On-Going Trauma, PTSD & (OTSD)
The Palestinian Experience

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Abstract: This research study aimed to get acquainted with the prevalence of PTSD, and other psychological suffering among Palestinian children living under severe conditions during 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 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%). Also results of factor analysis revealed four factors that interpret 39% of the total variance, re - experience factors and avoidance were not existed.

In September, 2000, a new Palestinian uprising began against the now 37-year old Israeli military occupation. The immediate cause was the visit of then Israeli Knesset Member Ariel Sharon accompanied by over 1000 fully armed Israeli riot police to what Jews call the Temple Mount and Muslims, the Noble Sanctuary ("El-Haram A-Sharif") on which sits Al-Aqsa Mosque. Palestinians' protest of the violation of their holy place resulted in Israeli police shooting several unarmed protesters. This event provided the immediate spark for Palestinian protests throughout the West Bank and Gaza Strip, as well as the name for an uprising that continues at this writing, "The Al-Aqsa Intifada." The more distant cause for this second and more violent Intifada was the evident failure of the Oslo peace process. Instead of a lasting peace between Israelis and Palestinians, Oslo agreement has followed by a 50% increase in Israeli settlement building and land confiscation (KUKA), a decrease in Palestinian freedom of movement and lack of civil liberties (KUKA), and economic de-development including high unemployment.

As the "Al–Aqsa Intifada" continues into its fourth year, the Israeli army frequently shells and destroys the Palestinian homes. Since October 2000 until 31 of January 2004, 3062 homes have been completely and partially demolished and 2524 homes need to be repair in Gaza Strip (UNRWA, 2004). The army uses a variety of methods to destroy homes, including tank shells, bulldozing, helicopter gunship, and fighter aircraft. As homes have been bombarded and made uninhabitable, many Palestinian families have found themselves living in tents.

When families witness the destruction of their own homes by enemy soldiers, the psychological effects can be serious. Loss of home can be a traumatic experience for not only material loss but for psychological meaning. The home means a shelter and heart of family life. It contains memories of joy and pain as well as attachment to the families' objects. Home is associated with feelings of security and consolation.

As in all modern wars, the victims of the latest Middle Eastern war are mainly civilians. We have an accumulated knowledge about the children's responses to air raids, bombardment, shelling, loss of family members and being target and witnessing killing and destruction. It involves research on acute responses during the II World war (Brander, 1941; Dunsdon, 1941; Freud & Burlingham, 1943), mental health Middle Eastern children during military attacks (Bryce & Walker, 1986; Baker, 1990; Macksoud & Aber, 1996; Milgram & Milgram, 1976; Ziv & Israeli, 1973; Saigh, 1991), as well as military violence and persecution in Africa (Dawes, 1992; Cliff, 1993) and Europe (Smith, Perrin, Yule, & Rabe-Hasketh, 2001). Children's responses to danger and life-threat include anxiety, somatization and withdrawal symptoms, and especially younger children may regress into the earlier stages of development (Yule, 2002). While almost all children respond with excessive fear, sleeping difficulties and clinging to parents in acute trauma, only a smaller minority develop posttraumatic disorders.

A substantial amount of research is available on the severity of PTSD symptoms and predictive factors among Middle Eastern children, especially of Kuwaiti children during the nine-months of Iraqi occupation (Hadi, & Llabre, 1998; Llabre & Hadi, 1994; Macksoud & Aber, 1996; Nader, & Pynoos, 1993; Pynoos, 1994; Nader, Fairbanks, Punamaki, 1984) and Israeli children during the Iraqi scud missile bombardment (Klingman, 1992;

Lavee & Ben-David, 1993; Laor, Wolmer, & Cohen, 2001; Laor, Wolmer, Mayers, Gershon, Weitzman, & Cohen, 1997; Weisenberg, Schwarzwald, Waysman, Solomon, & Klingman, 1993; Rahav & Ronen, 1994; Rosenthanl & Levy-Shiff, 1993). The percentages of PTSD diagnosis vary from 22% among Israeli (Laor et al., 1997, 27% among Lebanese (Saigh, 1991) 41% among Palestinian children from Gaza exposed to shelling, (Thabet & Vostanis, 1999) 48% among Cambodian refugee children (Kinzie, Sack, Angell, Manson, & Rath, 1996; Sack, Clarke, & Seeley, 1995), 52% among children from Bosnia-Hercegovina (Smith, Perrin, Yule, Hacam, & Stuvland, 2002), and 78-88% among Iraqi children exposed to bombardment (Dyregrov, Gjestad, & Raundalen, 2002). Longitudinal studies on the PTSD are rare, and they reveal that once the fighting and danger are over, the posttraumatic symptoms decrease considerable (Laor et al., 2001; Punamäki, Qouta, & El Sarraj, 2001). Among Kuwaiti children, the share of severe level of PTSD was 4% after one year of traumatic events, among Iraqi children and among Israeli children 0% after five years (Laor, et at. 2001). Dyregrow et al (2002) followed shelled children at six months, one year and two years, and showed first increase from 84% to 88%, and then decrease to 78% of PTSD.

The physical and emotional proximity, severity and nature of the traumatic event prescribe the nature and severity of psychological problems (Macksoud & Aber, 1996; Qouta, Punamäki, & El-Sarraj, 1996; Punamaki, 1998; Pynoos, et al., 1987; Klingman, 1992). For example, Bryce et al. (1989) found that especially displacement from home increased depression among Lebanese children and women during the 1982 Israeli invasion. Laor et al., (1997; 2001) found among Israeli children that while posttraumatic stress symptoms decreased generally after the Iraqi shelling, the symptoms increased among displaced children.

The present study examines the levels of PTSD among Palestinian children during the current Intifada. We guess that the nature of ongoing trauma will have its impact on the dimension on PTSD.

1 - METHOD1

1.1 - The Sample

The sample consisted of 944 children ranging between 10-19 years, randomly selected from all part of Gaza Strip with Arithmetic mean (15.1±1.5). 49.7% of the sample was boys while 50.3% were girls. Refugee children represented 76.8% of the sample and the rest were citizen's residents. Seven field workers had participated in the field work, which done at schools, with co-operation of the teacher and headmasters,

1.2 - Measurements

1.2.1 - Trauma questionnaire scale:

This was developed for this study by the Gaza Community Mental Health Programme. It consists of 12 traumatic events frequently experienced by Palestinian children during the "Al-Aqsa Intifada" (Box 1). Seven events refer to direct exposure to the traumatic events (e.g., tear gas, shooting, or deprivation of medical help), while five events refer to witnessing military violence, (e.g. witnessing killing and injuring). Reliability by Alpha Cronbach was .82.

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1.2.2 - . PTSD Scale (Posttraumatic Stress Disorder Scale) (DSMIV, American Psychiatric Association, 1994).

For the purposes of this study, PTSD refers to chronic and not acute PTSD since the events described by the youths were associated with lifetime trauma exposures. The scale was based the Clinician Administered PTSD published in the Journal of Traumatic Stress. **The Child Posttraumatic Stress Reaction Index (CPTS-RI)**: **)**: this follows DSMIV criteria, developed by Nader and used to measure PTSD in youths aged 12 and over.[i] Children's PTSD-*symptoms* were assed by the Child Posttraumatic Stress Disorder Reaction Index (CPTS_RI).[ii] The 20-symptom scale is used to assess the degree of a child's reactions to a selected traumatic event, and covers the intrusive re-experiencing of the event, avoiding related memories and numbing feelings and increased hyper-arousal. The older children (13-16) reported themselves and the interviewer estimated together with younger children the occurrence of the symptoms on a five-point scale: (0) none of the time, (1) little of the time, (2) some of the time, (3) much of the time, and (4) most of the time.

The maximum sum score is 80 and minimum 12, and in our sample the range was 11-68. Averaged sum variables were constructed for intrusive (9 items), avoidance (7 items) and hyper-arousal (4 items) symptoms. The CPTS_RI has been found to be reliable and valid in predicting trauma impacts among Arab children in Palestine (Punamaki et al., 2001; Qouta et al., 2001) and Kuwait (Nader & Pynoos, 1993; Hadi, & Llabre, 1998).

2 - RESULTS

Research on the "Prevalence of PTSD among Palestinian Child during in Gaza Strip" showed the results of the psychological suffering among Palestinian children living under severe conditions during the last two and half years of Al-Aqsa Intifada in hot and community areas of the Gaza Strip. The most prevalent types of trauma exposure for children in the community areas is for those who had witnessed funerals 94.6%, witnessed shooting 83.2%, witnessed shooting, 66.9 %; saw a friend or a neighbor being injured or killed 61.6% and were tear gassed 36.1%. (see table 1).

Table No (1)

Shows the Prevalence rate of the traumatic experiences among children in the community areas

Direct Personal experience	Frequency	Percentage (%)
Shelling of the home	179	19
Severe burns	89	9.4
Shot by live bullets	26	2.8
Shot by plastic bullets	31	3.3
Head injury with loss of consciousness	23	2.4
Deprivation of medical help	73	7.7
Witnessing traumatic events		
Saw shooting, fighting or explosion	785	83.2
Saw stranger being injured or killed	632	66.9
Saw friend or neighbor being injured or killed	584	61.6
Saw family member being injured	239	25.3
Saw funerals	893	94.6

It was found that 32.7% of the children in the community areas suffered from acute level of PTSD while 49.2.1% children suffered from moderate level of PTSD at the same time 15.6% children suffered low level of PTSD and we can say that 2.5% children had no symptoms while in hot areas 54.6% of the children suffered from acute level of PTSD (see table 2). While 34.5% children suffered from moderate level of PTSD at the same time 9.2% children suffered low level of PTSD and we can say that 1.7% children had no symptoms.

Table No(2)

Shows The severity of PTSD according to the child's gender PTSD score

PTSD score	All (boys and girls)	
	%	N
None or Doubtful (<12)	2.5	24
Mild (12-24)	15.6	147
Moderate(25-39)	49.2	464
Severe (>40)	32.7	309

The study found significant differences between boys and girls. In the acute level of PTSD, 57.9% girls developed such symptoms while the percentage among the boys was 42.1% (see table 3).

Results of factor analysis revealed 5 Factors that interpret 47% from variance. Re-experience Factor was dropped (see table 4).

Table No(3)

Shows the severity of PTSD according to the child's gender PTSD score

PTSD score	Girls		Boys	
	%	N	%	N
None or Doubtful (<12)	25	6	75	18
Mild (12-24)	38.8	57	61.2	90
Moderate(25-39)	50.2	233	49.8	231
Severe (>40)	57.9	179	42.1	130

Table No(4)

Shows the results of Factor structure of PTSD scale with loading N=947

Item No	Item description	Loading
Factor 1		
2	Do you get scared, afraid or upset when you think about (event)?	.59
5	Do you have good or bad dreams about (the event)?	.53
9	Do you feel more alone inside or more alone with your feelings – like other people really don't understand how you feel about what you went through?	.57
10	Have you felt so scared, upset, or sad that you couldn't even talk or cry?	.58
11	Do you startle more easily or feel more jumpy or nervous than before (the event)?	.62
14	Do thoughts or feelings about what happened get in the way of remembering things, like what you learned at school or at home?	.52
19	Do you have more stomach aches, headaches or other sick feelings since (the even) than you did before?	.62
20	Is it harder for you to keep from doing things you wouldn't have done before? For example, getting into fights, disobeying more, bike riding you take more recklessly, taking other kinds of chances, climbing on things, swearing at someone, not being carefully when you cross the street or during play?	.49
	Factor variance explained	16.84
Factor 2:		
1	Is (event/ what happened) something that would upset, or bother, most children your age a lot?	.63
3	Do you go over in your mind what happened that is, do you see pictures in your mind or hear sounds in your mind about (the event)?	.49
6	Do things sometimes make you think it might happen again?	.74
	Factor variance explained	8.29
Factor 3		
16	Do you want to stay away from things that make you remember what happened to you? (What you went though)?	.82
17	When something reminds you, or makes you think about (event) do you get tense or upset?	.41
	Factor variance explained	7.03
Factor 4		
12	Do you sleep well?	.63
15	Is it as easy to pay attention (concentration) as before (the event)?	.70
	Factor variance explained	6.67

3 - DISSCCUSION

Trauma is a field which has grown immensely, particularly in the wake of theory of posttraumatic stress disorder. As theories have become solidified in this field, however, societal and cultural considerations still constitute a large and important area of exploration, and there still exists an urgent need to develop new perspectives on coping with trauma which take these considerations into account.

At the same time as trauma has taken a preeminent role in psychiatry and psychology (mainly since the advent of posttraumatic stress disorder in 1980), it has also caused what can be seen as a paradigmatic break in both fields. While psychologists and psychiatrists were previously considered with the individual him/herself as a starting point, the study of trauma gives primacy to an event. The assumption in any case of traumatic stress is that the individual has experienced some event outside the range of usual human experience that makes it remarkable. The person then suffers a well-defined type of disorder which can be analyzed. Several questions are still raised, however:

- To which events do the concepts of "trauma" and "posttraumatic stress disorder apply"? What are the characteristics of the specific stressor?
- What is the precise relation between the event and its consequences?
- Is disorder the necessary result of an extreme event? Is anyone who has been confronted with the particular event by definition a patient?
- To which persons does the term apply – victims in the literal sense, bystanders, rescue wonders and other professionals, or family members?
- Are "trauma" and "posttraumatic stress disorder" universal concept in the sense that they allow us to understand the behavior of people in other cultures?

Key to answering all of these questions is recognizing one very important fact:

Contextual and circumstantial factors in the traumatizing experience and in their aftermath have to be taken into serious consideration. To this end, Summerfield argues in his essay that behavior is as much socially constructed as it is a function of the psychological attributes of an individual. Most models in medicine and psychology are limited because they do not embody a socialized view of mental health. However, exposure to trauma and its aftermath is generally not a private experience, and the social and cultural context in which it takes place must be considered. MacFarlane argues to the same end that the tools of measurement in this field are often significantly flawed. He shows that the reliability and validity of measures of the intensity of an individual's exposure have not been systematically examined, and the methods of statistical analysis contain a series of built-in assumptions that are seldom questioned. What these authors demonstrate is that trauma is indeed context-bound, and as a result we have the enormous task of carefully constructing context-bound definitions of illness, trauma, and expectable symptom logy.

This article reports the level of PTSD among Palestinian children currently exposed to war and bombardment, and the role of children trauma perspective to the future outlook. The results revealed a high level of PTSD: more than a half (32.7%) of the children suffered from severe level of PTSD symptoms. The percentage corresponds with the levels of PTSD among the Cambodian (Kinzie, et al., 1996; Sack et al., 1995), and Bosnia-Herzegovian (Smith et al., 2002) refugee children fleeing atrocities in their home countries. The level of PTSD was considerably higher than was reported among Lebanese and Israeli children, 22% (Laor et al., 1997), but lower than was reported among Iraqi children, 84% (Dyregrov et al., 1993).

There are some context-specific characteristic of the current trauma that may explain the children's high level of PTSD. First, the long duration for the conflict means more than an acute disaster for Palestinians as the children exposed to on going traumatic experiences, and that means the continuation of the stress for long periods, which damage the child psyche, and increased the rate of PTSD, and the results of the factor analysis revealed that the continuous trauma has specific characteristics, as the re-experience and avoidance factors did not exist, so we can say that we have new disorder can be called on-going traumatic Stress disorder(OTSD) which can applicable on the Palestinian context, as the child here has certain suffering that the concept of PTSD,not fit to be used

With regard to the source of trauma for the Palestinian people, many researches indicated that Israeli authorities were held responsible for the majority of direct trauma exposure, an attribution that has face validity since tear gassing, home demolitions and injuries due to bullet wounds have been widely reported by news agencies, Israeli and Palestinian human right organizations and an UNRWA field investigator (PCHR 2001, Palestinian National Authority, State Information Services, 2001). Not surprising under the circumstances, researches found a high level of behavioral problems and neurotic symptoms among the children, who had an average level of 6 PTSD symptoms. Again, this confirms the fact that a safe home fulfills a basic need and makes it possible to establish secure and adaptive human relationships. Tragically, the protective shield that is essential for children's mental health is dramatically destroyed when their families are faced with the shelling and demolition of their homes.

Our knowledge about the effect of violent trauma on children's mental health derives from the experience of both human-made and natural disasters. Studies on the effect of war on civilians come from the experience of the Second World War, contemporary conflicts in the Middle East, South Africa, Ireland and Bosnia, as well as the effect of urban violence targeted at American children. Traumatic experiences and conflicts are the reality of many people throughout the world. All of us have imagines of the civilians victims of contemporary conflicts and what happened for the Palestinian since 1948 uprooting, is a serious of disaster.

As in all modern wars, the victims of the latest Middle East war are mainly civilians. Palestinian uprising and Israeli military attach to suppress are mainly children. We have an accumulated knowledge about the human being's responses to air raids, bombardment shelling, loss of family member and being target and witnessing killing and destruction. Children's and adult's responses to danger and life-threat include anxiety, somatization and withdrawal symptoms, and especially among younger children regression to the earlier stages of development and clinging to parents. Family's ties are considered one of the most important protectors of the child mental health in war conditions.

Children living in conditions of political violence and war have been described as "growing up too soon", "losing their childhood", and taking political responsibilities ample maturation

(Boothby, Upton, & Sultan, 1992). This development is predicting to result in negative psychological consequences (Garbarino, Kostelny, & Dubrow, 1991).

It is tragic fact that Israeli and Palestinian children have become laboratories for the study of the relationship between trauma and violence, conflict, and children's well being during war. Wars and battles have been fought without interruption in the region for fifty years. None of these wars, however, have brought a solution to the conflict between Jaws and Arabs.

Palestinian children have not known a day of real peace. Since the war area is small it is difficult to protect children from sights of destruction, the dangers of war and insecurity. Many of these children have taken part in their national struggle. Even if they were not actively fighting on the streets, as so may were they still could not help but experience the national struggle on an emotional level. The atmosphere of insecurity, danger, violence, and hostility that prevailed during the Intifada inevitably left scars on the mental health of the Palestinians children.

Mental health professionals show increasing concern about developmental risks for children who fall victims to political violence and war. Family and parent-child attachment are considered important in providing a protective shield for children's psychological well-being in dangerous conditions (Freud & Burlingham, 1943; Garbarino, Kostelny & Dubrow, 1991).

However, the Intifada created a situation that apparently shook traditional parent-child relations and family hierarchy. First, the increased influence of political parties decreased the social role of the extended family. Second, children and youths played a very active role in the national struggle. They were an essential element in the initiation, planning, and organizing of demonstrations against and confrontations with Israeli soldiers (Kuttab, 1988).

Palestinians have expressed serious concern about the future consequences of these shattered parental bonds. Some believe that children who threw stones ("children of the stones") and fought against the occupation army also challenge their parents' authority. Parents face difficulties to protect their children from sights of destruction, violence, and abuse. Many Palestinian children have taken active part in their national struggle. Even if they were not actively fighting on the streets, as so may were, they still could not help but experience of the national struggle on an emotional level interact dynamically inside the child psyche as we see that (24.7%) expressed that "Fatma" can be a martyr in order to solve her concerns .

Researchers studied Palestinian children's and adult's vulnerability to trauma and resiliency from the first Intifada through seven years of practicing peace and building national institutes and currently during the three years of Al-Aqsa Intifada (Quota, Punamaki, & El Sarraj, 1995; Punamaki, Quota, & El Sarraj, 1997; Qouta, Punamaki, & El Sarraj, 2003). We found that family could function as a protective shield and secure base despite of the violence predicted children's resiliency. Loving and wise parenting associated with children's creativity and active participation, which then, once peace was there predicted good mental health.

We as a professionals had some questions about future of the Palestinian children and we asked ourselves at that time what kind of teachers, mothers and fathers they will be. We are very afraid to have next lost generation but unfortunately the Palestinian children started their wounds when the Al-Aqsa Intifada broke up the peace treaty and those children inter to the new stage and their psyche goes on. This time the Israeli violence is even more aggressive than during the first Intifada so that why the psychological consequences of traumatic experiences are negative influence of good children development, as those children did not know a day of real peace as their grandparents had been uprooted in 1948 and from that time their suffering had been started. The memory of Palestine is still alive in their mind and they try to keep it alive by telling stories to their sons, daughters and grandchildren about Palestine, about their own country and about their own land. In each home map of Palestine is on the wall to remind about their own country. So because the Palestine is all the time in the concise of the Palestinian children their grow up in high political environment and they grow too soon. Those children lost their right to have normal childhood they gradually stared to be involved in Palestinian-Israeli conflict. It is strange that such young children can carry such responsibility but this is the real characteristics for all area of conflict around the world. The biggest tragedy is that the children whom grow up in such environment can perceive their parents as unable to protect them. Some questions came to their mind; *"if my father is unable to protect me who can protect me?".* So when the chills had witnessed parent's humiliation his trust and his psychology development had been complete destroyed.

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