Resilience and psychological problems among Palestinians Victims of community violence

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المشاكل النفسية لدى الفلسطينيين ضحايا العنف المجتمعي وعلاقتها بالصمود النفسي

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Abstract

Aim: The purpose the study is to examine relationship between psychological problems in families' victims of community violence and resilience in the Gaza Strip.**Method:** A sample of 255 participants was selected, 120 were males (47.1%) and 135 were females (52.9%). Each participant was interviewed using sociodemographic scale, Arabic version of Symptoms Checklist-90-Revised, and Arabic version of Resilience Attitude Scale.**Results:** The results showed that the participants mean psychological symptoms were 121.48. Females reported more somatization, obsessive compulsive symptoms, anxiety symptoms, phobic anxiety symptoms than males. Hostility was more in families of low income families, paranoid was more in people from families of moderate income, psychosis was more in people coming from families of low income. While, mean resilience was 60.84, Males had more resilience than females, more committed, more able to control, and challenging than females. People living in north Gaza had less resilient and less challenging than people living in Gaza or Khan Younis.Psychological problems, obsessive compulsive, depression, anxiety, phobic anxiety, paranoid, and psychosis were correlated negatively with resilience. Also, total psychological problems, sensitivity, and phobic anxiety were correlated negatively with commitment. Sensitivity, anxiety and phobic anxiety were negatively correlated with control. With total psychological problems, obsessive compulsive, sensitivity, depression, anxiety, paranoid and psychosis were correlated negatively with challenge.**Conclusion:** The present study findings demonstrated that Palestinians in the Gaza Strip reported more psychological problems due to long-standing stress and trauma beside the community violence. Resilience as an outcome of experiences of stress and trauma and coping strategies, social support was affected by presence of psychological problems among Palestinian in which people with more psychological problems showed less resilience. This studyhighlights the need for community reconciliation between the factions and increase effort in social reconciliation, more programs for psychoeducation of subjects which may help in increasing coping and resilience. Also, families affected directly by such community violence should be targeted with their children by program including psychological intervention, social and community support group, stress management, and parenting training.

Keywords: Community violence, psychological problems, resilience, Gaza Strip

Declaration of interest: The authors have no competing interests.

Introduction

Palestinians in the Gaza Strip had been victims of political violence from the last decades. In 2005, Israelis military forces left the Gaza Strip which called unilateral Israelis withdrawal. In 2006, after llamas's legislative victories and has continued, politically and sometimes militarily up to this day. The community conflict, which erupted between the two main Palestinian parties, Fatah and llamas, resulted in the split of Palestinian Authority into two parties, both seeing themselves the true representatives of the Palestinian people – the Fatah ruled Palestinian National Authority in West Bank and the llamas Government in Gaza Strip.

In early June, 2007, another wave of community violence erupted, gunfire and rocket propelled grenades could be heard from the streets of Gaza Strip. In half a year, more than 150 Palestinians have been killed in factional fighting between Fatah and llamas; sparking the fear of a civil war in Gaza Strip. Another round of community fighting began on June 10 and ended on June 14, 2007. Throughout the four days of fighting, people in Gaza Strip experienced different types of traumatic events mainly hearing the gunfire sounds in the street, witnessing killing of relatives and neighbors, watching wounded and killed people in the TV, and being injured themselves. Llamas had taken control of the Gaza Strip from Beitllanoun in the north to Rafah in the south. Such fighting left more risk and adversity on the Palestinian community in the Gaza Strip and increase level of mental health problems among children and parents (Thabet et al., 2008)[1].

Studies reported that people who are resilient display a greater capacity to quickly regain equilibrium physiologically, psychologically, and in social relations following stressful events. Second, and equally important, is sustainability, or the capacity to continue forward in the face of adversity (Bonanno, 2004)[2]. Resilience is considered a multidimensional, dynamic construct made up of a variety of personal q qualities

(i.e.,spirituality, personal competence, social competence, family cohesion, social resources, and personal structure). Individuals who possess these personal qualities are more likely to positively adapt when exposed to a traumatic event (Campbell-Sillset al., 2006, 2007; Connor and Davidson, 2003; Luthar et al, 2000; Newman, 2005) [3, 4, 5, 6, 7].

Resilience refers to class of phenomena characterized by good outcomes in spite of serious threats to adaptation of development. It is usually arises from normative functions of human adaptational system, with the greatest threats to human development being those that compromise these protective systems. Resilience is made of ordinary rather than extraordinary outlook on human development and adaptation, as well as direction for policy and practice aimed at enhancing the development of children at risk for problems and psychopathology (Masten, 2001)[8]. However, specific operational definitions for resilience vary widely in the literature, as do the factors that define the construct. For example, Connor and Davidson (2003) [5] identified resilience as personal qualities that enable individuals to flourish in the face of adversity. Newman (2005)[7] defined resilience as positive adaptation in the face of a traumatic event. Richardson (2002)[9] described resilience as an internal motivational force that drives each individual to seek wisdom, self-actualization, altruism, and inner spiritual peace. In our view, resilience is best defined as an outcome of successful adaptation to adversity. Characteristics of the person and situation may identify resilient processes, but only if they lead to healthier outcomes following stressful circumstances.

Very little is known about the individual's mental health and of resilience (Caspi etal., 2003)[10]. Nrugham et al. (2010)[11] conducted a longitudinal study on a subset of a representative sample of 2,464 students, and revealed that resilience is a moderator oflifetime violent. Roy et al. (2011) [12] suggested a possible role for resilience as a protective factor mitigating the risk of making a suicide attempt for an individual who has experienced childhood trauma events and attempted suicide. Hourani et al, (2012) [13] in surveys of 475 active duty Marines attending a random sample of mandatory Transition Assistance Program workshops before leaving the military and responding to follow-up mail or web surveys an average of 6 months after returning to civilian life. The finding that resilience was only associated with mental health when functional impairment was included suggests that the effect of resilience may be in its ability to maintain an individual's functionality despite mental health problems and may not directly impact the risk of mental health symptoms per se.

The purpose of the present study is to examine relationship between psychological problems in families' victims of community violence due to factional fighting in the Gaza Strip between Fatah and Hamas parties and resilience.

Material and Methods

Subjects

The sample consisted of 161 Palestinian families affected by the factional fighting between two political factions in the Gaza Strip (Fatah and Hamas) on July 2007, 50 of those families were randomly selected for this study. Three areas of the five areas of the Gaza Strip were selected randomly. The sample consisted of 255 subjects, 120 were males (47.1%) and 135 were females (52.9%). The age ranged from 18-67 years with mean age was (M = 31.77+ 14.84).

Study procedure

In this study data collection team consisted of 6 trained female field workers who were attended training session with the two researchers to inform them about the questionnaire and sampling process. The researchers used the available data aboutthe distribution of the population and select randomly the sample. Formal letters were obtained from ethical committee to start the study. Participants wereinterviewed inside their homes. They were informed about the study objectives and they were told that their names will not be included and the data will be kept in safe place with the researchers.

Instruments

Sociodemographic data

The participants demographic data was collected by questionnaire include sex, age, income, marital status, and place of residence.

Symptoms Checklist-R (Derogatis, 1983)[14]

Mental distress was evaluated by the self-report ninety item Symptom Checklist (SCL-90-R), which is a general standardized measure of psychopathology. It has been tested and employed in various cultural and clinical settings including those concerning trauma victims in the Palestinian society (Afana et al., 2002)[15]. The symptom level of each item of the SCL-90-R is rated by the subject on a five-point scale of distress, from "not at all"(score 0) to "extremely" (score 4). The average of the scores of these 90 items, called the global severity index (GSI), indicates an overall degree of mental distress. The items of the SCL-90-R are known to factories into nine primary symptom dimensions, denoted by somatization (1, 4, 11, 29, 40, 42, 48, 49, 52, 58, 71), obsessive-compulsive (3, 9, 10, 28, 38, 45, 46, 51, 55, 65), interpersonal sensitivity (6, 21, 34, 36, 37, 41, 61, 69, 73) depression (2, 5, 14, 15, 20, 22, 26, 27, 28, 30, 31, 32,

54), anxiety (12, 17, 23, 33, 39, 57, 72, 79, 80, 86),hostility (13, 24, 63, 67, 74, 81), phobic anxiety (25, 47,50,70,75,78, 82), paranoidideation (8, 18, 43, 68, 76, 83), and psychoticism (7, 16,35,62,77,84, 85, 87, 88,are usually not reported (19, 44, 53, 59, 60, 64, 66, 89). For each of these nine dimensions, the average score of the items comprising this dimension constitutes the score of that dimension. Since a relatively large number of subjects will usually have a score 0 (not at all) for a given item, and the score digits range from 0 to 4, the mean scores for a large group often obtain values less than 1. This instrument was validated in Arab countries and in Palestine and showed high reliability (Cronbach's alpha = .92) (Maghriand Thabet, 2008)16. In this study, the internal consistency of thecomplete SCL-90-R was high (Cronbach's alpha = .96) and split half was 0.86.

The Resilience Attitude Scale by (Mekhaemer, 2002)[17]

The scale contains 47 items covering the resilience characteristics of commitment, feeling of control and willingness to take challenges. Children were instructed to evaluate on a three-point scale how well the feelings and thoughts describe theirs: not at all (0), to some extent (1), and very well (2). The total score ranges from 0–141, with higher score reflecting greater resilience. Three subscales were constructed: Commitment (16 items, e.g., "I care much for problems and things that happen around me"; "I care for all possible initiative that may help my family and community", Control (14 items, e.g., "I think luck and accidents play major role in my life"; "I think people's life is influenced by external forces that they cannot control") and Challenge (17 items, e.g., "I am curious to know the unknown"; "When I have solved one problem, I enjoy moving into to solving another one". The Resilience attitudes - scale has been validated in Arabic culture in Egypt by (Maekhemer, 2002)17, and has been found reliable among Palestinians in Gaza Strip (Cronbach's alpha = 0.84 and split half = .84) (Thabet et al 2008)1. In this study the internal consistency was (Cronbach's □ = .86).

Statistical analysis

Data analysis was carried out using a statistical software SPSS version 16.0.Descriptive statistics were used to report sociodemographic variables.Internalconsistency was assessed by Cronbach's α coefficient.

For continuous variables mean and standard deviation were used for data reporting and statistical tests used for comparison were t-test when comparing two groups. One way ANOVA tests were used to test differences between psychological problems and resilience and more than two groups of continuous variables such place of residence and family income. Rank correlation (Spearman's rho) was used to assess the correlation between the psychological symptoms scores, and resilience scores.

Results

Sociodemographic characteristic of the study

The sample responded to the interview were 255 participants with response rate of 96%, it consisted of 120 males (47.1%) and 135 females (52.9%). The age ranged from 18-67 years with mean age was (M = 31.77+ 14.84). According to place of residence, 34.1% were from North Gaza, 30.2% were from Gaza, and 35.7% were from Khan Younis. Regard marital status, 50.2% were single, 41.6% were married, and 8.2% were widowed. Regard the family monthly income, 3.5% have high monthly income (above 751 $), 79.24 % of the families have moderate (251-750 $) monthly income, and 17.3% of families have low (less than 250$) monthly income.

Table 1: Sociodemographic characteristic of the study sample (N = 255)

Variable	N	%
Sex		
Males	120	47.1
Females	135	52.9
Age 18-67 years, Mean = 31.77 years, (SD= 14.84)		
Place of residence		
North Gaza	87	34.1
Gaza	77	30.2
Khan Younis	91	35.7
Marital status		
Single	128	50.2
Married	106	41.6
Widowed	21	8.2
Place of residence		
North Gaza	87	34.1
Gaza	77	30.2
Khan Younis	91	35.7

Family monthly income		
High income (751$ and more)	9	3.5
Moderate income (351-750$)	202	79.2
Low income (less than 350$)	44	17.3

Means and Standard deviations of psychological symptoms (SCL-90 and subscales)

The results showed that the subjects of the sample psychological symptoms ranged from 17 to 219 symptoms (mean = 121.48, SD = 40.78), somatization ranged from 0- 39 (mean = 17.40, SD = 9.93), obsessive compulsive symptoms ranged from 2-30 (mean = 16.17, SD = 6.72), interpersonal sensitivity ranged from 0-24 (mean = 11.90, SD = 4.70), depression ranged from 0-42 (mean = 22.06, SD = 9.77), anxiety ranged from 2-31 (mean = 13.41, SD = 6.70), hostility ranged from 1-20 (mean = 8.67, SD = 4.75), phobic anxiety ranged from 0-26 (mean = 8.37 , SD = 4.91), paranoid ranged from 0-18 (mean = 8.74 , SD = 4.412), and psychosis ranged from 0-26 (mean = 12.03, SD = 7.29).

Table 2: Mean and Standard deviations of the SCL-90 items

	Minimum	Maximum	Mean	SD
Total SCL-90	17	219	121.48	40.78
Somatization	0	39	17.40	9.93
Obsessive-compulsive	2	30	16.17	6.72
Sensitivity	0	24	11.90	4.70
Depression	3	42	22.06	9.77
Anxiety	2	31	13.41	6.70
Hostility	1	20	8.67	4.75
Phobic anxiety	0	26	8.37	4.91
Paranoid	0	18	8.74	4.21
Psychosis	0	26	12.03	7.29

Differences in psychological symptoms and sociodemographic variables

In order to find differences in gender and psychological symptoms, t independent test was conducted in which total mental health problems and subscales were entered separately as the dependent variable and sex as independent variable. The results showed that females reported more somatization than males (t = -4.51, p = 0.001), more obsessive compulsive symptoms (t= -6.13, p = 0.001), more anxiety symptoms (t= -5.14, p = 0.001), and more phobic anxiety symptoms (t= -8.22, p = 0.001). No sex differences in other psychological problems.

Psychological problems and sociodemographic variables

ANOVA test was done in which each of the mental health subscales were the independent variables and marital status, place of residence, income as dependent variables. Post hoc test using Turkeys test showed that hostility was more in families of low monthly income than moderate or high income (F= 5.37, p = 005), paranoid was more in people from families of moderate monthly income than low or high monthly income (F = 6.32, p = 0.002), psychosis was more in people coming from families of low monthly income than of moderate or high monthly income families (F = 7.07, p = 0.001).

Regard place of residence, phobia was more in people living in north Gaza than in Gaza or Khan Younis (F= 50.33, p = .001) (F=4.97, p = 0.008).

For marital status, somatization symptoms were more in married that single or widowed (F= 50.33, p = .001), obsessive symptoms were more in single than in married or widowed (F = 15.55, p = 0.001), sensitivity was more in widowed than single or married (F = 4.63, p = 0.01), anxiety was in widowed than single or married (F= 3.24, p = 0.04), phobia was more in single that married or widowed (F= 3.80, p = 0.02),

Resilience in Palestinian families

Participants reported from 24 to 98 resilience items with mean = 60.84 (SD = 12.25), commitment subscale items ranged from 8 to 49 with mean =24.17 (SD = 4.99), control subscale items ranged from 7 to 39 with mean =17.41 (SD = 4.97), and challenging subscale items ranged from 5 to 30 with mean = 19.26 (SD = 4.49).

Table 3: Mean and Standard deviations of the resilience

	Minimum	Maximum	Mean	SD
Total resilience	24	98	60.84	12.25

Commitment	8	49	24.17	4.99
Control	7	39	17.41	4.97
Challenge	5	30	19.26	4.49

Gender differences in resilience

In order to investigat the sex differences in using resilience, t independent test was performed in which sex and age were the dependent variable and resilience, committment, control, and challenging as independent variables. The results showed that there were significant differences between males and females in total resilience toward males (t = 3.38, p = 0.001), commitment (t= 2.68, p = 0.01), control (t= 3.44, p = 0.001), and challenging (t= 3.75, p = 0.001).

Table 4: Sex differences in resilience and subscale

	Sex	Mean	SD	MD	t	p
Commitment	M	25.27	5.44	3.381	3.38	0.001
	F	23.19	4.34			
Control	M	18.28	5.43	2.684	2.68	0.01
	F	16.63	4.40			
Challenge	M	20.27	4.95	3.438	3.44	0.001
	F	18.37	3.84			
Resilience	M	63.82	13.54	3.752	3.75	0.001
	F	58.19	10.32			

Resilience and sociodemographic variables

ANOVA test was done in which total resilience and each of the subscales was the independent variables and marital status, place of residence, income as dependent variables. Post hoc test using Turkeys test showed that people living in north Gaza were less resilience and less challenge that people living in Gaza or Khan Younis (F= 5.98, p = 0.003; F = 4.18, p = 0.01).

Regard other socioeconomic items. The results showed no significant differences according to marital status or economic status of the families (low, moderate, high income)

Relationship between psychological problems and resilience

In order to find the relationship between psychological problems and resilience subscales such commitment, control, challenge and, a correlation coefficient Spearman test was done. The results showed that total psychological problems was correlated negatively with total scores of resilience (r = -0.28, p = 0.02), obsessive compulsive (r = -0.16, p = 0.05), sensitivity (r = -.31, p = 0.001), depression (r = - .24, p = 0.04), anxiety (r = -0.28, p = 0.001), phobic anxiety (r = -0.36, p = 0.001), paranoid (r = -0.19, p = 0.02), and psychosis (r = -0.25, p = 0.03) were also correlated negatively with total scores of resilience.

Total psychological problems (r = -0.27, p = 0.02), sensitivity (r = -0.26, p = 0.001), and phobic anxiety (r = -0.22, p = 0.01) were correlated negatively with commitment. Also, sensitivity (r = -0.18, p = 0.03), anxiety (r = -0.21, p = 0.02), phobic anxiety (r = -0.29, p = 0.001) were negatively with and challenge. Total psychological problems (r = -0.44, p = 0.001), obsessive compulsive (r = -0.23, p = 0.01), sensitivity (r = - 0.38, p = 0.001), depression (r = -0.36, p = 0.001), anxiety (r = -0.34, p = 0.001), paranoid (r = -0.35, p = 0.001), and psychosis (r = -0.41, p = 0.001) were correlated negatively with control.

Table 5: Correlation Coefficient of resilience and psychological problems

		1	2	3	4	5	6	7	8	9	10
Commitment	**r**	**-.27-***	**-.04-**	**-.14-**	**-.26-****	**-.21-**	**-.20-***	**-.01-**	**-.29-****	**-.14-**	**-.27-**
	p	**0.02**	**0.57**	**0.09**	**0.00**	**0.08**	**0.02**	**0.85**	**0.00**	**0.09**	**0.02**
Control	**r**	**-.042-**	**-.079-**	**-.049-**	**-.16--.06-**		**-.18-***	**0.14**	**-.22-****	**-.013-**	**0.01**
	p	**0.73**	**0.34**	**0.56**	**0.05**	**0.60**	**0.03**	**0.08**	**0.01**	**0.88**	**0.91**
Challenge	**r**	**-.44-****	**-.12-**	**-.23-****	**-.38-****	**-.36-****	**-.34-****	**-.14-**	**-.40-****	**-.35-****	**-.41-**
	p	**0.00**	**0.14**	**0.01**	**0.00**	**0.00**	**0.00**	**0.09**	**0.00**	**0.00**	**0.00**
Resilience	**r**	**-.28-***	**-.09-**	**-.16-***	**-.31-****	**-.24-***	**-.28-****	**-.001-**	**-.36-****	**-.19-***	**-.25-**

	p	**0.02**	**0.25**	**0.05**	**0.00**	**0.04**	**0.00**	**0.99**	**0.00**	**0.02**	**0.03**

1-Total SCL-90, 2- Somatization, 3- Obsessive-compulsive, 4- Sensitivity, 5-depression, 6- Anxiety, 7- Hostility, 8- Phobic anxiety, 9- Paranoid, 10- Psychosis

Discussion

Our results showed that females reported more somatization, obsessive compulsive symptoms, anxiety symptoms, and more phobic anxiety symptoms than males. This could be due to the cultural factors in which females in non-western society are expressing their emotional problems physically through somatic symptoms. Hostility was more in families of low income families than moderate or high income, paranoid was more in people from families of moderate income than low or high income, psychosis was more in people coming from families of low income than of moderate or high income families. The above mentioned finding showed that mental health problems were more common in poor families, which indicated that poverty is on of the risk factor for developing mental health problems in Palestinian society with more that 38.5% of families under the lines the poverty (PCBS, 2010)[18]. Phobia was more in people living in north Gaza than in Gaza city or Khan Younis. This could be the fact that this area is a border area with my repeated incursions and bombardment in last decade. Similar study in the area showed that adults reported higher level ofanxiety and fears (Thabet et al., 2008)[1].Our study finding of higher rates ofpsychological problems more than other studies, such as study of African American and Caucasian American students which showed that mean SCL-90 was 79.41 for African American and 96.61 for Caucasian American (Ayalon and Young 2009)[19], could be the current situation in the Gaza Strip with continuity of the siege andclosure of the area and repeated shelling and bombardment. Such chronic stressors and traumatic events are the cause higher rates of mental health problems including anxiety, depression, and PTSD.

Our study findings showed that male Palestinian were more resilient, committed, controling, and challenging in face of traumatic events due to factional fighting between Hamas and Fatah. This gender differences in resilience have been investigated less often, but one consistent finding is that resilient women tend to elicit and provide more social support for overcoming their adversities and problems. Others, in their study found that women reported significantly using higher levels of 'social support' than men, whereas men reported sub-significantly higher levels of 'personal competence than women (Werner, 2001)[20]. One explanation of our finding is that females are more willing to report or acknowledge their negative events and emotions, which might threaten and lower their psychological resilience. Another reason is that women are thought to be more sensitive to problems under high stress conditions. When encountering difficulties or stresses, females tend to evade or use maladaptive coping strategies, whereas males choose positive coping strategies that focus on the immediate problem (Hampeland Petermann, 2005)[21]. However, others found no gender comparison reached statistical significance in terms of resilience in previous research (Campbell-Sills et al., 2006)[4].

The results showed that people scored more psychological problems including obsessive compulsive, sensitivity, depression, anxiety, phobic anxiety, paranoia, and psychosis had been less resilient. People with more total psychological problems, sensitivity and phobic anxiety had less commitment. People with sensitivity, anxiety, phobic anxiety had less control. Also, people with more psychological problems, obsessive compulsive, sensitivity, depression, anxiety, paranoia, andpsychosis were less challenging. Our findings were consisted with study of Friborg et al., (2003)[22] of sample patients in Norway which reported that resilience was negatively related to the mental health problems. Also, King et al., (1998)[23], found that several factors, including higher levels of both perceived ("functional") and structural (i.e., membership in organizations) social support were associated with a lower likelihood of PTSD. Others postulated that resilient people are typically characterized by optimism, positive coping, and hardiness, and these characteristics are associated with better physical and mental health outcomes and more positive adaptive behaviors to negative life events (Connor and Davidson, 2003)[5]. Compared with young adults with low levels of resilience, those with high levels of resilience are less likely to have mental health problems, interpersonal conflicts, behavioural disorders, and poor academic performance (Rew et al., 2001)[24].

It is important to understand the relationships between mental health problems and other variables (e.g., personality traits and social support), and to testing the possible moderating effect of resilience between negative life events and mental health problems. Resilience enables people to thrive in the face of adversity. Improving resilience must be an important goal for treatment and prophylaxis (Dmitry et al., 2010)[25]. Negative life events may lead to mental health problems such as depression or anxiety, but an individual with a high level of resilience may cope with the difficulties more effectively and remain healthy.

Conclusion and clinical implication

The present study findings demonstrated that Palestinians in the Gaza Strip reported more psychological problems due to long-standing stress and

trauma beside the community violence. Resilience as an outcome of experiences of stress and trauma and coping strategies, social support was affected by presence of psychological problems among Palestinian in which people with more psychological problemsshowed less resilient. This study highlights the need for community reconciliation between the factions and increase effort in social reconciliation, more programs for psychoeducation of subjects which may help in increasing coping and resilience. Also, families affected directly by such community violence should be targeted with their children by program including psychological intervention, social and community support groups, stress management, and parenting training. Our study had several limitations such as we did not examine other Palestinian families affected by other political violence, children were not included in this study, and other factors such as political affiliation, social, and family support were not included.

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الملخص

الهدف من هذه الدراسة هو فحص العلاقة بين المشاكل النفسية في ضحايا الأسر الفلسطينية التي عانت من العنف المجتمعي والصمود النفسي في قطاع غزة.
تألفت العينة المختارة من وتتراوح اعمارهم ما بين 18 – 67 عاماً مع متوسط العمر كان 31ز77 عاماً وقد تم جمع البيانات من المشاركين بواسطة استبيان يشمل العمعلومات وقائمة الأعراض النفسية – 90 بند المراجع، ومقياس الصمود النفسي للبالغين.
أظهرت الدراسة بأن متوسط الأعراض النفسية كان 121,48 ، ومتوسط أعراض الجسدنة كان 17,40 ، وأعراض الوسواس القهري كان 16,17، 11,90، ومتوسط أعراض الحساسية الشخصية كان 11,90، وكان متوسط الإكتئاب 22,06، والقلق كان 13,41، وأعراض العدائية كانت 8,67 و متوسط رهاب القلق كان 8,37، ومتوسط جنون العظمة كان 8,74، ومتوسط أعراض الذهان كانت 12.03. أظهرت النتائج بأن الأناث أظهرن أعراض الجسدنة والوسواس القهري، والقلق أكثر من الذكور. وكان العداء أكثر في الأسر ذات الدخل المنخفض عنه عن الأسر ذات الدخل المتوسط والعالي، بينما كانت أعراض جنون العظمة أكثر في الناس من العائلات ذوات الدخل المتوسط أكثر من الأسر ذات الدخل المنخفض و العالي. بينما الذهان كان أكثر في الأشخاص المنحدرين من أسر ذات دخل منخفض عنه ذوات الدخل المتوسط أو العالي.
أما بالنصبة للصمود النفسي وكل من محاور الإلتزام، والتحكم، والمنافسة فقد كان أكثر في الذكور عنه في الإناث. وأظهرت النتائج أن الناس الذين يعيشون في شمال قطاع غزة هم أقل في الصمود النفسي عنهم عن الذين يعيشون في مدينة غزة أو خانيونس.
وقد أظهرت النتائج أن مستوى الصمود النفسي يرتبط عكسياً مع وجود المشاكل النفسية، وكذلك مع الوسواس القهري، والإكتئاب والقلق، ورهاب القلق، وجنون العظمة والذها، وبالخصوص كان هناك ارتباط عكسي بين الإلتزام طجزء من الصمود النفسي مع المشاكل النفسية عموماً، ومع الحساسية التفاعلية، ورهاب القلق، بينما كان هناك أيضاً أرتباطاً سلبياً ما بين التحكم والحساسية التفاعلية، والقلق ، ورهاب القلق. وكان هناك إرتباط عكسي ما بين التحدي كجزء من الصمود النفسي وكل من أعراضالوسواس القهري، والحساسية التفاعلية، والإكتئاب، والقلق وجنون العظمة، والذهان.

أظهرت نتائج الدراسة بأن الفلسطينيين في قطاع غزة يعانون أكثر من المشاكل النفسية عنهم من أشخاص آخرين في مناطق أخرى لأنهم تعرضوا لفترة طويلة لضغوط نفسية وصدمات نفسية مستمرة حتى يومنا هذا بالإضافة إلى العنف المجتمعي في الآونة الأخيرة بين الفصائل الفلسطينية الرئيسية في قطاع غزة والذي أدى إلى الإقتتال الداخلي. ذلك أدى إلى ظهور مزيد من المشاكل النفسية التي أدت إلى إنخفاض مستوى الصمود النفسي. ولذلك يجب العمل على مساعدة الأشخاص الذين يعانون من مشاكل نفسية في البحث عن طرق تؤدي إلى بناء صمود نفسي أكثر لمواجهة الظروف الحياتية الصعبة من عنف سياسي ومجتمعي. وكذلك تعزيز قدرات سكان قطاع غزة على التكيف بشكل أفضل في حياتهم اليومية من خلال برامج تدخل متخصصة.

كلمات أساسية: العنف المجتمعي، المشاكل النفسية، الصمود النفسي، قطاع غزة.