Due to current war and conflict many children lost their fathers and they found it difficult to cope effectively with the problems they face and life situations. Lack of adequate parental care and effective coping following the loss accounted for the increase in mental health disorder and there was some evidence that it acted as a 'vulnerability factor' increasing risk of depression during a 1 –year follow up period, in the presence of severe life event or major difficulty. *Traumatized children* experience hard and distinct situation, which reflect poor psychological problems; such as anxiety, and irritability, behavioral problems; avoidance, social withdrawal, emotional problems; depression, irritability, and shock, in addition to many other symptoms which has bad effect on the children development. *The coping strategies* for these children are mainly based on how these children cope to traumatic events and what are the events encountered, they will develop many different types of coping for such events and they will adopt many approaches to cope depending on the traumatic events itself, so different coping strategies will be used.

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Salem Al-Arjani

Coping of Traumatized Children: COPE Inventory Validation

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CHAPTER ONE

Introduction

Preface

In the shade of the crisis we live nowadays and suffering of political violence against Palestinian people, they suffer from different stressful life situations, and traumatic events. Due to current war and conflict many children lost their fathers and they found it difficult to cope effectively with the problems they face and life situations.

The author concern the children of martyrs as a special case, since they are the real loser. Fathers are considered as the backbone of the Palestinian family especially for the children who are in need for parental psychosocial and emotional support.

Lack of adequate parental care and effective coping following the loss accounted for the increase in mental health disorder and there was some evidence that it acted as a 'vulnerability factor' increasing risk of depression during a 1 –year follow up period, in the presence of severe life event or major difficulty (Bifulco et al, 1987; Al arjani, Thabet and Vostanis, 2008; Saidam and Al arjani, 2018; and Saidam and Al arjani, 2020).

Furthermore, after father absent, boys reported by their teachers as less advanced in moral development (Stantrock, 1975; Al arjani, Thabet and Vostanis, 2008). But that differ in study of Tehrani (2003) who found the longer the time of father loss, the higher the digit span scores of the bereaved adolescents.

However, most individuals who experience the loss or potential loss of a person or thing to which they ascribe importance in their lives undergo the process of 'normal grief (Tully, 2003; Al arjani, Thabet and Vostanis, 2008).

Families are the most central core and enduring influence in children's lives; the health and well-being of children are inextricably linked to their parents' physical, emotional, social health, social circumstances, and child-rearing practices (Village, 2003; Al arjani, 2005).

Children experience the same *traumatic events* in different ways, as anyone who has lost loved one " *martyrs"* will be different responses to the event. This is caused by different degrees of involvement: the children's distance from the "traumatic event" and complex individual characteristics that render children more or less vulnerable to the impact of life events(Al arjani, Thabet and Vostanis, 2008).

Frequently, they will develop specific mechanisms and manner to deal with these traumatic events. These mechanisms were developed to cope and accommodate the traumatic events which developed and called coping strategies.

Traumatized children experience hard and distinct situation, which reflect poor psychological problems; such as anxiety, and irritability, behavioral problems; avoidance, social withdrawal, emotional problems; depression, irritability, and shock, in addition to many other symptoms which has bad

effect on the children development(Al arjani, 2005; Al arjani, Thabet and Vostanis, 2008).

Thabet et al (1992) in a review of the referred children to Gaza community mental health program have traumatic event by witnessing violence against relatives and parents.

The *coping strategies* for these children are mainly based on how these children cope to *traumatic events* and what are the events encountered, they will develop many different types of coping for such events and they will adopt many approaches to cope rely on the traumatic events, so they will be different coping which used by them.

The coping strategies are conceptualized as purposeful responses that are directed toward resolving the stressful relationship between the self and the environment (problem-focused coping) or toward palliating negative emotions that arise as a result of stress (emotion-focused coping) or coping as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person (Lazarus and Folkman, 1984; Al arjani, 2005; Al arjani, Thabet and Vostanis, 2008) .

In this book the author will discusses the dimensions of coping strategies which are (1)problem- versus (2)emotion-focused coping, (3)primary versus (4)secondary control coping, and (5)engagement (approach) versus

(6)disengagement (avoidance) coping and the *traumatic events* that affect the children due to father loss.

This book will explore the *coping strategies* of *traumatized* children in Palestine, and the types of *coping* which used in response of traumatic events and father loss. Children and young people trying to use normative adaptive defense mechanisms to overcome their problems, and they use coping strategies to develop positive thinking and behavior accepted by Islamic society (Hundt et al, 2005; Al arjani, 2005; Al arjani, Thabet and Vostanis, 2008).

The author realizes that individual differences and religion play an important part in the coping with such events (e.g. go to pray, and listening or reading Qura'n may helpful coping to pass the stressful traumatic events).

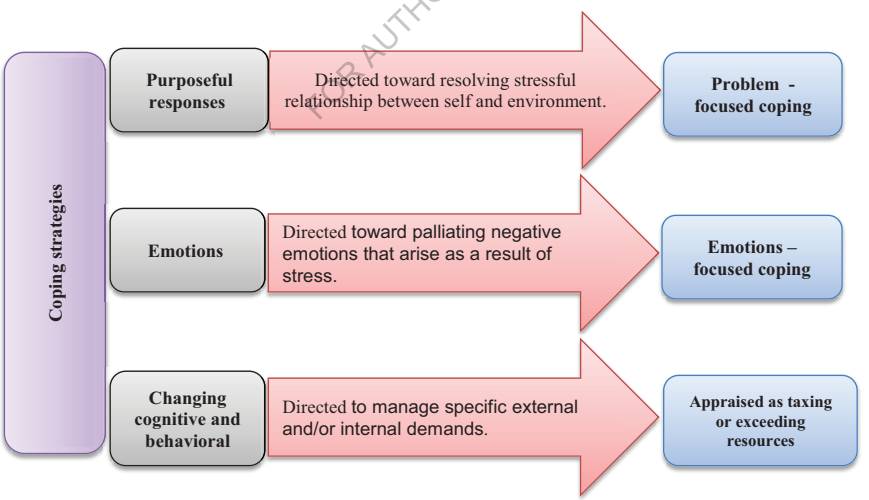


Figure: 1: conceptualization of coping strategies

CHAPTER TWO

loss and traumatic events

Loss and deprivation

Loss involuntary severance or detachment of the child from the parent(s) permanently (death occur), that due to war, violence, and different types of killing(Dosogi, 1997; Al arjani, 2005; Al arjani, Thabet and Vostanis, 2008). *Loss of father* also may be defined as '' separation, detachment, or absence of father from the child normal life in an early or late age due to sudden death, war, and direct killing by the occupying forces(Al arjani, Thabet and Vostanis, 2008).

By reviewing literature the author found that there are many studies that concerning the loss of father and its effect on the children, and how the children cope with these situation. Dosogi (1997) found significant differences in adjustment of family, health, social and emotional between siblings of divorced and siblings of deprived from their father in the standards of psychological adjustment and total adjustment in favor of siblings whom deprived from their father.

In addition to the importance of father presence in the children life, they concern the major and minor effects of father loss and clarified the issues and trends toward helping the children who lost their fathers (Blum, 2004; Boham, et al 2001; McCormick et al, 2000; Beaty , 1995; Mott, 1990; Stevnson, Black, 1988;Miller, 1984; Svanum et al, 1982; Earls, 1976).

Derivation as defined by (Brilingham, 1943) in A. Abu Zaied review; 2002 and Al arjani, 2005; as ‘’ children without shelters or families, their life destroyed because of hard circumstances, separated from their families, and psychologically deprived from their parents’’.

Moreover, in the same review *deprivation* defined as ‘’ those children who deprived from their parents and their natural families life, that expected to live’’.

In addition to, ‘’ deprivation of sons from parents, if they stay away from them, and lost their care and directions, and identification with their parents values due to divorce, separation, mortality, morbidity, disability or poverty(Al arjani, 2005; Al arjani, Thabet and Vostanis, 2008).

All the previous definitions carried out the family care and life, but in this book, the author focus on the loss of children from their father.

Father loss

The most clearest and proponent role in the family members is the father, who plays the major role in caring the children during the developmental stages, father is caregiver, problem solver, the one who meets the needs of the children, and give them psychological and emotional support(Al arjani, 2005; Al arjani, Thabet and Vostanis, 2008). Marjan (2003) She believed parents to be cornerstones of the family, and she characterized loss of a parent as equivalent to losing half of one's emotional support, love, physical and psychological assistance, also opportunities for learning.

The most important issues today that face the communities are the role of the father in caring for his children, and how to care them this is for the children who have parents (father), but what about the children who lost their father(Al arjani, 2005; Al arjani, Thabet and Vostanis, 2008).

They are traumatized, emotionally unstable, have psychological problems, and behavioral problems. In addition, nobody asks about them, in spite of the expectation that they are cared by one another did this compensate the presence of their father in their life?! absolutely not! children who lost their father suffer from many psychological problems and disorders, which must be assessed and evaluated to be treated(Al arjani, 2005).

A young child's loss of a parent in war due to a violent death or disappearance is a severe trauma by the most stringent of definitions. The alarming increase in terrorism, limited, civil, or ethnic wars are resulting in an ever increasing number of war orphaned children(Al arjani, 2005). In a review of mother loss, the finding indicates that there is an increase in clinical depression in adulthood, and another study estimated that young children cannot mourn like adult (Bifulco et al, 1987; Sekaer, 1987).

In another review of the impact of war on children are few and rarely examine the specific effect of parental loss other than retrospectively (Hart, 1993).

Bohm et al (2001) found that boys with divorced parents indicated more stress than do the comparative group.

Children and the loss in the family

It is important that to help children through the various stages of grief and they will need adult support to do this. Those who look after them will not want children to be hurt. They may want to avoid talking to the children in order to protect them from unnecessary pain(Al arjani, 2005). Yet in practice, this is unlikely to be possible, for children will soon notice that the surviving adults are behaving strangely, and that something is wrong.

Children, like adults, differ widely in their reactions to death (Sheppard, 2004). In addition, Sheppard added that it is best, if possible, to bring the news of the death to them individually. This makes it possible to choose the best words for each child. It may help those who care for children to know how they view death, and how this varies with the age of the child. *Religious* beliefs and the relationship with the deceased person will also be important factors.

Around the ages of seven or eight, a child feels that there is life where there is movement in nature. A cloud is alive as it blows across the sky. Water is alive when it gurgles and runs in the stream(Sheppard, 2004; Al arjani, 2005; Al arjani, Thabet and Vostanis, 2008). As children can now accept that some things are dead, they may begin to take an interest in what happens after death.

Seven or eight year old child may become fearful of death because they realize for the first time that it is real(Sheppard, 2004). They may feel very worried by the thought of losing a parent. Death can now be seen as

something that attacks you and takes life. Children are now able to accept that death is final. It is important for children of this age to show their sadness, anger, fear and guilt. At this age children often feel guilty, and this is partly because they still believe in magic. Almost all children at some time wish to eliminate their parents and siblings, and they may even dream about different ways to do it(Alarjani, 2005; Saidam and Al arjani, 2020).

Children of seven to nine may believe that their 'death wish' actually caused the death. They are much more likely to think about this than adults, for they are not yet wise enough to realize that this could not happen(Sheppard, 2004). Because children of this age are concerned with understanding death, they may search to find a 'cause' for it. They will then direct anger towards someone or something that 'caused' it. In the case of car crashes, it is best if the child feels angry about the driver of car, so that they do not have to search for other causes.

Children of this age may fear that death is a punishment for bad behavior even more than younger children(Sheppard, 2004; Al arjani, 2005). They may fear that their naughty behavior has brought about the death of a loved one, and that they are likely to be punished for it. They may fear that their other parent or they themselves will be the next to die. Because children simply cannot understand death like adults can, it is more difficult to rid themselves of feelings of anger and guilt than it would be for an adult.

More adult ideas about life and death develop roughly between the ages of nine and eleven(Al arjani, Thabet and Vostanis, 2008). By this age, children have learned that only people, plants and animals are alive. They know that something has happened which cannot be explained or understood.

Children of this age are not only sensitive to their own feelings, but can also share the feelings of others, and better understand what the loss may mean to them. Children aged nine to eleven need comfort and support, however, they can be a source of support and comfort to others, if they are given the chance to be helpful to others during the crisis. This can help them cope with their own feelings(Al arjani, 2005; Al arjani, Thabet and Vostanis, 2008).

Reactions to the loss

People of all ages experience losses. One of the many things children learn is how to *cope* with *loss* (Sylvia Ridlen*,* 1998). Where it may be relatively minor and require brief adjustment process or they may more significant, causing major changes life, either temporarily or permanently.

Separation anxiety, sleep disturbances, temper tantrums, aggressive behaviors, and regression in behavior and bodily functions are among common bereavement reactions in preschool children(Sylvia Ridlen*,* 1998; Al arjani, 2005).

Denial of the death, excessive guilt, phobic and hypochondriacally behaviors are among common bereavement reactions in school aged children between 6 to 10 years of age (Marjan, 2003; Al arjani, 2005).

One kind of loss that young children experience is death or *loss* of access parents or other significant adults through divorce, relocation, hospitalization institutionalization, or incarceration(Sylvia, 1998).

Another is the *loss* of home because of eviction home demolition. Usual reactions to loss include feelings sadness and regret. Fear is another common early childhood response to loss grief(Al arjani, 2005).

Young children do not express feelings like adults do, and they express them differently at different ages (Sylvia, 1998).

Different ages, children adjust to loss differently, depending on their intellectual and emotional development and social supports. Children's capacity to sustain sad emotions increases with age and maturity. Apparent lack of sadness may lead adults to believe they are unaffected by the loss. Normal signs of grief in children, particularly young children, include bed wetting, loss of appetite, tummy upsets, restlessness, disturbed sleep, nightmares, crying, attention-seeking behavior, difficulty concentrating, increased anxiety and clinginess(Sylvia, 1998; Marjan, 2003; Al arjani, 2005). These only become a cause for concern when they occur over a prolonged period. Particular characteristics of the loss can also influence a young person's reaction to loss. The loss of something or someone central to the security of the world of the adolescent will challenge the adolescent's ability to integrate the loss.

Parental loss through death or divorce, traumatic loss, abuse, loss of a treasured boyfriend or girlfriend or serious illness have all been associated with strong reactions among young people(Sylvia, 1998; Marjan, 2003; Al arjani, 2005).

However, some losses that a) may seem of a relatively lesser importance to others, b) whose effects are slow to develop or c) whose effects may not be recognized or are misinterpreted as related to other causes may be central to the world of the young person, and as such, lead to severe short- and long-term reactions (Murray, 2002).

Children are particularly vulnerable to the effects of *trauma* and may need to have specific interventions to assist them in their recovery. Typically children look to their parents for assurance and assistance when faced with painful situations (Richard and Rosse, 2004).

Older children often display changes in personality and alterations in psychosocial functioning including depressive mood, sleep and appetite disturbances, angelic behavior, rudeness, learning problems, lack of concentration and refusal to go to school. School work may be affected by underachieving or overworking(Murray, 2002; Richard & Rosse, 2004).

Boys, particularly teenagers, are likely to experience academic difficulties in the early months following parental death, but bereaved children do not necessarily develop long-term learning problems.

In adolescents, bereavement can cause a regression to a younger, more dependent stage in their development. Emotions may be suppressed, resulting in a display of apparent indifference or lack of feelings. Some teenagers start truanting, turn to petty delinquency or begin shop-lifting as a general protest against the upheaval in their family life. This is more likely in adolescents who have lost their mother, particularly girls. Others become silent, withdrawn and self-critical(Murray, 2002; Richard & Rosse, 2004).

Many young people will grieve privately and shed their tears in the solitude of their own rooms, maintaining a brave face in society. In an attempt to numb the pain some youngsters develop self-destructive behavior such as excessive drinking or drug taking(Alarjani, 2005).

Reaction to the fear of death may cause some teenagers to take unnecessary chances with their lives. By confronting death they try to overcome their fears and demonstrate their control over their own mortality(Al arjani, 2005; Al arjani, Thabet and Vostanis, 2008). Some children will assume the role of a parent taking on heavy responsibilities causing them to mature rapidly and denying themselves the opportunity or permission to grieve. Others will take this experience in their stride. Often after a major bereavement children suffer some form of depression and a loss of confidence.

Thus, it is important to help build up their resilience. Life has obliged them deal with a terrible blow and they may feel incapable of carrying on. They need help to examine their own skills and acknowledge the things they are

good at, to focus on the positive things that they can do, however small, to improve the situation (Drengenberg, 2001). Although they may have lost an important person in their life, they can usually find other support mechanisms, suicide, etc) are more likely to need specialist professional help, both at the time of the death and also in the years to come, as they mature and reflect on the death and why it happened.

The kinds of reactions to this *traumatic event* are numerous and depend on how this incident impacts an individual or family (Jacalyn, 2001). Did a loved one die as a result of the terrorist act?, was job or an opportunity lost?, did income vanish, was a trip for pleasure or to visit a family? or friend postponed?, and was a sense of security and safety threatened? Everyone has been affected differently and will experience different physical and emotional responses(Al arjani, 2005).

Responses to a *stressful event* are very similar to those experienced during the grieving process. Lump in the throat, frequent sighing, and sensitivity to noise, dry mouth, sleeplessness, indigestion and more. Many of these attitudes about children and loss are myths.

Children react differently to death and other losses than adults, but that does not mean that they don't feel the losses as strongly or for as long a time as adults (Roman et al, 2003; Al arjani, 2005).

Most often losses occur before children have language, so they can't put into words what they are feeling. Children may not understand death in the way

that adults do, but that does not mean that they are lesser affected by the changes that have taken place in their life(Roman et al, 2003).

In fact, *grief* and *loss* can be experienced even more intensely by children because they don't have the adult experience and understanding to help them cope. Just as adults try to make sense of a loss and struggle with the unreality and pain of loss, so do children — only they are without the maturity that comes in time and experience to help them make sense of the loss(Roman et al, 2003; Al arjani, 2005).

By understanding more about *loss* and *grief* from a child's viewpoint we are in a much better position to help them deal with losses when they happen. We can learn what to say and what not to say. We can get a better idea of when a child is acting normally in response to a major upset in his life and when that child might need some special attention or help to move on(Al arjani, 2005; Al arjani, Thabet and Vostanis, 2008).

Children are all too frequently the victims and observers of severely *traumatic* events. These events, whether arising from natural disasters, large scale, man-made catastrophes, or acts of violence or war, have both immediate and long-term consequences for children involvement. Despite an abundance of research in recent years concerning adult reactions to traumatic events, the body of knowledge addressing children's reactions and treatment of their reactions remains fairly limited (Hart, 1993).

This symposium will focus on three different categories of *trauma* to which children are exposed, and will examine some of the variables, which may influence their reactions(Al arjani, 2005). In addition, based on their research and/or clinical experience, the presenters will discuss approaches for the treatment of traumatized children.

Trauma

Trauma had different *types* and *levels* that affect a wide range of population on both sides local or international. However, trauma classification merge under two major types type I and type II as classified by (Teri, 2004). Furthermore, *traumatic events* if occur under the aforementioned types may takes place continuously in the life, or intermittent, and/or by direct/ indirect effects.

Also, may have profound psychological effects that attack all age group adults as well as children. The children of the Occupied Territories in the Gaza Strip and West Bank have confronted a variety of traumatic events, including witnessing act of violence to friends, relatives, experiencing physical trauma themselves, imprisonment, and shootings (Thabet et al, 1992; Al arjani, Thabet and Vostanis, 2008). This leads to defining *trauma*; that is a state of shock, it's the body self –protective response to being threatened. Trauma in the Gaza Strip has been continuous for individual cases; and in families, specific trauma has often been repeated (Thabet et al, 1992). *Trauma* considered one of the most topics that studied in the current

century in both sides locally or internationally, so we shall discuss children reactions to traumatic events in this chapter as dimension of the current study.

Children's reaction to traumatic events

For an event to be *traumatic*, and not just bad, the event must seriously disrupt how a person understands, remembers, and feels to such an extent that the event is usually forced from memory and symbolic understanding(Thabet et al, 1992). Although the *trauma* is forced from consciousness, however, it often returns in the form of physical symptoms. Healing from *trauma* thus must be accomplished by creating a symbolic form, most often a story, that allows the person to work through his symptoms and come to terms with the traumatic incident (Berger, 2003; Al arjani, Thabet and Vostanis, 2008).

Also, *trauma* is a *catastrophic* event so it shatters a person's psychic equilibrium that he cannot represent the event to himself--can't assimilate the event into any stories of the world or self he knows(Thabet et al, 1992). Instead, the event actually disintegrates the stories that connect the self to the world. Children's who experience traumatic events (such as loss of father, brother, or friend) are at high risk for generating negative emotional reactions.

Traumatic events can have a profound and lasting cognitive, emotional, and psychological functioning of an individual (Ahmad et al, 1999; Thabet et al,

1992). Children are particularly vulnerable to the effects of trauma and may need to have specific interventions to assist them in their recovery (Allen, 2004). *Reliance* on parental report of life events, as well as parental perceptions of the positive or negative impact of these events on the child, assumes that parents are accurate reporters of their child's experiences (Thabet et al, 1992; Loss, 1995; (Allen, 2004).

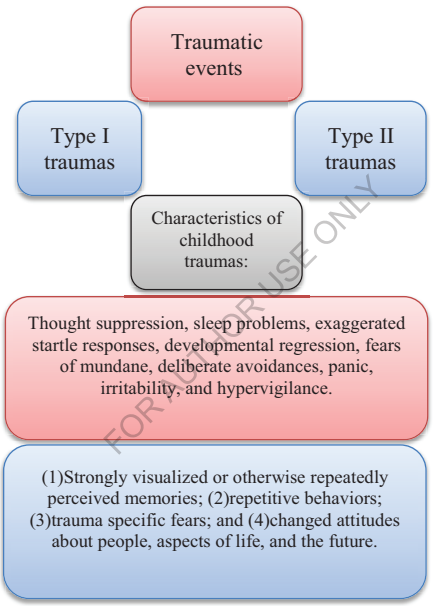


Figure2: types of traumas

CHAPTER THREE

Loss theory

Freud's psychoanalysis theory of loss

Freud's *mourning theory* has been criticized for assuming a model of subjectivity based on a strongly bounded form of individuation.

This model informs "*Mourning* and *Melancholia*" (1917), in which Freud argued that mourning comes to a decisive end when the subject severs its emotional attachment to the lost one and reinvests the free libido in a new object. Yet Freud revised his *mourning theory* in writings concerned with the Great War and in *The Ego and the Id* (1923), where he redefined the *identification process* previously associated with *melancholia* as an integral component of mourning.

By viewing the character of the ego as an elegiac formation, that is, as "a precipitate of abandoned object-cathexes," Freud's later work registers the endlessness of normal grieving; however, it also imports into mourning the violent characteristics of melancholia, the internal acts of moralized aggression waged in an effort to dissolve the internal trace of the other and establish an autonomous identity.

Freud's text offers a theory of mourning beyond melancholy violence, his account of the elegiac ego is shown here to ultimately undermine the wish for an identity unencumbered by the claims of the lost other and the past, and to suggest the affirmative and ethical aspects of mourning.

In Melancholia" (1917), Freud begins by defining similarities between the two responses to loss he otherwise seeks to distinguish. Mourning and melancholia entail similar symptoms: "profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, and inhibition of all activity".

Moreover, both "normal" mourning and "pathological" melancholia may arise in "reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as one's country, liberty, and ideal, and so on". Whether in response to literal death or symbolic loss, mourning names an experience of grief and a process of working through during which the mourner relinquishes emotional ties to the lost object. While drawing on prevailing assumptions about the mourning process, Freud suggested this detachment of libido takes place through a "testing of reality." Although he admitted a lack of complete knowledge about reality testing, Freud maintained that the mourner severs attachments primarily through a labor of memory: "Each single one of the memories and expectations in which the libido is bound to the object is brought up and hypercathected, and the detachment of the libido is accomplished in respect of it. When the work of mourning is completed the ego becomes free and uninhibited again".

As Freud concludes of *The Ego and the Id*, however, he largely undermines the insights of his own findings. Indeed, when he lays out the resolution of the oedipal complex Freud argues that identification with the rival object (rather

than the lost love object) governs “normal” subject formation. Consider, for example, his discussion of the “simple positive Oedipus complex in a boy,” which is characterized by an “ambivalent attitude to his father and an object-relation of a solely affectionate kind to his mother.

Freud claims that in negotiating the loss of the mother, the boy replaces this maternal object-cathexis “by one of two things: either an identification with his mother or an intensification of his identification with his father”.

Freud does acknowledge the possibility of the former mode of identification by suggesting the boy may identify with the lost maternal other; however, he renders this option an exception to the general rule in claiming that we “are accustomed to regard the latter outcome as the more normal”.

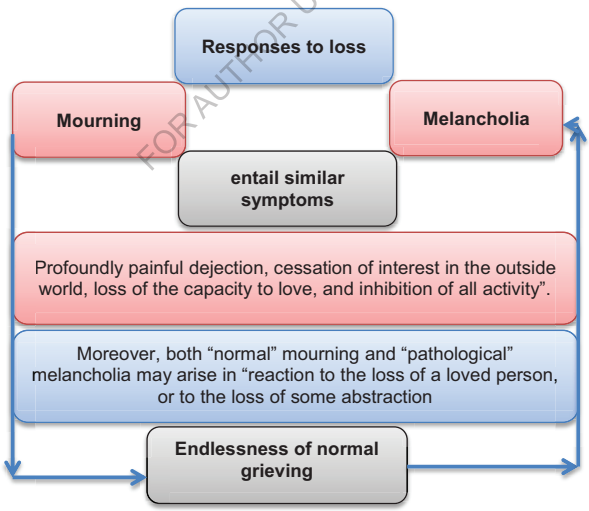


Figure:3: responses to loss

CHAPTER FOUR

Coping strategies

Coping strategies are one of the most widely used strategies to cope with *stressful*, and *traumatic events* by adult as well as children. Lazarus and Folkman (1984) defined *coping* as '' constantly changing cognitive and behavioral efforts to manage specific external and/or external demands that are appraised as taxing or exceeding the resources of the person''.

Also, *coping* is viewed as an ongoing dynamic process that changes in response to the changing demands of stressful events, and conceptualized as purposeful responses that are directing toward resolving the stressful relationship between the self and the environment(Al arjani, 2005; Al arjani, thabet and Vostanis, 2008).

Skinner and wellborn (1994) defined *coping* as '' how people regulate their behavior, emotion, and orientation under conditions of psychological stress''.

Coping strategies can be helpful guide for traumatized children, and must be learned them to cope traumatic events such as loss of father, brother or mother.

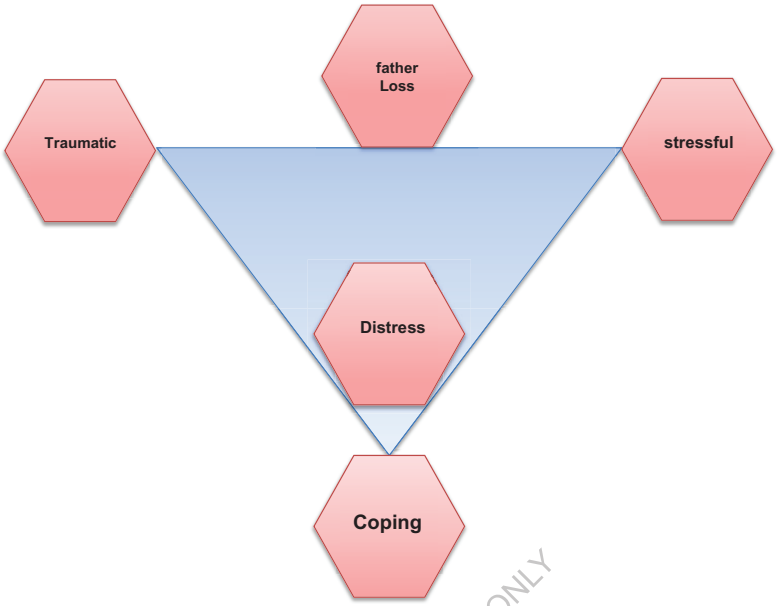
Terri et al (1997) added that *coping strategies* can be integrate traumatic events so that they can avoid developing chronic or delayed responses. Although the field of the coping research is indebted to the strides of this model, coping is a complex process involving array of involved strategies that serve to regulate the individual's stress response and mediate psychological outcome (Boeving, 2000).

Furthermore, *coping* is best conceptualized as a dynamic process rather than as a categorical behavioral response to a specific situation. *Coping* has been as a universal term to cover a wide range of variables, but there are two approaches in the literature, which resolve a round coping style and coping strategies (Boeving, 2000; Abbott, 2003).

Consequently, in this book the focus will be on five basic theoretical approaches to coping. *Psychoanalytic approaches* focus on the use of defense mechanisms, while *personality approaches* focus on coping styles. Both of these assume that adaptation is primarily a function of personal characteristics. In contrast, *the coping process approach* draws upon cognitive behavioral models, and is more likely to emphasize environmental demands and influences on coping(Al arjani, 2005; Al arjani, thabet and Vostanis, 2008).

Coping process approaches tie the *coping strategies* to a particular stressful episode. And, daily *coping processes* use experience sampling techniques to examine how individuals cope throughout the course of the day with a wide variety of problems. *Religious coping* is one of the most coping styles in our community, so we have identified religious coping to follow and consider instructions of our religion.

Furthermore, the author tries to draw a representative diagram for the cause –effect relationship between father loss that leads to traumatic and followed by situation of distress and causes the coping strategies.



Out-come

(**discrepancy**)

Figure:4 (Source: Al arjani, 200

Psychoanalytic approaches

Research on how individuals adapt grew out of early psychoanalytic studies of defense mechanisms, which are considered to be unconscious ways of warding off anxiety. DSM-IV (American Psychiatric Association, 1994) currently identifies seven major types of defense mechanisms, and orders them hierarchically from more to less severe.

1. *The most severe* is *defensive dysregulation*, which refers to frankly psychotic processes involving (projection, denial, and delusion);
2. *Action* refers to *(acting out*, passive aggression, or apathetic withdrawal);

3. *Major image-distorting* mechanisms include (autistic fantasy, projective identification, and splitting);
4. *The less severe* or "*immature*" mechanisms include disavowal (denial, projection, and rationalization),
5. *Minor image-distorting* (devaluation, idealization, and omnipotence);
6. *Mental inhibitions* (displacement, dissociation, intellectualization, repression, and the like); and
7. *High adaptive* or "mature" defense mechanisms include (altruism, humor, and sublimation, as well as suppression).

Cramer (1991) compared the similarities and differences between defense mechanisms and coping processes.

Defense mechanisms are unconscious, non-intentional, dispositional, hierarchical, and associated with pathology, while *coping processes* are conscious, intentionally used, situational determined, nonhierarchical, and associated with normality. In other words, defense mechanisms are designated a priori as being more or less adaptive, and are not consciously chosen(Cramer, 1991; Al arjani, 2005).

Individuals nonetheless can be characterized by primary defensive styles or defense mechanisms that they are most likely to exhibit under a wide variety of circumstances.

In contrast, *coping processes* are thought to be consciously chosen and are responsive to environmental demands(Carmer, 1991). Rather than

hierarchically ordered, the effectiveness of coping processes is thought to vary as a function of appropriateness to environmental demands.

Defense mechanisms are traditionally studied via the use of intensive interviews and case studies. However, as Cramer (1991) points out, there is a logical inconsistency in asking individuals to report on unconscious processes, and researchers are more likely to use observational methods and/or rely upon qualitative research coding interview or projective materials. In part because of the difficulty of systematically assessing defense mechanisms, there have been few large-scale studies of the adaptation outcomes of defensive strategies. Indeed, more research has been directed to identifying the developmental trajectory of defense mechanisms.

Coping styles

A major outgrowth of the psychoanalytic literature was the conception of *coping styles*, which borrowed some of the language from psychoanalysis but was more focused on how people deal with information than how they deal with emotions per se.

Coping styles (e.g. avoidant, optimism) are viewed as trait indicating that a person will always use their dispositional style of coping in all strategies (Abbott, 2003). Also, Abbott added that several *coping styles* have been described and given distinctive terminology by their respective authors, but there is a good deal of overlap, and hence confusion, between them.

The earliest typology was repression-sensitization. Repressors avoid or suppress information, while sensitizers seek or augment information.

This *dichotomy* has reappeared in many different guises over the past 40 years, with blunting-monitoring and approach-avoidance being the current manifestation of dichotomy.

In general, approach monitoring-vigilant *coping styles* have been shown to be associated with better outcomes in a variety of situations, while repression-avoidant-blunting styles are associated with poorer outcomes. *Dichotomizing* coping strategies into two broad modalities can be psychometrically appealing(Cramer, 1991; Abbott, 2003).

However, even early research by Lazarus and his colleagues showed that both types of coping were used in over 80% of episodes, and often individuals in highly stressful situations alternate between approaching and avoiding the problem (Folkman & Lazarus, 1980; Lazarus, 1983). Nonetheless, the use of particular emotion-focused coping strategies may be more consistent across time and strategies, suggesting that individuals may have characteristic ways of dealing with and/or expressing emotion.

By knowing *the coping styles* and its implication, it is not necessary to choose between the use of problem –focused versus emotion –focused coping approach or engaged coping strategies, both strategies can be employed in an interactive way to regulate oneself activity in the context of the a stressor (Boeving , 2000).

Coping process

As mentioned earlier, *the coping process approach* draws upon the cognitive behavioral perspective, and argues that coping is flexible and responsive to environmental demands, as well as personal preferences(Folkman and Lazarus, 1980; Lazarus, 1983). In this model, how individuals cognitively appraise situations is the primary determinant of how they cope.

The four primary appraisals are benign, threat, harm/loss, and challenge, and these are influenced both by environmental demands and individual beliefs, values, and commitments (Lazarus & Folkman, 1984). Rather than examining general coping styles, coping process approaches examine how individuals cope with a particular stressor.

Coping process approaches have recently come under attack from a variety of perspectives. Critics have charged that the factor structure for such inventories as the Ways of Coping is not stable, either across time or across samples although the factor structure for the COPE (Carver, Scheier, & Weintraub, 1989), another widely-used coping measure, is also less than satisfactory. Nonetheless, there is broad agreement concerning the types of coping strategies that exist.

There are five general types: (1)problem-focused coping, (2)emotion-focused coping, (3)social support, (4)religious coping, and (5)making meaning. Note that coping strategies are not mutually exclusive, and even strategies which may seem orthogonal, such as suppressing and expressing emotions, may

be used sequentially in the same situation. Within each general type of coping strategy, there may be several subtypes(Carver, Scheier, & Weintraub, 1989; Al arjani, 2005).

Problem-focused coping includes cognitions and behaviors that are directed at analyzing and solving the problem. It may include "chunking" or breaking a problem into more manageable pieces, seeking information, and considering alternatives, as well as direct action(Carver, Scheier, & Weintraub, 1989).

Sometimes delaying or suppressing action is seen as a separate problem-focused strategy. Delaying action or decisions may be used in health circumstances in which people are waiting for the outcome of tests, and suppressing action may be useful in avoiding actions which may make a problem worse, such as acting in anger.

Emotion-focused coping is often seen as a strategy in and of itself, but is best conceived as involving different sub-types. Avoidance and withdrawal may be different from expressing emotion, and suppression, setting one's emotions aside in the service of a problem-solving effort, is clearly different from the use of substances to regulate emotion(Carver, Scheier, & Weintraub, 1989).

Avoidance, withdrawal, and substance use are most generally associated with poor outcomes (Carver, Scheier, & Weintraub, 1989; Aldwin, 1994).

Seeking *social support* and *religious coping* are strategies that involve elements of both problem-focused and emotion-focused coping.

Support seeking may include asking for advice, concrete aid, emotional support, or justification for one's perceptions. Similarly, *religious coping*, which includes prayer, is generally considered a form of emotion-focused coping, but may involve asking for advice or even concrete aid(Carver, Scheier, & Weintraub, 1989).

The study of religious coping strategies is as yet in its infancy, and the associations of two outcome measures by vary by religious denomination. In general, religious coping may be most helpful with uncontrollable stressors (Aldwin, 1994) or for lower socioeconomic status groups and/or actions.

Daily process coping

Daily process coping involves the assessment of coping strategies generally directed at specific problems once or more per day (Aldwin, 1994). Respondents may be asked to fill out questionnaires every evening, or they may be beeped and fill out mini inventories on the spot.

The correlation between process and retrospective measures of coping is a matter of some controversy. Nonetheless, the associations between momentary coping and process outcome measures tend to be encouraging, although there are within-subject and between-subject (aggregated) analyses may differ in some curious ways which merit further investigation.

For example, Affleck et al. (2000) examined daily diary associates between coping and alcohol consumption in moderate- to heavy-drinking men and women. Aggregating the data, they found problem-focused coping had no

effect average consumption, emotion-focused coping was negatively-related to consumption, but avoidant coping was positively related. However, a very different pattern of results emerged from the within subjects analyses. Instead of the aforementioned pattern, they found an inverse relationship between problem-focused coping and alcohol consumption.

Hung (2001) said that what is *stressful* or *traumatic* for one child is not necessarily stressful or traumatic for another because of differences in cognitive appraisal and available coping behavior, and they notified that all children provided responses to the questions about coping behavior they used to. It is one thing to describe individual differences in dealing with everyday stressors or even life events, but it is quite another thing to generalize this to traumatic situations.

By definition, *traumatic situations* are generally outside of individuals' usual experience, and most individuals have not developed the necessary repertoires to know how to deal with such events (although military personnel and some categories of civil servants such as police, firefighters, and emergency medical technicians do receive training).

It would be tempting to argue that the environmental press of trauma is so great that there are few individual differences in reaction to it. However, closer examination of the trauma literature reveals marked individual differences in how people cope even with traumatic situations, although clearly environmental factors may constrain choices. Further, as the author

saw, how coping strategies can influence the long-term psychological and perhaps physical responses to the trauma.

Religious coping

The author claims that *religious* or *spiritual* coping is considered one of the most important coping in our community, since we believe in Allah our god(Al arjani, 2005; Al arjani, Thabet and Vostanis, 2008). Also, the known that most of the people pray, and believe that they must be patient in front of challenges and critical problems that face them such as loss of loved one, and they believe that they will be rewarded in the last life (religion day). So, their coping depends upon their credence with Allah(Al arjani, 2005). As the severity of the *traumatic event* increase our values increase and cope with it. Many of the studies pointed the importance of the religious coping like Al arjani (2005), Al arjani, Thabet and Vostanis (2008) and Thabet et al (1991). Evidence exists that African-American may cope differently with traumatic events or stressors as compared to their Caucasian counterparts, specifically these groups may differ in the degree to which they engage in the religious coping (Kaiser ,2002).

Kaiser added that many researchers have hypothesized that religiosity is more closely related to the psychological well –being. Therefore, higher rates of religious coping might not be expected to be associated with lower rates of psychological distress, but may in fact be elevated in an effort to cope with elevated level of stress.

Spirituality is viewed as an individual's life philosophy, as the back drop to which the individual makes sense out of his/her experience (Boeving, 2000). The author saw that *religious coping* provides every one with a context whose he/or she must be, in addition it provide the framework of how to cope with traumatic events(Al arjani, 2005).

Religious coping is most widely measured in adult response to stress or traumatic events, but it is neglected in the children research.

Seeking social support and *religious coping* are strategies that involve elements of both problem-focused and emotion-focused coping.

Support seeking may include asking for advice, concrete aid, emotional support, or justification for one's perceptions and/or actions.

Similarly, *religious coping*, which includes prayer, is generally considered a form of emotion-focused coping, but may involve asking for advice or even concrete aid(Al arjani, 2005).

As mentioned the study of religious coping strategies is as yet in its infancy, and the associations of outcome measures vary by religious denomination. In general, religious coping may be most helpful with uncontrollable stressors (Aldwin, 1994).

Proposed dimensions of coping (Carver et al, 1989)

According to the COPE instrument developed by Carver et al (1989), the author focused on the main subscale and the reason for its inclusion:-

- *Active coping:* is the process of taking active steps to try to remove or circumvent the stressor or to ameliorate its effects. It includes direct action, and increases one's efforts.
- *Planning:* is the process of thinking about how to cope with stressor. It involves coming up with action strategies, thinking about what steps to take and how best to handle the problem. It also, occurs during secondary appraisal; whereas active coping occurs during the coping phase.
- *Suppression of competing activities*: means putting other projects aside, trying to avoid becoming distracted by other events, even letting other thing aside.
- *Restraint coping:* is waiting until an appropriate opportunity to act and presents itself, holding oneself back, and not an acting prematurely. Also, it is active coping in the sense that person's behavior is focused on dealing effectively with the stressor and passive coping strategy in the sense that using restraint coping means not acting.
- *Seeking instrumental social support*: problem focused coping is seeking social support from others; also seeking advice, assistance, or information.
- *Seeking emotional social support*: getting moral support, sympathy, or understanding. That reflects "emotion focused problem".

- *Focus on and venting emotions*: the tendency to focus on whatever distress or upset one is experiencing and to ventilate those feelings. Such response may be functional e.g. " if a person uses a period of mourning to accommodate to the loss of a loved one and move forward".
- *Behavioral disengagement:* reducing ones' effort to deal with the stressor. Also, giving up attempting to attain the goal "helplessness".
- *Mental disengagement:* occurs via a wide variety of activities that serve to distract the person from thinking about the behavioral dimension. That includes using alternative activities to take one's mind off of a problem.
- *Positive reinterpretation and growth* "positive reappraisal": emotion – focused coping: coping aimed at managing distress emotions rather than at dealing with the stressor per se.
- *Denial:* a response that sometimes emerges in primary appraisal. It is often suggested to be useful because it minimizes distress and thereby facilitating coping.
- *Acceptance:* it is arguable that acceptance is a functional coping response, in that a person who accepts the reality of stressful situations would be a person who engaged in the attempt to deal with the situations.

- *Religious coping*: religion serves as social support and emotional support by relieving distress, and stressful situations that encounter the person.
- *Humor:* a coping strategy in which the person make jokes and funny situation concerning the distress events to escape from the confronting.
- *Substance use:* it is also a *passive* coping strategy in which the person goes to analgesia or alcohol drinking to make the things.

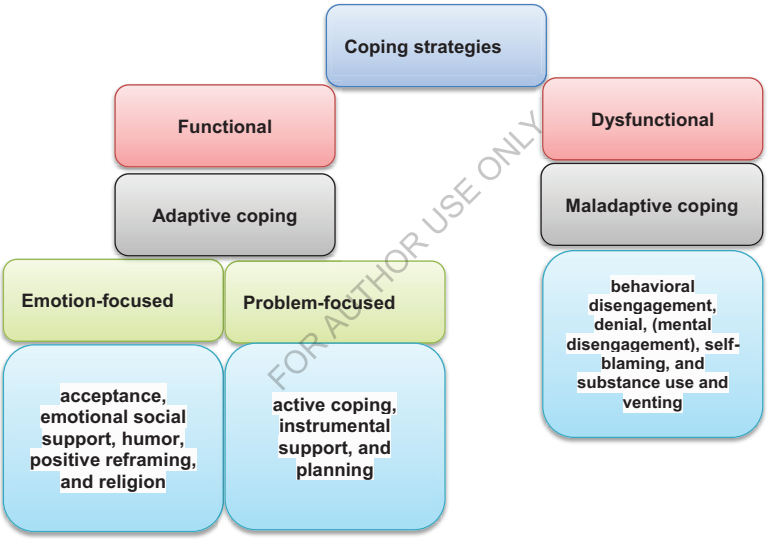


Figure: 5: coping strategies

CHAPTER FIVE

Coping theories

Theories of coping

The effects of trauma and stress are directly linked to coping(Al arjani, 2005; Al arjani, Thabet and Vostanis, 2008). The study of coping has evolved to encompass large variety of disciplines beginning with all areas of psychology such as health psychology, environmental psychology, neuropsychology and developmental psychology to areas of medicine spreading into the area of anthropology and sociology.

Dissecting coping strategies into three broad components, (biological / physiological, cognitive, and learned) will provide a better understanding of what the seemingly immense area is about.

Biological/physiological theory

The body has its own way of coping with stress. Any threat or challenge that an individual perceives in the environment triggers a chain of neuroendocrine events (Naughton, 1997). These events can be conceptualized as two separate responses, that being of sympathetic/ adrenal response, with the secretion of catecholamine's (epinephrine, norepinephrine) and the pituitary/ adrenal response, with the secretion of corticosteroids (Frankanhauser,1986).

The sympathetic/adrenal response takes the message from the brain to the adrenal medulla via the sympathetic nervous system, which secretes epinephrine and norepinephrine.

This is the basic "fight or flight" response (Cannon, 1929), where the heart rate quickens and the blood pressure rises.

In the pituitary/adrenal response, the hypothalamus is stimulated and produces the corticotrophin releasing factor (CRF) to the pituitary gland through the blood veins, then the adrenal corticotrophin hormone (ACTH) is released from the pituitary gland to the adrenal cortex. The adrenal cortex in turn secretes cortisol, a hormone that will report back to the original brain centers together with other body organs to tell it to stop the whole cycle. But since cortisol is a potent hormone, the prolonged secretion of it will lead to health problems such as the breakdown of cardiovascular system, digestive system, musculoskeletal system, and the recently established immune system. Also when the organism does not have a chance for recovery, it will lead to both catecholamine and cortisol depletion and result in the third stage of the General Adaptation Syndrome of exhaustion that exceed the alarm reaction (Seyle, 1956).

Social support has also been established by studies to be linked to stress (Bolger & Eckenrole, 1991; House, et. al, 1988). This can be seen as a

dimension of the biological component since it is closely linked to the biological environment of that individual.

There are many aspects to social support; the major categories would be of (1)emotional, (2)tangible, and (3)informational.

Personality types as so called Type A Personality have been defined to have such characteristics as competitive, impatient and hostile. Hostility has been linked to coronary heart disease which is thought be caused by stress (Rosenman, 1978).

Eysenck (1988) has coined the term Type C Personality for those who are known to be repressors and are prone to cancer. Hardiness also is a personality that seems to have much to do with how an individual handles stress. *Hardiness* is defined as having a sense of control, commitment, and challenge towards life in general. Although it may be possible to modifying ones personality, research has shown it to be heritable (Rahe, Herrig, & Rosenman, 1978; Parker, & Barret, 1992).

Cognitive theory

The cognitive approach to coping is based on a mental process of how the individual appraises the situation. Where the level of appraisal determines the level of stress and the unique coping strategies that the individual partakes. (Lazarus & Folkman, 1984).

There are two types of appraisals, the primary (1)and the secondary(2).

A *primary appraisal* is made when the individual makes a conscious evaluation of the matter at hand of whether it is either a harm or a loss, a threat or a challenge.

Then *secondary appraisal* takes place when the individual asks him/herself "What can I do?" by evaluating the coping resources around him/her.

These resources include, (1)physical resources, such as how healthy one is, or how much energy one has, (2)social resources, such as the family or friends one has to depend on for support in his/her immediate surroundings, (3)psychological resources, such as self-esteem and self-efficacy, and also (4)material resources such as how much money you have or what kind of equipment you might be able to use.

How much personal control one perceives to have is another factor to consider when looking at coping from the cognitive perspective. Usually an individual will find themselves feeling more stressful in uncontrollable situations (Naughton, 1997).

Also, since personal control is a cognitive process, the more one has a sense of personal control, better sense of coping ability one will have. The categories of the attribution theory give a good picture of the extreme ends of the "in control/lack of control" continuum. An individual will perceive to have

the most control where the situations fit the categories of internal, transient, and specific. At the opposite end of the scale are the categories of external, stable, and global where the person will perceive lack of control.

There are other ways of to approach coping from a cognitive perspective such as that of *constructive* and *destructive* thinking as conceptualized by Epstien and Meier (1989) a similar concept to that of optimistic versus pessimistic (Taylor, 1991), the perceived level of self-efficacy and self-esteem and so on.

Learned theory

The learned component of coping includes everything from various social learning theories, which assume that much of human motivation and behavior is the result of what is learned through experiential reinforcement, learned helplessness phenomena which is believed to have a relationship to depression, and even implications of the particular culture or society that the stress at hand is affected by can also be included in this component (Naughton, 1997).

Some of the examples for the *social learning* theories would be the wide range of stress management techniques that have been found to help ease stress. Changing how you cognitively process a particular situation, so called cognitive restructuring, changing how you behave in a particular situation, so called behavior modification, biofeedback which uses operant conditioning to alter involuntary responses mediated by the autonomic nervous system, and

the numerous relaxation techniques such as meditation, breathing, and exercise are all part of what is learned through experiential reinforcement. The learned helplessness phenomena has been linked to depression by such researchers as Coyne, Aldwin, and Lazarus (1981) when they studied subjects who tried to exert control when it was not possible to do so. Cultures and societies have their own set of rule of what they perceive to be stressful or not (Colby, 1987).

People will have different responses in a monogamous culture to that of a polygamous culture. In Africa, where polygamy is the norm, when they find out that the significant other has another partner, it means more workforces to take care of the children and the household chores. If the husband does not take on many wives, it can become a strain on the rest of the wives. An interesting study was done by using Holmes and Rahe's (1967) stressful life event measure in South Africa, and found that it correlated very little with standard distress measures (Swartz, Elk, & Teggin, 1983). This suggests the existence of such cultural/societal differences.

CHAPTER SIX

Validating COPE inventory

Description of COPE inventory

A standardized 60-item self-report measure designed to assess a broad range of coping responses. The COPE inventory was developed by Carver et al (1989) to assess a broad range of coping strategies and responses, several of which had an explicit basis in theory.

The inventroy includes some responses that are expected to be dysfunctional, as well as some that are ecpected to be functional. It also includes at least 2 pairs of polar –opposite tendencies. These were included because each scale is unipolar (the absence of this response doesn't imply the presence of its opposite), and because people engage in a wide range of coping during a given period.

Furthermore, the full COPE is a 60-item measure that yields 15 factors that reflect active versus avoidant coping strategies. In the "trait-like" version, respondents are asked to rate the degree to which they typically use each coping strategy when under stress. In the "state-like" version, respondents rate the degree to which they use each coping strategy to deal with a particular stressful event. Ratings are made on a 4-point Likert-type scale that ranges from "I (usually) don't do this at all" (1) to "I (usually) do this a lot" (4).

COPE inventory items:-

Table (1): illustrates the items of COPE inventory

1. I try to grow as a person as a result of the experience.	2. I turn to work or other substitute activities to take my mind off things.
3. I get upset and let my emotions out.	4. I try to get advice from someone about what to do.
5. I concentrate my efforts on doing something about it.	6. I say to myself "this isn't real."
7. I put my trust in God.	8. I laugh about the situation.
9. I admit to myself that I can't deal with it, and quit trying.	10. I restrain myself from doing anything too quickly.
11. I discuss my feelings with someone.	12. I use alcohol or drugs to make myself feel better.
13. I get used to the idea that it happened.	14. I talk to someone to find out more about the situation.
15. I keep myself from getting distracted by other thoughts or activities.	16. I daydream about things other than this.
17. I get upset, and am really aware of it.	18. I seek God's help.
19. I make a plan of action.	20. I make jokes about it.
21. I accept that this has happened and that it can't be changed.	22. I hold off doing anything about it until the situation permits.
23. I try to get emotional support from friends or relatives.	24. I just give up trying to reach my goal.
25. I take additional action to try to get rid of the problem.	26. I try to lose myself for a while by drinking alcohol or taking drugs.
27. I refuse to believe that it has happened.	28. I let my feelings out.
29. I try to see it in a different light, to make it seem more positive.	30. I talk to someone who could do something concrete about the problem.
31. I sleep more than usual.	32. I try to come up with a strategy about what to do.
33. I focus on dealing with this problem, and if necessary let other things slide a little.	34. I get sympathy and understanding from someone.
35. I drink alcohol or take drugs, in order to think about it less.	36. I kid around about it.
37. I give up the attempt to get what I want.	38. I look for something good in what is happening.
39. I think about how I might best handle the problem.	40. I pretend that it hasn't really happened.
41. I make sure not to make matters worse by acting too soon.	42. I try hard to prevent other things from interfering with my efforts at dealing with this.
43. I go to movies or watch TV, to think about it less.	44. I accept the reality of the fact that it happened.
45. I ask people who have had similar experiences what they did.	46. I feel a lot of emotional distress and I find myself expressing those feelings a lot.
47. I take direct action to get around the problem.	48. I try to find comfort in my religion.
49. I force myself to wait for the right time to do something.	50. I make fun of the situation.
51. I reduce the amount of effort I'm putting into solving the problem.	52. I talk to someone about how I feel.
53. I use alcohol or drugs to help me get through it.	54. I learn to live with it.
55. I put aside other activities in order to concentrate on this.	56. I think hard about what steps to take.
57. I act as though it hasn't even happened.	58. I do what has to be done, one step at a time.
59. I learn something from the experience.	60. I pray more than usual.

Source: carver, 2013.

Sub-scales: sum items listed

Table (2): illustrates the COPE inventory subscales

1.	Positive reinterpretation and growth:	1, 29, 38, 59
2.	Mental disengagement:	2, 16, 31, 43
3.	Focus on and venting of emotions:	3, 17, 28, 46
4.	Use of instrumental social support:	4, 14, 30, 45
5.	Active coping:	5, 25, 47, 58
6.	Denial:	6, 27, 40, 57
7.	Religious coping:	7, 18, 48, 60
8.	Humor:	8, 20, 36, 50
9.	Behavioral disengagement:	9, 24, 37, 51
10.	Restraint:	10, 22, 41, 49
11.	Use of emotional social support:	11, 23, 34, 52
12.	Substance use:	12, 26, 35, 53
13.	Acceptance:	13, 21, 44, 54
14.	Suppression of competing activities:	15, 33, 42, 55
15.	Planning:	19, 32, 39, 56

Coding: with no reversals of coding
1 = I usually don't do this at all
2 = I usually do this a little bit
3 = I usually do this a medium amount
4 = I usually do this a lot

Piloting

The COPE experimented over a sample of (45) pilot sample 20 males and 25 females, where The author applied this technique used to estimate and discuss the validity and reliability of the COPE inventory.

Validity of the COPE Inventory (Internal consistency validity)

To compute the internal consistency of the COPE inventory; the author calculated the correlation coefficients of every item (4 items) of the scale with the total scores of every scale.

Table (3): Internal consistency of cope inventory items with its dimensions

Sub-Scales	Item No	Corr. Coeff. ®	Sig. Level	Sub-Scales	Item No	Corr. coeff. ®	Sig. Level
1 Positive reinterpretation and growth	**1**	0.534	0.001	**2** Mental disengagement	**2**	0.666	0.001
	29	0.645	0.001		**16**	0.489	0.001
	38	0.532	0.001		**31**	0.582	0.001
	59	0.682	0.001		**43**	0.783	0.001
3 Focus on and venting of emotions	**3**	0.659	0.001	**4** Use of instrumental social support	**4**	0.588	0.001
	17	0.568	0.001		**14**	0.589	0.001
	28	0.661	0.001		**30**	0.662	0.001
	46	0.561	0.001		**45**	0.446	0.002
5 Active coping	**5**	0.695	0.001	**6** Denial	**6**	0.567	0.001
	25	0.629	0.001		**27**	0.425	0.004
	47	0.542	0.001		**40**	0.692	0.001
	58	0.579	0.001		**57**	0.637	0.001
7 Religious coping	**7**	0.540	0.001	**8** Humor	**8**	0.487	0.001
	18	0.731	0.001		**20**	0.329	0.027
	48	0.780	0.001		**36**	0.672	0.001
	60	0.440	0.003		**50**	0.630	0.001
9 Behavioral disengagement	**9**	0.601	0.001	**10** Restraint	**10**	0.509	0.001
	24	0.553	0.001		**22**	0.628	0.001
	37	0.619	0.001		**41**	0.667	0.001
	51	0.687	0.001		**49**	0.643	0.001
11 Use of emotional social support	**11**	0.685	0.001	**12** Substance use	**12**	0.667	0.001
	23	0.695	0.001		**26**	0.735	0.001
	34	0.636	0.001		**35**	0.737	0.001
	52	0.519	0.001		**53**	0.677	0.001
13 Acceptance	**13**	0.507	0.001	**14** Suppression of competing activities	**15**	0.674	0.001
	21	0.481	0.001		**33**	0.409	0.005
	44	0.458	0.002		**42**	0.694	0.001
	54	0.414	0.005		**55**	0.459	0.002
15 Planning	**19**	0.568	0.001				
	32	0.525	0.001				
	39	0.696	0.001				
	56	0.888	0.001				

As shown in table 3; there are all of the items had good levels of Internal consistency validity, were the correlation coefficients for all sub-scales ranged *R=(0.301-0.685)*; and significant at 0.01.

Table (4): Internal consistency of sub-scales with total scores of cope

Dimensions of cope	Correlation coefficients ®	Sig. Level
1- Positive reinterpretation and growth	0.701	0.001***
2- Mental disengagement	0.502	0.001***
3- Focus on and venting of emotion	0.520	0.001***
4- Use of instrumental social support	0.542	0.001***
5- Active coping	0.790	0.001***
6- Denial	0.446	0.002**
7- Religious coping	0.376	0.010**
8- Humor	0.323	0.030*
9- Behavioral disengagement	0.656	0.001***
10- Restraint	0.684	0.001***
11- Emotional social support	0.639	0.001***
12- Substance use	0.256	0.090
13- Acceptance	0.443	0.002**
14- Suppression of competing activities	0.427	0.003**
15- Planning	0.722	0.001***

*p< 0.05 **p< 0.01 ***p< 0.001

As shown in table 4; there are all of the sub-scales had good levels of Internal consistency validity with total scores, were the correlation coefficients ranged R= (0.323-0.790); and significant at 0.01.

Reliability of the COPE Inventory

To calculate the reliability of the cope inventory; the author used the following two methods:

Split half method

The author calculated the reliability of the COPE inventory by using split half method (part1 = 28 items & part2 = 28 items); where the person's correlation coefficient was (R_1 = 0.71) and by using the spearman-brawn equation to correct the length of the scale (R_2 = 0.83).

Cronbach's alpha equation

The author estimated the reliability of the COPE inventory by using the equation of Cronbach's alpha (No. of items = 60); where the value of alpha =

(0.86). The COPE inventory measurement device is valid and reliable for data collection from the martyr's children in Gaza Strip.

Where Carver et al (2002) Cronbach alpha for COPE cross 15 subscale were (0.74) and Knee and Zuckerman (1998) showed that the reliability of the scale by Cronbach's alpha was, alpha = (0.81) where the scale applied on the sample of students. The following diagram illustrates the reliability of COPE inventory over three samples; by using split half method and alpha Cronbach.

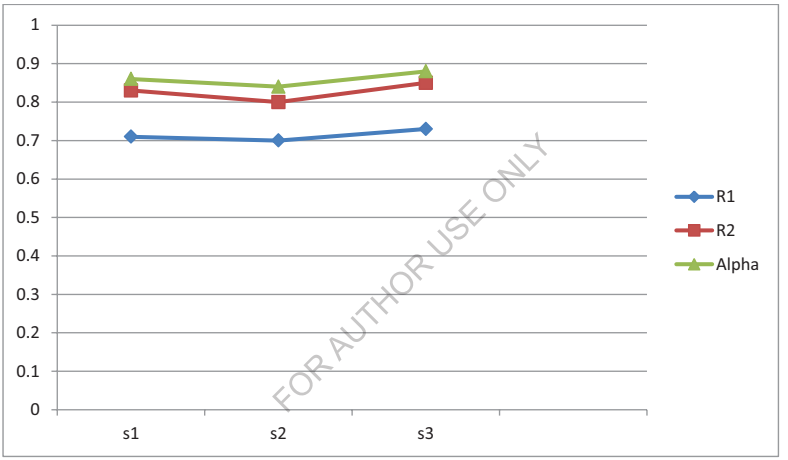


Figure 5: The person's correlation coefficient was (R_1 = 0.71) and by using the spearman-brawn equation to correct the length of the scale (R_2 = 0.83). the value of alpha = (0.86). The scale demonstrated good validity and reliability and applicable for any sample or group.

CHAPTER SEVEN

Rating of the Coping strategies

The author conducted another study on COPE inventory consisting of 250 child whom lost their fathers due to wars and violence acts and reported the responses for their actions. These children were exposed for traumatic events and the loss of their fathers.

The author reported their responses for traumatic events and father loss with the following rate of coping strategies.

The following table shows that the *coping strategies* rearranged by their using from the children who lost their fathers, where the ratio scales plays the role in this step. Where the highest coping strategies were used by the children were the *religious coping* 86.4%, *planning* 76.4%, and *positive reinterpretation* and *growth* 72.3%. While the lowest coping strategies were used by the children are the *substance use* 30.3%, *humor* 48.6%, and the *behavioral disengagement* 54.2%.

Table (5): Types of coping strategies in the whole sample

Coping strategies	N	Sum of scores	Mean	St. Dev.	Ratio scale %	Arrange-ment
Religious coping	250	3457.00	13.83	2.14	86.4%	1
Planning	250	3055.00	12.22	2.94	76.4%	2
Positive reinterpretation and growth	250	2891.00	11.56	2.82	72.3%	3
Active coping	250	2859.00	11.44	2.53	71.5%	4
Use of instrumental social support	250	2795.00	11.18	3.03	69.9%	5
Emotional social support	250	2669.00	10.68	2.88	66.8%	6
Acceptance	250	2656.00	10.62	2.64	66.4%	7
Restraint	250	2655.00	10.62	2.77	66.4%	7
Suppression of competing activities	250	2510.00	10.04	2.52	62.8%	9
Focus on and venting of emotion	250	2645.00	10.58	2.57	66.1%	10
Mental disengagement	250	2393.00	9.57	2.67	59.8%	11
Denial	250	2265.00	9.06	2.64	56.6%	12
Behavioral disengagement	250	2168.00	8.67	2.41	54.2%	13
Humor	250	1948.00	7.79	2.31	48.6%	14
Substance use	250	1212.00	4.85	1.65	30.3%	15
Total mean of coping strategies	250	38178.00	152.71	21.20	63.63%	

The author identified that the most used coping was *religious coping* because it reflected the nature where they live in "Islamic community" that gave a great dimensions for those children since they and we believe in Allah who controls all; they go to pray in mosques, pray to Allah, call for help from only one who's able and capable to meet the needs and demand of who call him.

However, they trust in only one who is responsible and accountable for their presence in the world. These children reared in Islamic community, family, and country; where the families play the major role in defining the children future, behavior, manners, and relationship with others.

Furthermore, the Palestinian culture which reflect the Islamic nature of martyr's children and the magnitude of the seriousness of their development by that nature, also that related to the life they experienced which is stressful and traumatic. If we look for the habits, norms, customs, and other ceremonies in our community we will find that differ greatly from that of other communities from which; if we have martyr in our community we will find a wedding party occur and this wouldn't happen in other communities since we believe in Allah and we believe that the martyr will take place in the paradise.

The second most used coping *was planning* ; this reflect the importance of spirituality dimension in their life, so they cope effectively trying to solve the encountered problems and seeking information to coming up with action strategy; also involves thinking about what steps to take.

The *third* coping strategy *positive reinterpretation* and growth; used mainly on the basis of the previous mentioned strategies since this stem from the recognition of the encountered problem and the behavior that adapted to cope effectively.

The *fourth* coping strategy was *active planning* and this come as supporter and completer for the previous coping styles; since the martyr's children try to take active steps to remove or circumvent the stressor or ameliorate its effects.

The *fifth* coping strategy *instrumental social support*; where the children were used to family social support and neighbors since the results showed

percentage of 69.9 from their coping behavior and this percentage is low when compared by other studies and communities for example Bliech et al (2002) results. The author attributed that our community depends on the family and the surrounding neighbors in their social support, but the other communities depend on the social support that come from institutionalized associations and their states that make available psychologists and social worker personnel on the service of the affect persons in its region. Also, the emotional support in our community received from the family; since they're more close to each other and they have no such support from others because they're the only that valued these feeling and this supported by our culture " family".

The *seventh* coping was restraint; that's an *active coping* depend on their interpretation of the event and the encountered stressful situation; since they wait until the appropriate situation come and cope effectively in front of the traumatic experiences, also it considered *passive* coping in which the children may kept away from the traumatic event and stay until the appropriate time. This reflects their maturation of cognitive thinking.

The *eighth* coping: focus on and venting of emotions used by martyr's children when they confronted with father loss they used as a period of mourning to accommodation. This depends on their understanding of the situation and the encountered events.

However, on *suppression of competing activities* the martyr's children tend to concentrate on the traumatic experience they live, trying to find port in its analysis. This is a positive aspect in the surrounding environment.

Mental –and behavioral –disengagement also are considered when children unable to accommodate the encountered problem they strive to make things off mind since the experience stressors overlapped and paralyze the thinking in a critical point.

Humor was the little used one because they reared in concrete society which builds active and planed behavior.

Substance and drug use was the lowest and nearly disappeared because of our religion and Islamic nature that prevent and such use.

Coping strategies and trauma levels (mild– moderate– severe)

The author investigated the differences between trauma levels (mild; 0-4 scores, moderate; 5-10 scores, and severe; 11 and above scores) by considering one-way ANOVA analysis.

The results denoted significant differences between the means of positive reinterpretation and growth ($f = 4.98$; $P< 0.01$), mental disengagement ($f = 4.27$; $P< 0.05$), focus on and venting of emotion($f = 7.14$; $P< 0.001$), use of instrumental social support ($f = 8.24$; $P< 0.001$), active coping ($f = 10.17$; $P< 0.001$), religious coping ($f = 4.96$; $P< 0.01$), restraint($f = 3.48$; $P< 0.05$), emotional social support ($f = 7.51$; $P< 0.001$), acceptance ($f = 3.47$; $P< 0.05$), and planning ($f = 6.89$; $P< 0.001$) according to trauma levels. However, the total mean of coping strategies indicated that these subscales more used in case of severe traumatic events.

But, there were no significant differences between the means of the remaining coping strategies (denial, humor, behavioral disengagement, and suppression of competing activities) according to trauma levels.

Table (6): One-way ANOVA comparing coping strategies according to levels of trauma

Coping strategies	Source of variance	Sum of Squares	Df	Mean Square	F- value	Significant Level
Positive reinterpretation and growth	Between Groups	77.00	2	38.50	4.98	0.008**
	Within Groups	1908.47	247	7.73		
	Total	1985.48	249			
Mental disengagement	Between Groups	59.43	2	29.71	4.27	0.015*
	Within Groups	1719.78	247	6.96		
	Total	1779.20	249			
Focus on and venting of emotion	Between Groups	89.75	2	44.88	7.14	0.001***
	Within Groups	1553.15	247	6.29		
	Total	1642.90	249			
Use of instrumental social support	Between Groups	143.34	2	71.67	8.24	0.001***
	Within Groups	2149.57	247	8.70		
	Total	2292.90	249			
Active coping	Between Groups	121.06	2	60.53	10.17	0.001***
	Within Groups	1470.42	247	5.95		
	Total	1591.48	249			
Denial	Between Groups	17.41	2	8.70	1.25	0.289
	Within Groups	1722.69	247	6.97		
	Total	1740.10	249			
Religious coping	Between Groups	43.89	2	21.95	4.96	0.008**
	Within Groups	1093.71	247	4.43		
	Total	1137.60	249			
Humor	Between Groups	5.65	2	2.83	0.53	0.589
	Within Groups	1317.53	247	5.33		
	Total	1323.18	249			
Behavioral disengagement	Between Groups	7.82	2	3.91	0.67	0.511
	Within Groups	1437.27	247	5.82		
	Total	1445.10	249			
Restraint	Between Groups	52.51	2	26.26	3.48	0.032*
	Within Groups	1862.38	247	7.54		
	Total	1914.90	249			
Emotional social support	Between Groups	117.96	2	58.98	7.51	0.001***
	Within Groups	1940.79	247	7.86		
	Total	2058.76	249	0.96		
Substance use	Between Groups	1.92	2	2.73	0.35	0.70
	Within Groups	674.31	247			
	Total	676.22	249	23.80		
Acceptance	Between Groups	47.60	2	6.85	3.47	0.033*
	Within Groups	1693.06	247			
	Total	1740.65	249	16.95		
Suppression of competing activities	Between Groups	33.90	2	6.28	2.69	0.069
	Within Groups	1551.69	247			
	Total	1585.60	249	56.89		
Planning	Between Groups	113.78	2	8.26	6.89	0.001***
	Within Groups	2039.12	247			
	Total	2152.90	249	4129.06		
Total COPE	Between Groups	8258.118	2	419.71	9.84	0.001***
	Within Groups	103669.15	247			
	Total	111927.26	249	0.96		

*p< 0.05 **p< 0.01 ***p< 0.001

Post –hoc analysis according to Scheffee statistical test was done that indicated the means of every coping strategies according to the levels of trauma “mild 0-4 - moderate 5-10 –and severe 11 and above", as shown in the following table (7). Also, the following table represents that; there were nearly positive relationship between the ten significant coping strategies and the level of trauma. (i.e. if the levels of trauma increase this lead to increasing the means of coping strategies). But there were no relations observed from the means of the remaining coping strategies according to trauma levels, where these means were poorly attached to each other.

Table (7): Means of coping strategies according to trauma levels

Coping strategies	Mild (N = 104)	Moderate (N = 91)	Severe (N = 55)
Positive reinterpretation and growth *	10.91	11.95	12.16
Mental disengagement *	9.05	9.74	10.29
Focus on and venting of emotion *	9.88	11.15	10.96
Use of instrumental social support *	10.29	11.90	11.67
Active coping *	10.65	11.77	12.36
Denial	8.78	9.14	9.45
Religious coping *	13.40	14.35	13.76
Humor	7.92	7.80	7.53
Behavioral disengagement	8.70	8.47	8.95
Restraint *	10.19	10.64	11.40
Emotional social support *	9.97	11.53	10.60
Substance use	4.93	4.74	4.87
Acceptance *	10.12	11.07	10.85
Suppression of competing activities	9.70	10.04	10.67
Planning *	11.44	12.62	13.04
Total mean of coping strategies*	145.94	156.90	158.58

The results showed that there were significant differences between the means of positive reinterpretation and growth, mental disengagement, focus on and venting of emotion, use of instrumental social support, active coping, religious coping, restraint, emotional social support, acceptance, and planning, according to the levels of trauma.

The author assumed that these differences are related to increase use of the coping strategies when confronted with traumatic events or stressful situations.

Also, the traumatic event require more coping styles and mechanisms to be controlled when it occur. In addition, the author posed that from Scheffee statistical test the increase of the traumatic level ranged between moderate to severe trauma will be followed by an increase of the following coping strategies; positive reinterpretation and growth, mental disengagement, focus on and venting of emotion, use of instrumental social support, active coping, religious coping, restraint, emotional social support, acceptance, planning. There is a positive relationship between the traumatic level and the used coping strategies.

Conclusion:

The findings indicated that the area of coping research in children and adolescents could benefit from attention to the individual's assessment of the personal importance of social support, the possible relationship between religion and coping strategies.

Also the different subscale of coping strategies inventory have been differently used by the martyr's children under the same circumstances; so this reflect the importance of studying the coping strategies of martyr's children under similar and different situations they experience.

Fortunately, the chance let us to study such variables among the martyr's children to determine the degree they report used coping strategies in case of father loss; and we hope that to be more deepest in the future and concern more the life they experience from different trends, since the martyr's children account for the building stone of our scarifying community. So, we in need for the following instructions to promote positive coping strategies for children:-

Promote an active participation through TV program realizing the coping strategies and its benefits through long life and its importance in front of traumatic father loss.

Reinforce the religious coping as a coping mechanism that adapted by the martyrs' children in front of the traumatic events.

Provide psychosocial support for martyrs' children since they're in real need for such services that mediate the trauma effects.

Demonstrate the importance of active coping in the traumatic experiences and in case of father loss.

Establish educational programs including instructions on how the community participates in helping, supporting, and cooperate with the martyr's children to pass traumatic events.

Prevent any illegal dissemination of martyrs or injured photos on mass media especially television that make children emotionally arousal.

Father loss has psychological, legal and socio-economic implications for children and their families. In strengthening families for life, it is

recommended that ‘social provisions for families and developments in family according to the undertaken policy.

There is potential for schools to play an important role in dissemination of information about support services for children of martyrs. All schools should be provided with a list of accredited counselors for referral purposes for children who will not/cannot avail themselves of school counseling.

Provide post-husband loss counseling and information services to help them to communicate and maintain positive relationships with their children over time, and to help them to understand their children’s changing concerns and needs over time.

Services should be easily accessible to reduce barriers to access and uptake. They should be available in a wide range of settings, should be locally accessible, and should be affordable (including services provided on a sliding scale, and free services supported by the government).

The needs and rights of both children and their mothers should be given due consideration in the development of family policy on father loss. Family policy in this area should be child-centered and take account of the developmental needs and the rights of individual children.

***

"Allah and His angels praise and venerate the Prophet. Believers, praise and venerate him and pronounce peace upon him in abundance".

Verse 56, Al Ahzab, H

Arabic Translated version of COPE (60 –items)

Table 8: illustrates the items of COPE in Arabic

1	أحاول أن أنمو كشخص خاض تجارب وتعلم منها.	31	أنام أكثر من المعتاد.
2	أنهمك في نشاطات جانبية ثانوية لأتجنب التفكير في المشكلة.	32	أحاول وضع خطة تساعدني في حل المشكلة.
3	أنزعج ولا أستطيع التحكم في انفعالاتي.	33	أركز على حل المشكلة وأترك بعض الأمور الأخرى.
4	أحاول أن آخذ نصيحة من شخص آخر في السلوك الذي أريد فعله.	34	أتعاطف وأتفهم رأي الآخرين.
5	أركز جهودي على فعل شيء يتعلق بالحدث.	35	أشرب الكحول أو آخذ منبهات حتى أفكر في المشكلة بشكل أقل.
6	أقول لنفسي أن هذا أمر غير معقول.	36	أتعامل مع المشكلة بشكل غير جدي وهزلي.
7	أثق بالله .	37	أتوقف عن المحاولة حتى أحصل على ما أريد.
8	أضحك ولا أهتم بالحدث.	38	أبحث عن شئ جيد يحدث.
9	أقر لنفسي عندما لا أستطيع أن أكبح رغباتي.	39	أفكر كيف يمكن أن أعالج المشكلة بشكل جيد .
10	أمنع نفسي من عمل أي شيء بشكل متسرع تجاه الحدث.	40	أتظاهر بأنه لم يحدث أي شيء.
11	أناقش مشاعري وأحاسيسي مع شخص آخر .	41	أحاول التأكد من أن ما سأقوم به ليس خطأ.
12	أستخدم الكحول والمنبهات ليكون شعوري أفضل.	42	أحاول بصعوبة أن أمنع تداخل أشياء أخرى مع جهودي في معالجة المشكلة.
13	أحاول أن أحصل على فكرة سابقة تتعلق بما حدث.	43	أشاهد التلفاز ليقل تفكيري في المشكلة.
14	أتحدث مع شخص ما لأجد حلاً لمشكلتي.	44	أتقبل حقيقة الشيء الذي حدث.
15	أحفظ نفسي من السرحان والحيرة بالانشغال بأفكار أو أنشطة تتعلق بالحدث.	45	أسأل أناس لديهم خبرة في حل مثل هذه المشكلة.
16	أكثر من أحلام اليقظة لأبتعد عن التفكير في الحدث.	46	أشعر بضغوط كبيرة تجعلني لا أستطيع التحكم في انفعالاتي.
17	أدرك بأنني متضايق.	47	أتخذ طريقة مباشرة ومحددة لحل المشكلة.
18	أطلب المساعدة من الله.	48	أحاول أن أجد راحة وطمأنينة باللجوء للدين.
19	أخطط لسلوكياتي وتصرفاتي.	49	أجبر نفسي على الصبر حتى الوقت المناسب لحل المشكلة.
20	ألجأ إلى قول النكت والمزاح.	50	أسخر من الموقف.
21	أتقبل الحدث وأسلم بأنه أمر لا يمكن تغييره.	51	أقلل جهودي التي أبذلها في حل المشكلة.
22	أتوقف عن عمل أي شيء تجاه المشكلة حتى تسمح الفرصة.	52	أتحدث مع شخص آخر عن مشاعري.
23	أسعى للحصول على دعم وجداني وعاطفي من الأصدقاء والأقارب.	53	ألجأ إلى الكحول والمنبهات لتساعدني على الخروج من المشكلة.
24	أتوقف عن محاولاتي للوصول إلى هدفي.	54	أتعلم أن أتعايش مع المشكلة.
25	أتصرف بشكل آخر حتى أتخلص من المشكلة.	55	أضع الأنشطة الأخرى جانباً لكي أركز في حل المشكلة.
26	أتهرب من المشكلة بشرب الكحول واستخدام العقاقير المخدرة.	56	أفكر بجدية وعمق في الخطوات التي يجب اتباعها.
27	أرفض الاقتناع والتصديق بوقوع هذا الحدث.	57	أتصرف كما لو لم يحدث شيء.
28	أترك الحرية لمشاعري.	58	أحاول أن أتخذ الخطوة المناسبة في الوقت المناسب.
29	أحاول أن أرى الحدث بشكل مختلف ليبدو إيجابياً.	59	أتعلم شيئاً من خبرتي بهذه المشكلة.
30	أتحدث إلى شخص آخر يستطيع أن يقدم حلاً لمشكلتي.	60	أصلي أكثر من المعتاد عندما تصادفني مشكلة.

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