Coping and mental health problems among Palestinian refugee families.

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Abstract

Aim: The aim of the study was to find the rate of mental health problems among refugee's families, to explore type of coping strategies used to overcome the stress and trauma and to explore the relationship to mental health problems and ways of coping in face of stress and adversities.

Method: A sample of 116 Refugee participants living in three refugee camps in Gaza Strip (Beach, Nusirate and Khan Younis camps) was selected. The sample consisted of 78 males (67.2%) and 38 females (32.8%). Age ranged from 19-65 years with a mean age of 41.3 years. Participants completed measures of Brief Symptom Inventory and Family Crisis Oriented Personal Evaluation Scale.

Results: The study showed than mean Brief Symptom Inventory was 64.97, anxiety mean was 9.79, somatization mean was 7.34, depression mean was 8.45, hostility mean was 3.91, obsession mean was 8.37, sensitivity mean was 5.88, paranoid mean was 5.31, phobia mean was 5.76 and psychoticism mean was 4.16. The results showed that Palestinian families coped with stressful situations by: 75% said that is God wish, 39.7% said they will ask for advice from relatives and grandparents and 35.3% attending religious meetings. The results showed that mean total coping of family was 109.17, acquiring social support mean was 16.37, reframing mean was 30.64, seeking spiritual support mean was 16.37, positive appraisal mean was 13.83 and mobilizing family to acquire and accept help mean was 14.83.

The study showed that total FCOPE was positively correlated with phobia, acquiring social support was positively correlated with phobia , reframing was correlated negatively with obsession, positive appraisal was positively correlated with hostility, obsession, paranoid, phobic anxiety and psychoticism, mobilizing family to acquire and accept help was positively correlated with somatization, phobic anxiety and psychoticism.

Clinical implications: This study had shown that refugees in Gaza Strip had mental health problems and they used more religious coping strategies to overcome the war-related traumatic experiences and distress. Such findings highlight the importance of developing mental health services. Future research that includes the training of primary health care professionals, health workers, counselors in the effects of trauma and culturally adapted counseling skills that capitalize on people empowerment and building on strengths appears particularly relevant. We suggested, as integrating mental health services into primary health care, religious organizations and community outreach efforts may make care more accessible, help to destigmatize mental health problems and thus help individuals and families make use of available resources.

Keywords: Coping, Family, Gaza, Mental health problems, Refugee.

Accepted on June 21, 2017

Introduction

Refugee camps in West Bank and Gaza Strip have existed since the uprooting of the Palestinians in 1948, and there are now over two million people living in Gaza Strip, with most of the population living in overcrowded, dilapidated refugee camps with little infrastructure. Over half a million Palestine refugees in Gaza live in the eight recognized Palestine refugee camps, which have one of the highest population densities in the world [1]. The eight refugee camps in Gaza are characterized by severe overcrowding, lack of medical and mental health resources, and economic malaise [2,3]. The impoverished conditions of those living in refugee camps in Gaza have not improved compared with those living in non-camp communities, particularly in domains such as legal standing, language, religion, skills and culture, resulting in extreme poverty that breeds further disenfranchisement, violence, and disorganization [4].

Psychological effects of refugee experiences may include feelings of helplessness, grief, anxiety, depression, somatization, shame, anger, shattered assumptions, sensitivity to injustice and survivor guilt. Refugees may experience extreme isolation, humiliation, and immense losses, some of which are existential, including loss of loved ones, the homeland, culture, identity, hope, trust, meaning in life and faith in a justified world [5]. A systematic review of research on mental disorders in resettled refugees found that refugees were diagnosed with PTSD at rates 10 times that of native post resettlement community members [6].

Several studies, in settings as diverse as, West Bank [7], had examined the role of daily stressors in helping to explain the high rates of psychological distress so often found among survivors of armed conflict. Thus far, the data have consistently shown that daily stressors also have powerful effects on mental health outcomes. Similarly, in a longitudinal research study on 490 trauma-exposed Cambodians who were refugees 20 years after their resettlement to the United States identified that mental health symptoms were long-term and debilitating [8]. Another meta-analysis that included a sample of over 80,000 refugees and people affected by conflict identified torture as a strong predictor for the development of posttraumatic stress disorder (PTSD), for which they identified a weighted prevalence rate of 13–25%. In research on refugees from Burma, specifically, Schweitzer et al. [9] reported frequencies of PTSD (9%), anxiety (20%), depression (36%) and somatic symptoms (37%). In a study of 497 Iraqi refugees resettled to the United States examined associations between torture and physical symptoms and identified increased reporting of physical and mental health symptoms (yes/no) among torture survivors compared to refugees who did not report torture, as well as associations between reporting physical and mental health symptoms [10]. Furthermore, Hoffman et al. [11] in a retrospective cross-sectional analysis of 111 electronic health records of adult Karen refugees seen at a primary care clinic in the Minneapolis – St. Paul Metropolitan area. PTSD diagnosis by the medical provider was significantly higher in the primary torture group, 30%, versus 6% in the secondary torture group.

Coping

Conceptualizations of stress and coping, mostly guided by the transactional model, focused primarily on individual cognitive and emotional processes associated with the experience of stress and coping responses. The transactional model posits that individuals (a) experience stress when they perceive that their available resources are insufficient to meet the demands of a particular situation and (b) cope with stress through emotion- or problem-focused responses [12]. Two studies conducted in Brisbane, Australia, used qualitative methods to explore coping strategies used in the premigration, transit and post-migration phases amongst 13 Sudanese refugees [13] and 23 Sudanese refugees [14]. Both of these studies suggested that religious beliefs and social support are critical factors that assist Sudanese refugees to cope. Also carried out in Brisbane, a quantitative study with 63 Sudanese refugees (87% Christian, 13% Muslim) assessed the relationship between pre-migration traumatic experiences, post-migration living difficulties and social support, with symptoms of anxiety, depression, somatisation and PTSD [15]. Results indicated that most of the participants had experienced several traumatic events. Both traumatic experiences and post-migration living difficulties were significant predictors of lower mental health outcomes, while higher social support, particularly from family members and the Sudanese community, was significantly predictive of higher psychological wellbeing. In Melbourne, Australia, 30 Sudanese young people (aged 18-30 years) were interviewed about what gave their life meaning and about their social connectedness [16]. Participants in this project described the negative consequences that many have experienced following traumatic events, including a breakdown of meaning in life, severely disrupted schooling, long-term mental health problems, living in survival mode, disruption of social networks, separation from family and friends, and a lack of trust in authority, particularly the government. Yet the young people interviewed tended to describe feeling socially connected in Australia and finding meaning in their life during resettlement. The participants strongly valued many aspects of their new environment such as multiculturalism, freedom, peace, security, having rights and educational opportunities, although some found the individualistic nature of Australia and the lack of sense of belonging to be disheartening. Interactions with institutions could play a positive or negative role, with some young people experiencing racism, discrimination or feeling disadvantaged. Social support was critical to quality of life, particularly having family present in Australia and positive connections to the Sudanese community, whereas young people who were generally isolated or without their parents in Australia were described as vulnerable. In Canada, a mixed-methods qualitative and quantitative study conducted with 220 recently arrived Sudanese refugees and immigrants, showed that higher psychological distress was associated with economic hardship and with discrepancies between expectations of life in Canada and actual experiences in Canada [17]. Interestingly, Goodman found that the Southern Sudanese youth sometimes used bodily metaphors in their discourse on coping with suffering, for instance, 'in my blood I can feel hunger because my brother is suffering'. Another small qualitative study with Sudanese minors in the US found that the participants had a range of definitions for trauma, often inconsistent with standard definitions employed by practitioners [18]. Psychosocial factors impact on mental health by either increasing the vulnerability to, or protecting the individual from, the trauma and stressors of life. Psychosocial factors can include: social support, language proficiency, education, employment and world-view. South Sudanese refugee women in the Netherlands who had experienced sexual violence during the war were also found to use silence as a coping strategy and tended to distract themselves from the past and focus on rebuilding their lives in the resettlement environment, as disclosure of

taboo experiences such as rape were not acceptable in their cultural master narrative [19]. The relationship between trauma, coping strategies and outcome is complex. In general, positive religious coping has been found to be associated with desirable mental health outcomes whereas negative religious coping has been found to be linked to psychological distress. Moreover, Robertson et al. [20] explored relationships between trauma, social support, coping, and level of function in 449 Somali and Oromo refugees resettled in the Twin Cities. Findings in women (48% of sample) suggested that a history of torture alone was not a significant modifier of the effect of trauma. The authors interpreted their findings to mean that while torture was an important influence on function and coping, other factors such as social support and dependent care responsibilities displayed a similar impact. The study aims were 1) to find the rate of mental health problems among refugee's families In the Gaza Strip, 2) to explore type of coping strategies used to overcome the stress and trauma, 3) to explore the relationship to mental health problems and ways of coping in face of stress and adversities.

Method

Participants

The study sample included 116 Refugee participants living in three refugee camps in Gaza Strip (Beach, Nusirate, and Khan Younis camps). The sample consisted of 78 males (67.2%) and 38 females (32.8%). Age ranged from 19-65 years with a mean age of 41.3 years (SD=11.49).

Measures

Demographic information: The questionnaire included questions about the participant's age, gender, locality of residence, parents' monthly income and type residence.

Brief symptom inventory: Severity of psychological symptoms was assessed with one standardized measure, the Brief Symptom Inventory [21] which is a self-report scale that have been translated into numerous languages and demonstrated to be valid and reliable with refugee populations [22]. On the BSI, clients are presented with 53 symptoms and are asked to rate the degree to which each symptom was distressing along a 5-point scale. Scoring of the BSI yields individual subscale scores as well as a Global Severity Index (GSI), a general summary measure of clinical distress. This study examined the depression, anxiety, and somatization subscales of the BSI. It provides scores in nine primary symptom dimensions and three global indices. Internal consistency for the nine dimensions is very good, with alpha coefficients ranging from a low of 0.71 to a high of 0.85 and test-retest reliability coefficients ranging from 0.68 to 0.91. In our previous study of handicapped adults, the Cronbach's alpha was =0.95 and split half was 0.90 [23]. In this study the Cronbach's alpha was α=0.93

Family crisis oriented personal evaluation scale [24]: Family Crisis Oriented Personal Evaluation Scales (F-COPES) is a self-report measure used to assess family coping strategies. The F-COPES was used in this study because coping as a construct deals with plans or actions that ameliorate the experience of stress [24]. The scale is composed of 30 items, which result in five subscale scores and a total score. The five subscales are: (a) Acquiring Social Support; (b) Reframing; (c) Seeking Spiritual Support; (d) Mobilizing Family to Acquire and Accept Help; and (e) Passive Appraisal. A score is obtained for each subscale and the total score by summing the respondents score for each of the items. The norm group for the final F-COPES scale consisted of 2,740 spouses and adolescents. Percentiles, means, and standard deviations are provided for subscales and the total score. Alpha reliabilities for the scales ranged from 0.63 to 0.83. The reliability of the total scale was 0.86. Test-retest reliability estimates range from a low 0.61 to a high of 0.95 for the subscales. Total scale test-retest reliability was 0.81 (n=116, 4 weeks interval). In this study the Cronbach's alpha was α=0.82 and the split-half reliability coefficients were 0.78.

Study procedure

The refugee adults were selected randomly from three refugee camp. One street was selected randomly in each camp, and every other household that fulfilled the sample criteria were selected till we get the total number of 116 adults. The data collection was carried out by 4 trained mental health professionals, under the supervision of the first author. Permission from Ethical Helsinki Research Committee was obtained. The participants were interviewed at their homes. They were informed about the aim of the study and formed consent was obtained from the subjects following a description of the study.

Statistical analysis

Statistical analyses were carried out using IBM SPSS Statistics version 20.0. Continuous variables were presented as M ± SD and categorical variables were expressed as frequencies. Group comparisons were tested using independent sample t tests for continuous data. Spearman's correlation coefficient tested the association between psychological symptoms, and coping strategies by families' scores. Linear regression investigated the association between psychological problems as dependent variable and coping strategies as independent variable was conducted to find the predictor factors of coping strategies. A two-tailed p value<0.05 was considered statistically significant.

Results

Description of sociodemographic data

The sample consisted of 116 adults, 78 were males (67.2%) and 38 were females (32.8%). Age ranged from 19-65 years with a mean age of 41.3 (SD=11.49). Regard place of residence, 43.1% of live in Beach camp, 43.1.7% live in Nusirate camps, and 13.8% live in Khan Younis camp. According to family monthly income, 50.5% of the families' monthly income is less than $ 300, 24.2% ranged from $

301-500, 18.9% of families' income ranged from $ 501-750 and only 6.3% had income more than $ 751 monthly income (Table 1).

Means and standard deviation of mental health problems measured by Brief Symptom Rating Scale (BSRS)

The study showed than mean BSRS was 64.97 (SD=28.22), anxiety mean was 9.79 (SD=4.94), somatization mean was 7.34 (*SD*=4.13), depression mean was 8.45 (*SD*=4.87), hostility mean was 3.91 (*SD*=2.91), obsession mean was 8.37 (SD=4.52), sensitivity mean was 5.88 (*SD*=2.90), paranoid mean was 5.31 (*SD*=2.91), phobia mean was 5.76 (*SD*=3.56), psychoticism mean was 4.16 (SD=2.43). In order to find the gender differences in mental health problems, T independent test was conducted. The Results showed that females were significantly reported more mental health problems than males: anxiety ($t(116)=4.34$, $p<0.001$), somatization (t $(116)=2.56$, $p<0.01$), depression (t $(116)=2.82$, $p<0.003$), hostility (t $(116)=2.20$, $p<0.001$), obsessive compulsive (t (116)=2.62, $p<0.003$), sensitivity (t (116)=1.63,<0.004), paranoia ($t(116)=1.22$, $p<0.03$) and phobic anxiety (t $(116)=2.47$, $p<0.001$), psychoticism (t $(116)=-2.12$, $p<0.001$) (Table 2).

Sociodemographic differences in mental health

In order to measure the sex differences in metal health problems, independent t test was conducted. The results as shown in Table 3 showed that females reported more mental health problems in all BSI-53 subscales.

Table 1. *Characteristics of refugee sample (N=116).*

	No	%
Sex		
Male	78	67.2
Female	38	32.8
***Age* 19-65 years, mean=41.3 (SD=11.49)**		
Place of residence		
Beach camp (Gaza city)	50	43.1
Nusirate camp (Middle area)	50	43.1
Khan Younis camp (South area)	16	13.8
No. of children		
<4	33	28.4
5-7 children	39	33.6
>8 children	44	37.9
Family monthly income in US dollar		
<$300	48	50.5
$301-500	23	24.2
$501-750	18	18.9
>$751	6	6.3

Table 2. *Means and SD of the mental health measured by Brief symptom rating scale (BSRS).*

	Mean	SD	%
Anxiety	9.79	4.94	28
Somatization	7.34	4.13	29.3
Depression	8.45	4.87	24.1
Hostility	3.91	2.91	19.6
Obsessive compulsive	8.37	4.52	27.9
Interpersonal sensitivity	5.88	2.9	29.4
Paranoia	5.31	2.91	26.6
Phobic anxiety	5.76	3.56	23
Psychoticism	4.16	3.21	20.8
Other	6	2.4	30

Family coping strategies

The results showed that Palestinian families coped with stressful situations by: 75% said that is God wish, 39.7% said they will ask for advice from relatives and grandparents and 35.3% attending religious meetings.

Means and standard deviations of family coping strategies

The results showed that mean total coping of family was 109.17 (SD=13.28), acquiring social support mean was 16.37 (SD=2.75), reframing mean was 30.64 (SD=4.33), seeking spiritual support mean was 16.37 (SD=2.75), positive appraisal mean was 13.83 (SD=3.31) and mobilizing family to acquire and accept help mean was 14.83 (SD=3.31) (Table 4).

Differences in means and standard deviation of family coping strategies and sex

The results as shown in Table 3 showed that there were no statistically significant differences in coping strategies according to gender (Table 5).

Relationship between coping strategies used by refugee families and mental health

The study showed that total FCOPE was positively

Table 3. *Differences in means and standard deviations of psychological symptoms (BSI and subscales)* and sex.

	Sex	Mean	SD	t	p
Anxiety	Male	8.5	4.53	4.34	0.001
	Female	12.45	4.72		
Somatization	Male	6.67	3.91	2.56	0.01
	Female	8.71	4.29		
Depression	Male	7.53	4.93	3.03	0.001
	Female	10.34	4.19		
Hostility	Male	3.19	2.54	4.08	0.001
	Female	5.39	3.09		
Obsessive compulsive	Male	7.51	4.4	3.03	0.001
	Female	10.13	4.31		
Interpersonal sensitivity	Male	5.35	2.7	2.93	0.001
	Female	6.97	3.01		
Paranoia	Male	4.91	2.94	-2.15	0.03
	Female	6.13	2.72		
Phobic anxiety	Male	4.95	3.32	-3.7	0.001
	Female	7.42	3.51		
Psychoticism	Male	3.46	3.02	-3.5	0.001
	Female	5.58	3.14		

Table 4. *Means and standard deviations of family coping strategies.*

	Mean	SD	%
Total family coping	109.17	13.28	72.8
Acquiring social support	31.47	5.13	69.9
Reframing	30.64	4.33	76.6
Seeking spiritual support	16.37	2.75	81.9
Positive appraisal	13.19	2.78	65.9
Mobilizing family to acquire and accept help	14.83	3.31	74.1

Table 5. *Differences in means and standard deviations of coping strategies and sex.*

	Sex	Mean	SD	t	p
Total FCOPE	Male	108.38	13.16	0.89	-0.91
	Female	110.79	13.55		
Acquiring social support	Male	31.17	5.19	0.85	-0.9
	Female	32.08	5.01		
Reframing	Male	30.56	4.49	0.2	-0.26
	Female	30.79	4.03		
Seeking spiritual support	Male	16.35	2.8	0.43	-0.14
	Female	16.42	2.69		
Positive appraisal	Male	12.97	2.71	0.86	-1.2
	Female	13.63	2.91		
Mobilizing family to acquire and accept help	Male	14.59	3.14	0.64	-1.11
	Female	15.32	3.63		

correlated with phobia (*r* (116)=0.21, *p*<0.001), acquiring social support was positively correlated with phobia (*r* (116)=0.24, *p*<0.001), reframing was correlated negatively with obsession (*r* (116)=-0.26, *p*<0.001),positive appraisal was positively correlated with hostility (*r* (116)=0.23, *p*=0.001), obsession (*r* (116)=0.26, *p*<0.001), paranoid (*r* (116)=0.22, *p*<0.001), phobic anxiety (*r* (116)=0.28, *p*<0.001) and psychoticism (*r* (116)=0.20*,* *p*<0.001), mobilizing family to acquire and accept help was positively correlated with somatization (*r* (116)=0.24, *p*<0.001), phobic anxiety (*r* (116)=0.22, *p*<0.001), and psychoticism (*r* (116)=0.23, *p*<0.001) (Table 6).

Prediction of coping strategies by mental health problems

The relationship between coping strategies and mental health outcome was investigated by a series of stepwise multiple linear regression analyses, with each of 53 psychological symptoms were entered as the predictor and total coping strategies score as the dependent variable. The results showed that the following psychological symptoms were predicting negatively coping strategies: others not giving you proper credit for your achievements (β =-0.34, *t* (116)=6.53, *p*<0.001), feeling very self-conscious with others (β=-0.29, *t* (116)=-3.75, *p*<0.001), trouble concentrating (β=-0.19, *t* (116)=-2.35, *p*<0.001). While the following psychological symptoms were positively predicted coping strategies: feeling that you are watched or talked about by others (β=0.21, *t* (116)=2.37, *p*<0.001), feeling that most people cannot be trusted (β=0.26, *t* (116)=3.07, *p*<0.01) and feelings of guilt (AD) (β=0.21, *t* (116)=2.68, *p*<0.008) (R^2=0.12, *F* (1, 115)=8.91, *p*<0.001) (Table 7).

Discussion

The aim of the study to find the rate of mental health problems, coping strategies and evaluate the relationship to mental health problems and ways of coping in face of stress and adversities among refugee families in the Gaza Strip. The study showed than mean total psychological problems was 64.9, anxiety was 9.79, somatization mean was 7.34, depression mean was 8.45, hostility was 3.91, obsession was 8.37, sensitivity was 5.88, paranoid was 5.31, phobia was 5.76, psychoticism was 4.16. The study showed that females were significantly reported more mental health problems than males in symptoms of anxiety, somatization, depression, hostility, obsessive compulsive, sensitivity, paranoia, phobic anxiety and psychoticism. Similarly, Basoglu et al. [25] in a cross-sectional survey with 1358 survivors of the war in former Yugoslavia and found that 22% and 33% of the sample met criteria for current and lifetime PTSD and 10% met

Table 6. *Pearson correlations coefficient test of coping strategies and mental health problems.*

	Total FCOPE	Acquiring social support	Reframing	Seeking spiritual support	Positive appraisal	Mobilizing family to acquire and accept help
Total 53 items	0.06	0.13	-0.19	-0.04	0.22	0.15
Anxiety	0.04	0.11	-0.17	-0.04	0.13	0.18
Somatization	0.03	0	-0.11	0.05	0.03	0.24 **
Depression	0.06	0.15	-0.17	-0.05	0.18	0.14
Hostility	0	0.03	-0.13	-0.1	0.23 *	0.05
Obsession	-0.04	0.08	-0.26 **	-0.18	0.26 **	-0.06
Sensitivity	-0.07	0.01	-0.16	-0.08	0.06	-0.02
Paranoid	0.05	0.09	-0.1	-0.01	0.22 *	0.03
Phobia	0.21 *	0.24 *	-0.05	0.11	0.28 **	0.22 *
Psychoticism	0.11	0.13	-0.16	0.02	0.20 *	0.23 *

Table 7. *Linear regression analysis of psychological symptoms and coping strategies of refugee families.*

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B	
	B	SE	Beta			Lower Bound	Upper Bound
Others not giving you proper credit for your achievements (PA)	-3.762	1	-0.32	-3.78	0.001	-5.73	-1.79
Feeling that you are watched or talked about by others (PA)	2.663	1.12	0.21	2.37	0.01	0.44	4.88
Feeling very self-conscious with others (S)	-3.299	0.88	-0.29	-3.75	0.001	-5.04	-1.55
Feeling that most people cannot be trusted (PA)	3.098	1.01	0.26	3.07	0.003	1.1	5.09
Feelings of guilt (AD)	2.698	1.01	0.21	2.68	0.008	0.7	4.69
Trouble concentrating (O)	-2.359	1	-0.19	-2.35	0.02	-4.34	-0.37

criteria for current major depression. Another meta-analysis of research on refugee mental health (n=56 studies) found that post displacement factors moderated mental health outcomes [26]. Furthermore, the results of a survey conducted with 7,000 refugees from seven countries suggested that 96.3% of refugees experience PTSD and depression [6]. Furthermore, in another study conducted Kabul by Miller et al. [27] with 160 female and 160 male participants. The results indicated that for women, daily stressors were a better predictor of overall mental health (with the exception of posttraumatic symptoms) than war related experiences were. For men, daily stressors were more predictive of depression and functional impairment than war-related experiences were. Similarly, a recent study by Gokay et al. [28] of a random sample of 352 refugees (aged 18 to 65 years) of the 4,125 Syrian refugees who lived in the camp in Gaziantep, Turkey, found that 33.5% of the sample had PTSD, being acute in 9.3% of individuals and chronic in 89%. The average number of traumatic events that these refugees experienced was 3.71 events. Also, our study was consistent with Shin and Lee [29] study of 97 female North Korean refugees who had checked out of Hanawon, a South Korean government resettlement center for North Korean refugees, the average score for PTSD was 2.48 points. On average, the highest score for specific symptoms on SCL was somatization (1.30), followed by depression (1.16), anxiety (0.98), obsessive-compulsive disorder (0.98), psychoticism (0.91), interpersonal sensitivity (0.89), hostility (0.77), paranoid ideation (0.64), and phobic anxiety (0.60). Similarly, Tekin et al. [30] in study is to investigate the prevalence and gender-based differences in symptoms of PTSD and depression among Iraqi Yazidis displaced into Turkey. Of the participants, 42.9% met the DSM-IV diagnostic criteria for PTSD, 39.5% for major depression and 26.4% for both disorders. More women than men suffered from PTSD and major depression. More women than men with PTSD or depression reported having experienced or witnessed the death of a spouse or child. Women with PTSD reported flashbacks, hyper vigilance and intense psychological distress due to reminders of trauma more frequently than men.

In another Palestinian in Gaza Strip sample consisted of 449 subjects. The age ranged from 21 to 60 years with mean age 41.5 years. The study showed than 52.6% had anxiety and 50.6% had depression. Females scored more anxiety and depression than males. Mental health symptoms were more in family with family monthly income $300 and less and in families with 8 and more children [31].

The results of this study showed that Palestinian families coped with stressful situations by religious coping strategies such as it is God wish, attending religious meeting. The results showed that the common coping of family was reframing, acquiring social support and seeking spiritual support. Similarly, in another study of 338 Oromo and Somali refugee youth, the most frequently endorsed coping mechanisms were praying, sleeping, reading, and talking to friends [32]. Clearly, the nature of social support as coping strategies that is sought is strongly influenced by cultural context. For example, Kim et al. [33] found that unlike European Americans, Asians and Asian Americans are more likely to utilize and benefit from social support that does not involve explicit discussion of stressful events. Consistent with our study, Thabet et al. [34] in study a sample of Palestinian 374 adults showed that 42% reported full criteria of PTSD.

The study showed that total coping strategies used by refugee were positively correlated with phobia, acquiring social support was positively correlated with phobia, reframing was correlated negatively with obsession, positive appraisal was positively correlated with hostility, obsession, paranoid, phobic anxiety, and psychoticism, mobilizing family to acquire and accept help was positively correlated with somatization phobic anxiety and psychoticism.

Positive religious coping (such as seeking a lesson from God, seeking spiritual support and seeking religious direction) is also often reported to have positive mental health outcomes among those who have been exposed to conflict and trauma. In Muslim countries, emotion and social coping include discussing feelings with others, talking to someone to find out more about a situation, getting emotional support from friends and seeking sympathy and understanding from others [14]. Also, among Afghan participants, emotion and social coping has been commonly reported. In a study of Afghan and Kurdish refugees, socializing was one of the most common ways of handling stress, with over half of the women interviewed reporting that they would often discuss their problems with friends or family, and that these friends and family were able to provide emotional support [35]. Similarly, in study Palestinian in Gaza Strip sample consisted of 449 subjects. The results showed that mean total family coping strategy was 107.28. Males were significantly reported more coping strategies, including acquiring social support, reframing, seeking spiritual support, and mobilizing family to acquire and accept help. Total mental health problems were negatively correlated with total family coping strategies, acquiring social support, reframing, seeking spiritual support and positive appraisal [34]. In another study of 358 patients with cancer in the oncology department at Shifa Hospital in Gaza Strip. The study showed that 42.5% of patients had PTSD, patients commonly used affiliation, reinterpretation and by self-control as main coping strategies. There were positive significant correlation between wish and avoidance thinking and re-experience of PTSD. In addition there were positive significant correlation between accountability, trouble and escape and total PTSD scores, re-experience, avoidance, hyper arousal. While, there were negative significant correlation between problem solving, avoidance, affiliation, reinterpretation, self-control and re-experiences, avoidance, hyper arousal [36]. Additionally, Wildt et al. [37] in a study examined the relationship between war trauma and distress and the potential moderating role of emotion and social, avoidant and religious coping among 81 participants seeking medical services at a primary care clinic in Kabul. Results revealed a significant contribution of war-

related traumatic events (11%) to symptoms of distress and an additional contribution of non-war-related trauma (7%) to distress. Emotion and social coping and avoidant coping were positively correlated with distress.

Study Limitations

Several study limitations should be noted. First, the cross-sectional nature of this study precludes any conclusions regarding causal directionality among variables and future research should be conducted to clarify associations using longitudinal research designs. Further, participant selection was restricted to only three refugee camps in the Gaza Strip. Also, some of the measures used also posed difficulties. Culturally grounded and standardized measures were used whenever possible. English and Arabic translated measures appropriately during administration. This study raises some interesting questions to be examined in future research. For example, research might further examine the use and meaning of social support and family support in this refugee population and what types of coping strategies are considered beneficial in dealing with trauma. Also, interest may be the long-term use of avoiding talking about traumatic events and its mental health effects over time. Future studies may involve the creation and standardization of a religious coping scale that is valid and reliable in Palestinian culture. Additionally, as participants reported using religious coping, future studies may focus on what aspects of religion are correlated with mental health and well-being, and explore the role of turning to God versus turning to people in dealing with distress in high-conflict areas.

Clinical Implications

This study and previous studies in the Gaza Strip had shown that war-related traumatic experiences are prevalent in Gaza Strip and that they are associated with heightened distress, which further underscores the importance of developing mental health services. Future research that includes the training of primary health care professionals, health workers, counselors in the effects of trauma and culturally adapted counseling skills that capitalize on people empowerment and building on strengths appears particularly relevant. We suggested, as integrating mental health services into primary health care, religious organizations, and community outreach efforts may make care more accessible, help to destigmatize mental health problems and thus help individuals and families make use of available resources.

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