.32	243.50				

Previous table showed that children who came to mental health clinic and received treatment from both groups (medication & play therapy) are satisfied with place

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of hospital as mean rank score 14.77 for medication group and mean rank sore 16.32 for play therapy group.

Mann-Whitney showed that **no statistical significant differences** between both groups (medication & play therapy). Null hypothesis is not rejected. Results showed that asymp Sig=(0.653) , and that mean both groups are satisfied with place of service. (Shalah, 2008) study showed that families for Down syndrome children are satisfied with services as a whole.

5.3.4 Interpretation the result of the fourth question;

As a general to all domains, there was a high percent of families who benefited from different types of services in mental health clinic- Ministry of health study results assured the result when most of the participant said “that our children benefited too much from mental health clinic in Gaza”.

Most families were satisfied with different types of services that provided by clinic specifically psychotherapeutic interventions. This result come congruous with the study result of (Thabet, 2008), as he found that students benefited from psychotherapeutic interventions. The researcher's result is consist with result of the research studies for (Armen & others, 2003), (Young & Parr, 2003), (Mayou, 2003), (Yule, 2006), (Goenjian & others, 2005), (Thabet, 2005)& (Gupta & Zimmer, 2008) all of them reported that there was statistical significant between different types of psychotherapeutic interventions and decrease symptoms of PTSD among different age groups, especially children. The result of this study was congruous with the result of the researcher study after finding that the families satisfied with all services, except the hospital service, as it mentioned in (Shalah, 2008) study. In other hand, researcher found that play therapy group is more satisfied then medication group regarding to the hospital service, and this result not found in other researches.

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Chapter 6

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Chapter 6
Recommendations and suggestions

6.1. Introduction;

In this chapter, the researcher recommend and suggests some recommendation that could help the policy maker and service provider to improve services for traumatic children to reach qualified level of services, and that deepened in the following results;

5. Cognitive behavioral therapy not used in professional and theoretical manner in mental health clinic ministry of health.
6. Children who are using play therapy or medication are improved equally after treatment.
7. Play therapy group improved more then medication group from family perspective.
8. Play therapy group satisfied more then medication group with hospital services.

6.2. Recommendations;

After analysis the result of this study, the researcher recommended some points to manager of Gaza mental health hospital in order to provide the best qualified service, another recommendation is to manager of mental health sectors in order to take care of this category of children in Gaza strip.

First- Recommendations to Gaza mental health Hospital;

1. Policy maker of hospital should be informed with the result of the study to make decision regarding the negative aspects that need more development to improve service.
2. Service provider should be integrated with highly graduated external training skills program to improve their abilities and to keep updating with newly challenges and skills.
3. According to the study result, most of families satisfied with services, but still families are not satisfied with psychological interventions, which need more improvement.
4. Try to motivate community health worker by increase and improve their role and increase their training regarding to psychotherapy.

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5. Improve community working by increasing contact with children and their families thought home visit.
6. Try to have consultant or specialist in play therapy as a treatment for children.
7. Use medication carefully with the children.
8. Improve and increase different types of psychotherapy in a ware zone areas.
9. Help in identifying and improving cognitive behavioral therapy.

Second- Recommendation to Managers of Mental health sectors;

1. The researcher recommends to manager of mental health sector to study and discuss the availability to increase training in children psychotherapy.
2. The researcher recommends increasing cooperation between governmental and nongovernmental organization to highlight the quality for caring for PTSD cases among children.
3. The researcher recommends increasing the awareness of people regarding to the service and involving them in psychotherapeutic interventions for their children.

Suggestions;

The researcher found this category of children needs to make more suggested research study as the following;

1. The researcher suggests conducting a research study to compare between all types of psychological interventions that used to improve quality of care in Mental Health Clinic- Ministry of Health.
2. The researcher suggests conducting a research study about psychological interventions that provided for children in Palestinian context.
3. The researcher suggest conducting a study to evaluate the way of conducting psychotherapeutic sessions in Palestinian context..
4. The researcher suggests conducting a longitudinal study to evaluate the cases of PTSD for long time and to see best interventions in such cases.
5. The research suggests conducting a study to perceive service provider perceptions about the services in Mental Health Clinic-Ministry of Health.

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6. The researcher suggests conducting a study to measure the satisfaction of community mental health worker and it is effectiveness on the quality of services provided for mental illness patients.
7. The researcher suggests conducting a research to evaluate the psychological interventions in all mental health clinics that provided a care for patients in Gaza.
8. The researcher suggests conducting a study about family perspective with psychological interventions, and how to improve it.
9. The researcher suggests conduct a study about side effects of medication that given for children.
10. The researcher suggests conducting a study about criteria that should be used in mental health clinic to select best psychological intervention for a child with PTSD.

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Annexes

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Annex1

المنارة للاستشارات
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Annex 2

بسم الله الرحمن الرحيم

السيد الدكتور/ة ----------------------- حفظه/ا الله

السلام عليكم ورحمة الله وبركاته

الموضوع/ استبانة تقييم لبعض الطرق العلاجية المستخدمة فى مركز الصحة النفسية بوزارة الصحة الفلسطينية لأطفال غزة بعد الأزمة

أرجو الله تعالى أن تكونوا بخير وعافية وبعد،،،

الاشارة الى الموضوع أعلاه ، فإنني أتشرف بأن أضع بين أيديكم عدة استبانات بعنوان:

- **تقييم لبعض الطرق العلاجية المستخدمة في مركز الصحة النفسية بوزارة الصحة الفلسطينية لأطفال غزة بعد الأزمة .**
- **مقياس القوة والصعوبات للمشاكل النفسية للأطفال- للوالدين 4-16 سنة**
- **مقياس كرب ما بعد الصدمة.**
- **استبيان الحالة الاجتماعية والاقتصادية.**

الاستبانات المذكورة والمرفقة في هذه الرسالة، هي الأدوات التي ستستخدمها الباحثة في إعداد بحث لنيل درجة الماجستير من قسم الصحة النفسية المجتمعية في كلية التربية بالجامعة الإسلامية والذي يحمل عنوان تقييم لبعض الطرق العلاجية المستخدمة في مركز الصحة النفسية بوزارة الصحة الفلسطينية لأطفال غزة بعد الأزمة ، تحت إشراف الأستاذ المشارك في قسم علم النفس بالجامعة الاسلامية / د. سناء أبو دقة.

إن الباحثة قامت باستخدام عذه استبانات لتقوم بتطبيقها على عينة من المستفيدين من خدمات العلاج النفسي المقدمة من مركز الصحة النفسية بوزارة الصحة الفلسطينية في غزة.

لذا أرجو التكرم بإبداء رأيكم وتوجيهاتكم في الاستبانة المرفقة من حيث ملائمة العبارات والفقرات، وسلامتها اللغوية والقيام بتقييم أو حذف بعض العبارات أو الفقرات التي ترون أنها بحاجة إلى تعديل أو حذف.

أثمن لكم عاليا حسن اهتمامكم ، وكلي أمل أن أتلقى ردكم في القريب العاجل، سائلة المولى عز وجل أن يجعل ذلك في موازين حسناتكم ، وجزاكم الله خيرا.

شاكرة لكم حسن تعاونكم وكريم جهدكم

وتفضلوا بقبول فائق الاحترام والتقدير

الباحثة / رانية محمد طلب عياش

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Annex 3

استمارة وصف الاستبانة للمشاركات في الدراسة

عزيزتي الأم/ ....

السلام عليكم ورحمة الله وبركاته وبعد.....

إنني أثمن مشاركتك الصادقة والأمينة في تعبئة الاستبانة التي تمثل جزءا من مشروع دراسة ماجستير بمجال الصحة النفسية المجتمعية بالجامعة الإسلامية بغزة، إذ أن الهدف من هذه الدراسة هو تقييم لبعض الطرق العلاجية المستخدمة في مركز الصحة النفسية بوزارة الصحة الفلسطينية لأطفال غزة بعد الأزمة.
فمشاركتك بهذه الدراسة سيكون لها دور قيم في معرفة مدى فاعلية هذا البرنامج، وكذلك في وضع السياسات والخطط المستقبلية في برامج هذه العيادة، وسيكون لها بالغ الأثر والتأثير ، مع العلم بأن المشاركة اختيارية، مع حرصنا وتأكيدنا لك على سرية المعلومات التي تقدمينها في الاستبانة وان الإجابة لن تؤثر على تلقيك للخدمة.

الباحثة/ رانية عياش

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Annex 4

استبيان الحالة الاجتماعية والاقتصادية

1. العمر ....

2. الصف
الابتدائي ....   الإعدادي..........................   الثانوي............................

3. الجنس
ذكر.......................   أنثى...............................

4. مكان السكن: شمال غزة ....   غزة ....   الوسطى
خانيونس............................   رفح....................

4.نوع السكن :   مدينة...............   مخيم.......................   قرية...............................

5. عدد الإخوة: ....

6. سنوات تعليم الأم: ....

7. سنوات تعليم الأب: ....

8. عمل الأم: ربة بيت.............................   موظفة ....   عاملة ....   أخرى
حدد........................

9. عمل الأب: لا يعمل...................   موظف........................   عامل........................
صانع.................   مزارع........................   تاجر.........................   أخرى.....................

10. دخل الأسرة الشهري: أقل من 600 شيقل.....................   من 601-1200 شيقل..................
من 1201-2500 شيقل......................   من 2501_3000شيقل...........................   أكثر من
3000 شيقل...............................

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Annex 5

تقييم الطرق العلاجية المستخدمة في مركز الصحة النفسية بمستشفى الطب النفسي بوزارة الصحة الفلسطينية لأطفال غزة بعد الأزمة

البيان	لا أوافق بشدة	لا أوافق	لا أعرف	أوافق	أوافق بشدة
أولا: الرضا العام					
1. بصورة عامة أنا راضية عن الخدمات التي يتلقاها طفلي في المستشفى					
2. إذا احتاج طفلي لأي خدمات علاجية في المستقبل سأعود لنفس المستشفى					
3. لو أتيحت الفرصة بخيارات أخرى سأواصل تعاملي مع نفس المستشفى					
4. أنا راضية عن الطريقة التي يتعامل بها المعالجين مع طفلي					
5. أنا راضية عن مستوى الخبرة التي يتمتع بها المعالجون					
6. أنا راضية عن الوقت الذي يقضيه طفلي أثناء الجلسة العلاجية.					
7. لا أشعر أن طفلي يستفيد من خدمات التدخل المبكر مقارنة مع غيره من الأطفال					
8. أنا راضية عن عدد جلسات طفلي أثناء الفترة العلاجية					
9.أنا راضية عن التحسن في وضع طفلي مع الخدمة المقدمة له					
10. أنا راضية عن الوقت الذي يقضيه المعالج النفسي مع طفلي					
ثانيا : أداء العاملين في البرنامج					
1. يقترح المعالجون الخطة العلاجية التي تلبي رغبات العائلة					
2. يشرح المعالجون بإسهاب كل خيارات العملية العلاجية الموجودة بالطريقة اللتي أفهمها					
3. يناقش المعالجون معي كل التوقعات المحتملة لحالة طفلي					
4. يتأكد المعالجون من أن قدرات طفلي معروفة تماما لكل العاملين معه					
5. يتقبلني المعالجون أنا وعائلتي بصورتي الحالية					
6. يعطيني المعالجون إجابة منطقية لكل أسئلتي					
7. يخبرني المعالج عن السبب في حال اختياره لخطة علاجية معينة					
8. يعرض المعالجون دائما تغذية رجعية ايجابية ويشجعونني					
9. يتأكد المعالجون من تواصل الفريق معي وبشكل دائم					
10. يعطني المعالج الفرصة في الوقت والمكان المناسب لتلقي المعلومات.					
11. يسألني المعالج عن وجهة نظري في الخدمة المقدمة					

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12. يراعي المعالج توفير الجو المناسب لي ولعائلتي					
13. يحرص المعالج على تلبية احتياجات طفلي قياسا بسنه					
14. يتعامل المعالج معي ومع طفلي كانسان أكثر من كونه كحالة					
15. يتأكد المعالج من وجود طاقم على درجة عالية من الذوق والعطف للتعامل معي					
16. لا أشعر بسرية أثناء تعاملي مع المعالج					
17. يتوفر لدى المعالج المعلومات الكافية عن حالة طفلي والحالة المستقبلية له					
18. يراعي المعالجون مشاعر العائلة لوجود طفل مريض لديهم					
19. أشعر باحترام المعالج لي					
20. أشعر باهتمام لي ولطفلي من قبل طاقم المستشفى					
21. أشعر بأن المعالج يبدي اهتمامه التام للسماع لي					
22. أشعر بأنني أعاني المشقة في سبيل الحصول على الخدمات المطلوبة لطفلي					
23 . المعالج يبدي كل جهوده في مساعدتي للحصول على الخدمة					
24. أشعر بأن لي دور في تنفيذ الخطة العلاجية لطفلي					
25. أنا راضية عن مدى مشاركتي في ذلك					
ثالثا: مدى الاستفادة من الخدمات النفسية					
26. أنا راضية عن الخدمات النفسية التي تتم لطفلي في المستشفى					
27. أملك القدرة الكافية على التعامل مع طفلي في المنزل لتحديد وضعه النفسي					
28. أصبحت قادرة على التعامل مع بعض المشاكل النفسية لدى طفلي					
29. لو احتاج طفلي علاج أو مشورة خارج المستشفى، أنا راضية عما تقدمه المستشفى في تلك الحالة					
30. الخدمات النفسية في المستشفى تغني عن الذهاب إلى أي مستشفى أخرى					
31. المعالجين النفسيين يحرصون على عمل فحوصات طبية إذا لزم الأمر					
32. إذا احتاج طفلي لتحويله إلى مكان أكثر تخصصا لا أجد صعوبة في ذلك					
33. أشعر أن مشاكل طفلي النفسية تزداد منذ التحاقي بهذه المستشفى					
34. إذا احتاج طفلي أي دواء فهو متوفر في المستشفى					
رابعا: مدى الاستفادة من خدمات المستشفى					
35. أنا راضية عن عدد زيارات فريق العمل لطفلي للتواصل معه					
35. فعليا أنا مستفيدة من الاستشارة المقدمة من فريق العمل في كيفية التعامل مع طفلي لو تعرض لأي مشكلة نفسية					
36. أنا راضية عن المساعدات المقدمة من المستشفى					

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37. أنا راضية عن الندوات والو رشات التي يعقدها الفريق لتوعية الأسرة والمجتمع					
38. أشعر بأن الندوات والو رشات ساهمت في تقبل مرض طفلي بشكل كبير					
39.المعالج النفسي يحرص على عمل زيارة ميدانية في البيت لتقييم وضع الطفل فيه					
40. إذا تعرض طفلي لأي مشكلة فان فريق المعالجين هو أول من يزور طفلي في البيت					
خامسا: مدى الاستفادة من خدمة التوجيه والإرشاد النفسي					
41. أرى أن المعالج النفسي يقدم لي كل الخدمات المتعلقة بطفلي بصراحة					
42. أرى بأن المعالج النفسي يحثني على السؤال والاستفسار عن طفلي					
43. أرى بأن التثقيف والإرشاد الأسري كافي للتعامل مع طفلي بأمانة					
44. أشعر بأن طفلي يتحسن كلما ازداد الدعم النفسي من المعالج					
45. خدمة التوجيه والإرشاد النفسي لها بالغ الأثر في تخفيف التوتر لدي					
46. أشعر بأن خدمة الإرشاد النفسي ساعدتني على التكيف مع مشكلة ابني بشكل كبير					
سادسا: إمكانية الوصول للخدمة					
47.مكان المستشفى ملائم للمواصلات العامة والمسافة					
48. ساعات الدوام في المستشفى ملائمة لي لزيارتها					
49. أعتقد بأن المواعيد التي يحددها مقدمو الخدمات لي للمراجعة والاستفسار ملائمة					
50. أنا راضية عن سهولة المواصلات (باصات خاصة)					

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Annex 6

مقياس القوة والصعوبات للمشاكل النفسية للأطفال- للوالدين 4-16 سنة

اسم الطفل--------------------------------------- الجنس: ولد------ بنت: -------- العمر--------

عزيزي الأب/ عزيزتي الأم
أمامك مجموعة من البنود التي تصنف التصرفات التي يظهرها بعض الأطفال بعد كل إجابة هناك ثلاث أعمدة (لا، أحيانا، نعم) تماما خلال الستة أشهر الماضية، إذا كان في اعتقادك بأن الطفل لا يظهر التصرف فضع علامة صح على الخانة الموجودة تحت العمود الأول "لا" إذا أظهر الطفل تصرف ولكن أقل درجة و اقل حدوثا نضع علامة صح في الخانة الموجودة تحت العمود الثاني "أحيانا" . إذا أظهر الطفل التصرف الموصوف في الاستبانة نرجو أن تضع علامة صح تحت العمود الثالث "نعم".

البنود	لا	أحيانا	نعم
1. يعمل حساب لمشاعر الناس الآخرين			
2. غير مستقر في مكان واحد ويتنطط من مكان لأخر وكثير الحركة			
3. يشكو من صداع، وجع في المعدة ، والشعور بالمرض			
4. يشارك الأطفال الأخريين في الألعاب والأدوات المدرسية			
5. تنتابه نوبات من فقدان السيطرة على أعصابه تماما مع الصراخ والحركات الغاضبة			
6. وحيد ويميل إلى اللعب لوحده			
7. مطيع على وجه العموم ويفعل ما يطلبه منه البالغون			
8. عنده هموم عديدة، عادة يبدو عليه القلق			
9. يساعد الآخرين إذا ما حدث لهم مكروه أو شاهدهم متضايقين			
10. يتململ وعصبي باستمرار			
11. لديه على الأقل صاحب واحد وحيد			
12.عادة يتعارك مع الأطفال الأخريين ويعاكسهم			
13. عادة غير سعيد والدموع في عينيه			
14. على العموم محبوب من الأطفال الآخرين			
15. من السهل شد انتباهه وتركيزه قليل			
16. عصبي أو متشبث بالآخرين في المواقف الجديدة ومن السهل أن يفقد ثقته في نفسه			
17. لطيف مع الأطفال الأصغر منه			
18. عادة ما يكذب ويغش			
19. يستهزأ منه ويعاكسه الأطفال الآخرين			
20. عادة ما يتطوع لمساعدة الآخرين (الوالدين، المدرسين، الأطفال الآخرين)			
21. يفكر كثيرا قبل التصرف في أي شئ			
22. يسرق من البيت ، المدرسة أو أي مكان أخر			
23. . يتماشى أحسن مع البالغين عنه مع الأطفال الآخرين			
24. لديه مخاوف وسهل اخافته			
25. يكمل واجباته للنهاية ولديه انتباه جيد			

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Annex 7

نموذج تقييم اضطراب ضغط ما بعد الصدمة

إليكم قائمة في عدد من العوارض التي تظهر لأشخاص قد مروا في تجربة صادمة, نطلب التفكير في التجربة والتركيز على الجزء الأصعب خلال تعبئة هذا النموذج. اقرأوا الجمل التالية بتمعن, اشروا بتقييمكم من خلال وضع عدد من 0- 3 الذي يصف بشكل دقيق قدر الإمكان إلى أي مدى أثارت تلك التجربة ضيق خلال الأسبوعيين الأخيرين.

0 = بتاتا غير صحيح, أو قد حصل فقط مرة واحدة.
1= مرة في الأسبوع أو أقل.
2 = 2-4 مرات في الأسبوع.
3 = 5 مرات أو أكثر في الأسبوع وكأنه كل الوقت.

1	أفكار أو مشاهد من الحدث تبدأ وتدخل قصرا	0 1 2 3
2	أحلام مزعجة وكوابيس على الحدث الصادم	0 1 2 3
3	شعور جديد كأنها تحدث الآن	0 1 2 3
4	شعور في دوران الذي يذكر في التجربة (ذهول, غضب, حزن, شعور بالذنب)	0 1 2 3
5	ردود فعل فيزيولوجية جسمية تذكر في الحدث الصادم (تعرق, دقات قلب بشدة)	0 1 2 3
6	محاولات عدم التفكير أو الكلام عن الحدث، أو الشعور بمشاعر مرتبطة به	0 1 2 3
7	محاولات امتناع عن أماكن، أعمال،أشخاص التي تذكر بالحدث	0 1 2 3
8	عدم القدرة على تذكر جزء مهم من الحدث	0 1 2 3
9	هبوط وتراجع في الاهتمام بالمشاركة بكثير من الفعاليات المهمة	0 1 2 3
10	شعور بالاغتراب والانقطاع عن أشخاص في بيتك	0 1 2 3
11	شعور في تبلد المشاعر (تبلد عاطفي) مثل عدم استطاعة البكاء أو الحب	0 1 2 3
12	شعور في أن المستقبل سلبي وأن البرامج الشخصية سوف لا تتحقق (مثل أن لا تكون لك مهنة، زواج، أولاد، حياة طويلة)	0 1 2 3
13	صعوبة في النعاس أو عملية النوم	0 1 2 3
14	شعور في عدم الهدوء ، نوبات غضب	0 1 2 3
15	صعوبات تركيز (مثل، شرود الفكر خلال التكلم، صعوبة متابعة حديث في التلفاز، صعوبة تذكر ما تم قراءته)	0 1 2 3
16	شكوك مبالغة (مثل كل شئ سئ سوف يحدث)	0 1 2 3
17	يقظة مبالغة (مثل كأن شخص ما يلاحقك)	0 1 2 3

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Annex 8

SDQ for Psychological problem among children- For parents 4-16 years

Child Name: ----------------- Sex: Boy---------- Girl---------- Age------------

Dear Mother/ Dear Father
In front of you there are many behaviors that appear on your child, after every answer you can find three columns (No, Some times, Yes) in the previous six months, If you think that your child has the following behaviors check in the box that has No. If some behaviors appear in small manner put some times. If child has the following behaviors put right.

Items	No	Some time	Yes
1. Care about the feelings of others			
2. Cant stay in one place, jump from place to other, has a lot of movement			
3. Complaints of headache, stomach pain, and sickness			
4. Share other children with plays, and school activities			
5. Complaints of nervousness, a lot of shouts , with angry movement			
6. Isolated and like to play alone			
7. Obey order and do what adult asking him			
8. Has a lot of problem and appear anxious			
9. Help others if they have problems			
10. easily to be boring and nervous always			
11. Has at least one friend			
12. Usually has a fight and problems with others			
13. Usually unhappy and appear tearfulness			
14. Other children like him			
15. It easy to attract his attention and has low concentration			
16. Nervous and depend on other if there is any new idea, and doesn't trust him self			
17. Like Small children			
18. Usually lying and cheating			
19. Mocks and fun brain by others			
20. Always help others like parents, teachers, and friends			
21. Think a lot before doing anything			
22. Steal from home, school, or other place			
23. Deal more with adults then with other children			
24. It easy to make him anxious and has anxious feeling always			
25. Do all of his homework and has good concentration			

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Annex 9

Dear DR./-----------------------------

May God's peace and mercy be upon you,,,

<u>Subject: The questionnaire of the Evaluation of Selected therapeutic interventions Implemented in the mental health clinic of the Palestinian Ministry of Health for Gaza children after Crisis.</u>

Referring to the above subject, I am glad to put in your hands the questionnaires entitled;

- **Evaluation of Selected therapeutic interventions implemented in the mental health clinic of the Palestinian Ministry of Health for Gaza children after Crisis.**
- **SDQ**
- **PTSD Questionnaires**
- **Socio demographic questionnaires**

The mentioned questionnaires, which are attached to this letter, is the tool used by the researcher in preparing for the Master's degree in the department of Community Mental Health in Islamic University/ College of Education , which is entitled " Evaluation of Selected therapeutic interventions Implemented in the mental health clinic of the Palestinian Ministry of Health for Gaza children after Crisis", under supervision of associate professor in the department of Psychology in the Islamic University, Dr. Sana Abu Dagga.

The researcher used these questionnaires to be applied to a sample of the beneficiary of mental health clinic in governmental hospital in Gaza.

Thus, I ask you kindly to give your opinion and guidance about this questionnaires regarding: the phrases and paragraphs, language, and making all the suitable amendments, or deleting certain words or paragraphs, which you believe need to be modified or deleted.

I highly appreciated your cooperation, and hope to hear from you soon.

With my best regards.

Yours Sincerely,

Researcher: Rania Aiash

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Annex 10

Description of Questionnaires to Share in the Study

Dear Mother,
May God's Peace and mercy be upon you.

I highly appreciate your sincere and honest participation in filling these questionnaires, which is part of the study for obtaining a Master Degree in Community Mental Health from Islamic University-Gaza.
The objective of this study is to evaluate the selected therapeutic interventions Implemented in the mental health clinic of the Palestinian Ministry of Health for Gaza children after Crisis. Your participation in this study will have a valuable role to learn the effectiveness of psychotherapeutic interventions , as well as, the development of policies and programs in the future plans of his society, noting that the participation in this questionnaires is confidential and will not effect the service you receive from society.
Researcher/ Rania Aiash

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Annex 11

Socio demographic Status Questioners

1. **Age: ……………….**

2. **Class:**

Primary…………………… Preparatory……………… Secondary………………

3. **Sex:**

Male………………… Female…………………..

4. **Place:**

North………………. Gaza City………………. Middle area……………. Khanyounes…………….. Rafah…………………

5. **Type of area:**

City………….. Camp………………. Village…………….

6. **Number of brothers & sisters: …………………..**

7. **Mother's education………………………..**

8. **Father's education………………………**
9. **Mother's occupation**

House wife…………… Employee……………… Worker……………. Other things………………

10. **Father's occupation**

No work…………………. Employee……………. Worker……………. Maker……………. Farmer…………… Dealer…………… others…………….

11. **Family's Salary**

Less then 600 shekel…………….. From 601-1200 shekel…………… From 1201-2500 shekel………………… From 2501-3000 shekel………….. More then 3000 shekel

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Annex 12

Evaluation of psychotherapeutic interventions and services that provided in mental health clinic_ Ministry of Health for children in Gaza after crisis.

Statement	Strongly disagree	Disagree	Don't Know	Agree	Strongly Agree
First: General Satisfaction:					
1. You are satisfied with the services that received by your child in the hospital.					
2.If my child need any treatment I will return to the same hospital.					
3. If you have the opportunity of finding other options, you will continuo your interaction with the hospital.					
4. You are satisfied with the way your child is treated by psychotherapist.					
5. You are satisfied with the performance level of the psychotherapist in the hospital.					
6. You are satisfied with the time you wait before receiving the treatment.					
7. You feel that your child not benefits from early interventions.					
8. You are satisfied with the number of psychotherapeutic sessions that given for your child.					
9. You are satisfied with the service that provided to your child.					
10. You are satisfied with the time that psychotherapist spend it with your child.					
Second: Assessing the performance of the service providers in the program.					
1. The workers present the remedial plan that suits your child (psychotherapy or medication).					
2. All workers explain the plan's therapeutic options.					
3. Psychotherapist discusses with you					

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4. Workers are keeping that the capabilities of your child will be known to all.					
5. Psychotherapist receive you and your child with respect					
6. Psychotherapist answer your questions truthfully					
7. Psychotherapist tell you about the reason for selecting specific plan for your child					
8. Psychotherapist encourage you to ask questions about every thing you do not understand of the plan					
9. Psychotherapist will be sure about your interaction with team.					
10. Psychotherapist give you the opportunity at the appropriate time and place to receive information.					
11. Psychotherapist asks about your point of view of the therapy provided.					
12. Psychotherapist provides the right atmosphere for you and your child during receiving the service.					
13. Psychotherapist is keen to meet the needs of your child as she /he progress in age.					
14. Psychotherapist deal with me and my child as a human more then as a case.					
15. I feel that psychotherapist have a good way in dealing with us.					
16. You do not feel the confidentiality during the work with your child.					
17. You feel that psychotherapist has enough formation about your child status and his prognosis.					
18. Psychotherapist respect family emotion as they have a sick child.					
19. You feel that the psychotherapist respect you.					

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20. Team takes care of me and my child.					
21. I feel that psychotherapist listen to me carefully.					
22. You feel that you suffer hardship in order to obtain the services required for your child.					
23. Psychotherapist presents all his/her efforts in helping you to obtain service.					
24. I feel that I have role in implementing psychotherapeutic plan.					
25. I am satisfied in sharing.					
Third: Benefits from psychotherapeutic service.					
26. I am satisfied with psychotherapeutic service that provided for my children.					
27. I have the ability to deal with my child psychological problem in the house.					
28. I able to deal with some psychological problem.					
29. If my child need any advise or help outside the hospital , I satisfied with the one I got it inside my hospital					
30. Psychotherapeutic services in this hospital is enough for my child					
31. Psychotherapeutic team care to do medical checkup if the case needed.					
32. If my child needs transfer to a specialist, I don't find any problem among this hospital.					
33. I feel that my child psychological status become more worse when I came to this hospital					
34. If my child needs any medication, it will be available in the hospital.					
Fourth: Benefits from hospital services.					
35. I am satisfied with the number of					

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home visit that the team provided it to my child.					
35. I benefit from the consultation that given to my child in the hospital regarding to his psychological status.					
36. I am satisfied with the help that provided from the hospital					
37. I am satisfied with sessions and workshop that given to us to improve social status for the family.					
38. I feel that sessions and workshop that provided in hospital help me to accept my child illness.					
39. Psychotherapist care to visit my child in home to follow his status.					
40. If my child complaints from any problem psychotherapist team is the first one who visit him.					
Fifth: Benefit from Psychological guidance					
41. I feel that psychotherapist provide me with all services that I need it to my child					
42. I see that psychotherapist encourage me to ask about my child.					
43. I feel that the psychological guidance help me to deal with my child honestly.					
44. I feel that my child improve when he got psychological support.					
45. Psychological guidance help me in decreasing my attention.					
46. Psychological guidance help me in adapting with my child problem.					
Sixth: Ability to reach to service.					
47. It easy to reach to the place of service					
48. Work time is good to me to reach to them.					
49. Appointment time is good to me for follow up.					
50. I am satisfied with transportation.					

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Annex 13

Evaluation of PTSD

This is a list of some symptoms that appear on a client after having a trauma, Please, try to think and concentrate on the difficult part when you fill this paper. Read the following sentences carefully, Describe the situation by choosing the numbers from 0-3, which describe clearly if the pervious traumatic experience effect you in the last tow weeks.

0= not happened, or at least once only.
1= Once a week or less.
2=2-4 times a week.
3= 5 times or more a week.

1	Thoughts or views from traumatic experience start and enter to your mind		
2	Night mars or terrors about traumatic event.		
3	Feeling that it is happened now		
4	Feeling of events that remind the person of traumatic experience (unreality, angry, sadness, guilt feeling)		
5	Physiological response that remind person with event (sweating, palpitation)		
6	Try to prevent thinking or talking about the event, or feeling about it		
7	Prevent places, works, or people that remind person with the event.		
8	Inability to remind an important part of event		
9	Decrease sharing in many events		
10	Feel loneliness in your house.		
11	Loss feeling about sadness or love		
12	Hopelessness about the future (EX: no work, inability to get married, or have children, or have long life)		
13	Difficulty in sleeping process		
14	Not quite and nervous		
15	Difficulty in concentration (decrease concentration while talking, inability to follow conversation in the television, inability to remember what he or she read)		

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16	Sever doubt (Every things bad will happened)		
17	Hypervigellence (As if some body follow you)		

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