

**Exposure to Trauma and Social Phobia among
Children Attending Mental Health Services in
Riyadh, Saudi Arabia**

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ABSTRACT

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Background

Experiencing traumatic events can lead to a range of mental health problems such as Post Traumatic Stress Disorder (PTSD), depression and anxiety. A range of risk factors have been found to mediate exposure to trauma. However, there is limited knowledge regarding the relationship between trauma and social phobia, and the underpinning mechanisms.

Research aims

The aims of this study were to investigate the association between exposure to trauma and social phobia as well other emotional disorders; and to establish whether parenting factors mediated this relationship.

Methods

A clinical sample of 89 children aged 9-16 years was recruited from consecutive attenders in three mental health services in Riyadh city, Saudi Arabia. Children were diagnosed with emotional disorder, following a clinical interview using the K-SADS. Measures were completed by parents and children on socio-demographic information, child psychopathology (Impact of Event Scale, Revised Children's Manifest Anxiety Scale, Children's Depression Inventory, Social Phobia Questionnaire and Strengths and Difficulties Questionnaire); exposure to trauma; and parenting factors (Parenting Rearing Style, Parenting Stress Index-Short Form and General Health Questionnaire).

Results

Exposure to trauma was not directly associated with social phobia symptoms. However, when exposure was measured as a dichotomous variable (exposed to any or no traumatic events), children exposed to trauma exhibited higher scores of social phobia symptoms. Other predictors included the child's increasing age, parental stress and reduced emotional warmth. Furthermore, there was a significant association between the degree of trauma and PTSD symptoms. Depressive symptoms were predicted by the child's age, parental rearing style and parental mental health problems. In contrast, anxiety and general mental health problems were only predicted by the child's age.

Conclusions

The findings provide support for the role that trauma and parenting factors may play in the development and maintenance of social phobia. These findings are discussed in the context of previous evidence. Clinical and research implications as well as recommendations for future research are considered.

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DECLARATION

This is to declare that this thesis is the student's own work, and has not been submitted in substantially the same form for the award of a higher degree elsewhere.

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Introduction

When I graduated with a Bachelor's degree in Psychology, my first case was a social phobia patient and this had a significant effect on me, because I had not realised the potential impact of this condition on the sufferer's life. After completing my Master's degree, I developed my interest further in this condition. When I obtained a PhD scholarship, I was keen to identify a project in relation to this topic. Since Saudi Arabia is a developing country, a study on the impact of trauma on child mental health would have implications for other types of disorder and associated interventions. After a preliminary search, the idea of studying the relationship between trauma and social phobia started to develop. My motivation was thus influenced by both the theoretical significance of this notion and real-life phenomena.

The first and still a major obstacle that I faced in pursuing my goal was the use of English, both oral and written. I moved to the UK to learn the language at an appropriate academic level before registering for the PhD. I had to learn all four key skills—reading, writing, listening and speaking—at the same time and to an optimal standard. With the difficulties of a new language also came challenges of acculturation in many aspects of everyday life, including differences in religion, routines, food, dress and interactions with people, socially and professionally.

After the initial stage of the PhD, I moved to the phase of data collection, which I had to prepare well in advance and mostly from the UK, so that I could obtain

maximum benefit from my time in Saudi Arabia. Once there, I faced other hurdles, namely the lack of resources, information and service systems which did not run smoothly, and a paucity of mental health statistics. The majority of the research had to be completed through perseverance and personal connections. In particular, obtaining ethical approval required concentrated efforts and substantial time, which delayed the start of data collection.

Attending the hospitals, working with colleagues and particularly meeting children and families was rewarding and enjoyable. However, delays in recruitment or families dropping out of the study were also demoralising, as I had relatively fixed periods for data collection while commuting between the two countries. Overall, I developed problem-solving skills in managing the research process, which was a great experience and will hopefully serve me well in undertaking further academic research in future.

My knowledge of statistical analysis was initially at undergraduate level, and of generic rather than specific focus. I had not used these skills for a long time, despite studying towards a Master's degree in a Psychology department in Saudi Arabia, which provided students with statistical support. Therefore, I had to refresh my statistical knowledge in the UK. Since I would be using the SPSS program, I attended several short courses to familiarise myself with data coding, entry and analysis. I received substantial help from Dr. John Bankart, Medical Statistician at Leicester University, in extracting and interpreting the findings, with further advice from Dr Pat Dugard , Senior Statistician, during the writing up stage.

Over the course of my study, I had to augment my skills and knowledge in various aspects of life. I learned a new language, critical reading of the literature, research methods, statistical analysis, dealing with and solving a range of problems, interpersonal skills to relate to different people in the UK and in Saudi Arabia, and integrating major socio-cultural differences into my work. This would not have been possible without the confidence and enthusiasm of my supervisor, Professor Panos, whose faith in me has given me the strength to overcome all adversities. He was with me step by step, phase by phase. I had his help, support and endorsement throughout my study at a professional, academic and even personal level.

Chapter One

Social phobic disorders in childhood and adolescence

1.1 Introduction: Definitions, classification and diagnostic criteria

Social Phobia (SP) is an internationally recognised and debilitating psychiatric condition. Its recognition has increased during the last two decades building on the emerging evidence-base from epidemiological and other types of research. Social phobia was initially defined in 1980 by the American Psychiatric Association as "a persistent fear of one or more situations (the socially phobic situations) in which the person is exposed to possible scrutiny by others, and fear that he or she may do something or act in any way that will be humiliating or embarrassing" (APA, 1987). SP also includes the fear of humiliation and embarrassment due to the anxiety of the individual that is unable to interact with unfamiliar people, and in social sittings such as parties, public speaking or dining out (APA, 1994). According to the DSM-IV classification, the essential defining characteristics are:

- 1) A marked and persistent fear of social or performance situations in which embarrassment may occur;
- 2) Exposure to the social or performance situation almost invariably provokes an immediate anxiety response (APA, 2000).

A major difficulty for people who suffer from SP is a fear that is excessive or unreasonable (Van Velzen, Emmelkamp, & Scholing, 2000). Furthermore, phobic people cannot balance such fear with the circumscribed situation (Stemberger, Turner, Beidel, & Calhoun, 1995). Normally, individuals have the

essential social skills to be effective in their interactions with others (Kashdan & Steger, 2006). However, it is their fear of negative evaluation that prevents them from interacting. Instead, fear leads to avoidance of situations or focus on their own internal physiological reactions to anxiety (Spector, Pecknold, & Libman, 2003). Consequently, they can appear to others as disinterested in social relations, as they avoid meeting with new people, making conversations and attending social activities, as well public speaking and functioning (Kashdan, 2002).

The diagnostic criteria for SP underwent a number of revisions, with debates arising from its overlap with other disorders, particularly agoraphobia and simple phobia. For this reason, SP was not recognised in its own right until 1980. Despite Marks's classification, some researchers did not agree until that point that SP was a separate diagnosis. Others, predominantly clinical researchers increasingly reported on its distinct entity. For example, Nichols (1974) stated that "the use of the term SP has grown and it is now commonly found to be in use as part of the everyday language of the clinic". Roth (1969) supported the use of the term SP as being more applicable than other phobias to the specific phenomenon it described. At present, in both the DSM-IV and the ICD-10, SP and agoraphobia are two distinct phobic conditions, and their criteria have been validated in relation to other phobic disorders. Specialists around the world use the diagnosis criteria of either DSM-IV by the American Psychiatric Association (APA, 2000) or ICD-10 by the World Health Organization (WHO, 1993). Table 1.1 describes these criteria.

**Table 1.1: Diagnostic criteria for social phobia
according to DSM-IV-TR and ICD-10**

	DSM-IV	ICD-10
1	A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or possible scrutiny by others.	Either of the following must be present: marked fear of being the focus of attention, or fear of behaving in a way that will be embarrassing or humiliating; marked avoidance of being the focus of attention, or of situations in which there is fear of behaving in an embarrassing or humiliating way.
2	Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situational bound or situational predisposed panic attack. In children, this may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.	At least two symptoms of anxiety in a feared situation must have been manifest at some time since the onset of the disorder, together with at least one of the following symptoms: blushing or shaking; fear of vomiting; urgency or fear of micturition or defecation.
3	The person recognizes that the fear is excessive or unreasonable. In children this feature may be absent.	Significant emotional distress is caused by the symptom or by the avoidance, and the individual recognizes that these are excessive or unreasonable.
4	The feared social or performance situations are avoided, or else are endured with intense anxiety or distress.	Symptoms are restricted to, or predominate in, the feared situations or contemplation of the feared situations.
5	The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships; or there is marked distress about having the phobia.	The symptoms listed in the criteria above are not the result of delusions, hallucinations, or other disorders such as organic mental disorders, schizophrenia and related disorders, mood (affective) disorders, or obsessive-compulsive disorder, and are not secondary to cultural beliefs.
6	In individuals under the age of 18 years, the duration is at least six months.	
7	The fear or avoidance is not due to the direct physiological effects of a substance (e.g. drug abuse) or a general medical condition, and is not better accounted for by another mental disorder, e.g. panic disorder with or without agoraphobia, separation anxiety disorder, body dysmorphic disorder, pervasive developmental disorder or schizoid personality disorder.	
8	If a general medical condition or another mental disorder is present, the fear is not of stuttering or trembling in Parkinson's disease; or exhibiting abnormal eating behaviour in anorexia or bulimia nervosa.	

Although there is broad agreement between the ICD-10 and DSM-IV diagnostic criteria, the essential difference relates to the distinction between social phobia disorder and agoraphobia. ICD-10 suggests that if this distinction is difficult, precedence should be given to agoraphobia, whereas DSM-IV differentiates between the two conditions on the basis of fear of social situations. In other words, if the fear is of being scrutinized by others in a particular social situation or set of social situations, then the preferred diagnosis is social phobia. In contrast, if the concern is about having a panic attack, or becoming incapacitated (e.g. fainting) in a situation or a set of situations, then the preferred diagnosis is agoraphobia.

Both classification systems describe the necessary features of fear of scrutiny by other people in social situations, fear of criticism or humiliation, and avoidance of feared situations. The condition may be diffused/generalized, i.e. involving almost all social contacts, or discrete/non-generalized, i.e. restricted to specific social activities or performance situations.

1.2 Epidemiology

1.2.1 Prevalence

SP is one of the most common anxiety disorders, with reported prevalence rates of up to 16% (Van Ameringen et al., 2003). (Kessler et al. (1994); Kroenke, Spitzer, Williams, Monahan, and Löwe (2007)) estimated the 12-month prevalence in the US in the range of 7-8%, a higher rate than that determined by earlier studies (Davidson, Hughes, George, & Blazer, 1993; Schneier, Johnson, Hornig, Liebowitz, & Weissman, 1992). In a community study of

adolescents and young adults in the US, a lifetime prevalence SP of 9.5% in females and 4.9% in males was established according to DSM-IV criteria (Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996; Schneier et al., 1992; Wittchen, Stein, & Kessler, 1999). Several epidemiological studies have attempted to determine the lifetime prevalence, and these have been found to vary between 2.4% and 16% in Western countries (Furmark, 2002; Mohammadi, Ghanizadeh, Mohammadi, & Mesgarpour, 2006; Schneier et al., 1992). In Australia a prevalence of 2.8% was found according to the International Classification of Mental and Behavioural Disorder (ICD-10) and 2.3% according to DSM-IV diagnostic criteria (Seidman et al., 2002). This variation of prevalence can be explained by cultural and a measurements issue, in addition to the definition of social phobia, which is based upon these studies.

Social phobia in children and adolescents has attracted attention in recent years in clinical practice and research. Some studies estimated DSM-III and DSM-III-R rates of social phobia in children at approximately 1% (Kashani & Orvaschel, 1990; R. McGee et al., 1990). In the US Kendall and Warman (1996) provided evidence that DSM-IV diagnostic rates of social phobia in children is equal to the rates of DSM-III-R. In Germany, Essau, Conradt, and Petermann (2000) found a DSM-IV lifetime rate of 16% in adolescents. To date, there have been no studies of DSM-IV social phobia prevalence rates in children, although some studies reported cases of social phobia in children by using diagnostic criteria from prior versions of the DSM classification (Velting & Albano, 2001).

In a clinical study in Saudi Arabia among patients attending a psychiatric out-patient clinic in Riyadh over a period of one year, SP was diagnosed in 9.2% of all psychiatric disorders (Arafa et al., 1992). According to Chaleby (1987), more than 13% of patients who visited psychiatric clinics in Saudi Arabia had SP. Interestingly, little is known about the prevalence of SP amongst women in this country, as the majority of visits to psychiatric clinics are by men, due to cultural reasons. Bassiony (2005) explored these cultural reasons in more detail in the Saudi culture, and suggested the following potential explanations. The work force is predominantly composed of males, which exposes them to more social interactions, thus more pressure and opportunities to seek medical advice. Access to health services is easier for males than for females, because if females wish to attend, they usually need to be accompanied by a male relative, who may not be convinced that this is a necessity, and this acts as a treatment barrier. Moreover, psychiatric consultation in Saudi culture is still affected by stigma, and this is disproportionately higher for females, whose confidentiality is even less protected as they have to inform a male relative.

Although there has been less evidence on the prevalence of SP in children and young people compared to adults, there have been some important studies. Among Saudi adolescents with mental health problems, the most frequent symptoms were of phobic anxiety (17.3%) (Mahfouz et al., 2009). Al Gelban (2009) found that phobic anxiety symptoms were the most prevalent (16.4%) in 545 Saudi girls students. To date, there have been no epidemiological studies with children for SP in Saudi Arabia or other Arab countries, which supports the

need to conduct the present study with children in Saudi Arabia to address this research gap.

1.2.2 Age of onset

The age of onset is usually in late adolescence or early adult life (Amies, Gelder, & Shaw, 1983; Bruce et al., 2005; Kessler et al., 2005; Lieb et al., 2000; Marks & Gelder, 1966; Stemberger et al., 1995; Van Ameringen, Oakman, Mancini, Pipe, & Chung, 2004). Some researchers have suggested that SP may begin earlier, often in childhood, where it may shade imperceptibly with behavioural inhibition and avoidance of novelty (Davidson et al., 1997). Bögels and Tarrier (2004) stated that an earlier onset SP in infancy and early childhood might exist, but developmentally appropriate instruments to measure it have yet to be developed.

In a US study, the mean age at onset was 15.5 years, while first onset after the age of 25 years was uncommon (Schneier et al., 1992). In Sweden, Öst (1987) found that the mean age of onset among social phobics was 16 years. The National Comorbidity Survey and the Epidemiologic Catchment Area study established an average age of onset of 16.0 and 15.5 years respectively (Magee et al., 1996; Schneier et al., 1992). Some studies have reported an earlier age of onset. For example, Rapee and Spence (2004) found the average age of onset of SP to be prior to adolescence. A similar study by Otto et al. (2001) indicated that the majority of individuals with SP reported a mean onset of 10 to 13 years. This trend was similar to the NIMH Epidemiologic Catchment Area Study, which indicated an onset of prior to 11 years of age (Chartier, Walker, & Stein, 2003),

while Beidel, Turner, and Morris (2000) reported an even earlier onset of eight years.

Overall, most studies established that the mean age at onset was during adolescence, while few studies found that the mean age was during childhood. These inconclusive results indicate that culture, instruments and sampling may have played an important role in the outcome of those studies.

1.2.3 Co-morbidity

SP has been found to co-present with other psychiatric disorders. Several researchers have confirmed high rates of co-morbidity between SP and depression. In one of the earliest studies, Weissman et al. (1996) found that 23.7% of people suffering from SP were also suffering from major depression. Liebowitz, Gorman, Fyer, and Klein (1985) showed that almost half of patients with SP met DSM-III-R criteria for major depression and depressive symptoms. Stein, Tancer, Gelernter, and Vittone (1990) investigated further the relationship between major depression and SP. Patients with SP and those with panic disorder had comparable past rates of major depression, 37% and 30% respectively. Chambers, Power, and Durham (2004) examined the relationship between SP, depression and anxiety among 8-14-year-old children, and found high comorbidity rates. This has been a consistent pattern across several studies with adults and children, including available research from Arabic countries. Arafa et al. (1992) investigated the clinical profile of SP in Saudi patients. Depression was the main co-morbid disorder, while general symptoms of anxiety, hypochondriasis and paranoid ideation were other co-morbid

conditions. Personality assessment indicated neurotic and withdrawal characteristics.

SP is associated with an increased risk for abuse of illicit substances. For example, in a study by Clark and McManus (2002), a large proportion of adolescents who abused alcohol also met criteria for SP. Other studies found that the occurrence of substance abuse, either for alcohol or for illicit drugs, was two times higher for those with SP compared with those not having social phobia (Page, Jones, & Wilson, 2004; Zimmermann et al., 2004). Phobic people often use alcohol to cope with anxiety and relax, thus reduce the degree of pressure in such situations.

SP is also a common co-morbid diagnosis in a wide range of mental disorders such as autism spectrum (Gillott, Furniss, & Walter, 2001), affective psychosis and bipolar disorders (Cassano, Pini, Sacttoni, & Dell'Oso, 1999; Dell'Oso et al., 2003; Freeman, Freeman, & McElroy, 2002). SP could be secondary to mental impairment (Thomas, Randall, & Carrigan, 2003). For example, individuals with autism have difficulties in social interaction that can lead to socially embarrassed behaviour as well as to misinterpretation of others' behaviour. This is true in psychotic disorders too (Bögels & Tarrier, 2004). Depression could, however, be the cause of social isolation that is related to SP (Stein et al., 2001).

1.2.4 Gender

Studies on gender differences in SP are largely inconclusive. In psychiatric clinics, Marks and Dar (2000) showed that women are less preponderant among social phobias than among other phobias. In Saudi Arabia, two studies showed that social phobic patients were predominantly male. Arafa et al. (1992) found that 97.2%, and Chaleby (1987) that 80% were male respectively. This possibly largely reflects cultural influences in service utilisation, as discussed previously. They may also be cultural factors involved that explain gender differences in the development, presentation and detection of SP in Saudi Arabia, and these will be considered in more depth in chapter 3 on the sociocultural aspects of that society.

This trend of gender differences is less conclusive from studies with children. For example, Strauss and Last (1993) found that approximately equal proportions of male and female children were referred with SP and simple phobias. This is inconsistent with findings from studies on children's subclinical fears, in which girls reported more fears and worries than boys (Buka, Stichick, Birdthistle, & Earls, 2001; Strauss & Last, 1993; Turk et al., 1998). Essau, Conradt, and Petermann (1999) studied 1035 adolescents, aged 12-17 years, and found that more girls than boys received the diagnosis of SP and that prevalence increased with age.

It is plausible to consider that gender effects interact with age, and that there may be different profiles in the general population and clinical samples. Clearly, the gender proportion of patients presenting for treatment also varies from

culture to culture. In particular in the Saudi culture and Arabic countries in general, the cultural mechanisms on help-seeking and attendance possibly become more pronounced as children enter late adolescence and young adult life. The researcher could not find studies that aimed to explain the reasons for gender differences among children. Understanding a number of other risk factors involved in the development and prognosis of SP are, however, important, as several vulnerabilities are often inter-related, and these will be reviewed in the next section.

1.3 Aetiology of social phobia

The aetiology of SP is presented in three sections: internal, environmental and cultural factors, which will be addressed in more detail.

1.3.1 Internal factors

1.3.1.1 Genetic predisposition

Genetic factors appear to play an important role in the development of SP. Twin studies provide us with specific information about genetic influences in the development of SP. Kendler, Neale, Kessler, Heath, and Eaves (1992) reported that the familial aggregation of SP was consistent with phobia proneness and heritability estimates, indicating that these play an important but not predominant role in the aetiology of SP. Several studies have suggested the family nature of SP, and have established considerably higher rates of SP among first degree relatives (Chapman et al., 1995; Reich & Yates, 1988).

Rapee and Spence (2004) demonstrated that genetic factors can play a significant role in the development of SP in childhood. (Rowe et al., 1998) specifically proposed that a repeat polymorphism in the dopamine transport gene was associated with SP in children. Another study by Arbelle et al. (2003) found a significant correlation between shyness and the long forms of the serotonin transporter repeat polymorphism. However, Theall-Honey and Schmidt (2006) found no correlation between shyness in four-year olds and the same receptor genes. Overall, studies on the genetic contributions did not take in account environmental effects which could be important in the aetiology of social phobia.

1.3.1.2 Temperament

The previous findings may also indicate the importance of temperament traits. Susceptibility to emotional stimulation, customary strength and speed of response, quality of prevailing mood, and fluctuation and intensity of mood are the characteristic phenomena of an individual's emotional nature known as temperament. This is regarded as dependent on their constitutional makeup, and therefore largely hereditary in origin (Caspi & Shiner, 2006). Although several classification schemes for temperament have been developed, none has achieved consensus among academics (Rimm-Kaufman & Kagan, 2005).

1.3.1.2.1 Behavioural inhibition

'Inhibited' characteristics, which are known as 'passivity' (a subdued, nervous, and fearful demeanour), were identified by Kagan (1989) as the only psychological quality that persisted over time. Recently, research interest in this

early temperament construct has increased. Whether, and to what extent, inhibited temperament in childhood poses a developmental challenge, or contributes to mental health problems is an interesting research question (Gladstone, Parker, Mitchell, Wilhelm, & Malhi, 2005). A study by Van Ameringen, Mancini, and Oakman (1998), revealed that individuals with SP also rated themselves much higher in retrospective behavioural inhibition compared to those with other anxiety disorders.

A study by Hayward et al. (2000) found a 4:1 odds ratio for students who reported a history of childhood behavioural inhibition between those with social phobia and students without any disorders. Schwartz, Snidman, and Kagan (1999) established a significant association between an inhibited respondent and SP in adolescence. Moreover, teenage girls who reported childhood inhibition were also more likely to present with SP symptoms. In a study by Chaleby and Raslan (1990), 20% of adults with SP retrospectively described their childhood as poorly adjusted, and recalled having been inhibited, withdrawn and with few friends.

It can thus be concluded that childhood behavioural inhibition may significantly contribute towards a psychological tendency for the development of social phobia in adolescence and young adult life.

1.3.1.2.2 Neuroticism

Emotional vulnerability to stress is the definition of the personality trait of neuroticism (Luteijn & Bouman, 1988). Negative effect, worries, and reports of

somatic symptoms are often related to this personality type (Gray & Watson, 2007). Watson et al. (2005) analyzed the connection between neuroticism/negative emotionality, extraversion/positive emotionality, and mood and anxiety disorders. The results showed a strong correlation between extraversion/positive emotionality, 'anhedonia/depressed' affect and SP. In children, McNaughton and Gray (2000) found that half of heritable and related anxiety disorders were linked to the personality trait of neuroticism. Overall, evidence suggests that neuroticism is not specific to SP, as it also implicated in the development of other emotional disorders such as anxiety and depression; however, this is another trait that could act as a risk factor.

1.3.1.2.3 Cognitive factors

Individuals with SP consistently rate their behaviour in social situations negatively, which supports the theory that cognitive factors are important in both the aetiology and maintenance of SP. Clark and Wells (1995) established that negative self-evaluative thoughts are more prominent in people with SP. Similarly, Voncken, Alden, and Bögels (2006) found that people with SP were inclined to overestimate the visibility of their anxiety and to underestimate how interesting and agreeable they were. They still viewed their performance negatively, even after a substantial period of time (S. T. Wallace & Alden, 1997).

Reavis (2005) conducted a study of 65 children aged between 9 and 13 years. Findings indicated that lower self-perception of acceptability to other children and more cognitive errors were more common in children with severe SP symptoms. Cartwright-Hatton, Tschernitz, and Gomersall (2005) undertook a

similar study with children aged between 10 and 11 years. They established a reverse relationship between self-perception performance and SP. In particular, children with more severe SP symptoms were more likely to express negative self-evaluation thoughts, and to place more attention on their nervous dispositions. This body of evidence was influential in the development of cognitive-behavioural therapy (CBT) and related psychological interventions for SP.

1.3.1.2.4 Social skills deficits

The lack of social skills accentuates both the development and maintenance of SP. Parent-child interaction styles are affected by negative reinforcement of avoidance behaviours, and the influence of peer relations as operant factors contribute to the perceived and imagined social threat or traumas to maintain SP (Kashdan & Herbert, 2001). People with SP perceive themselves as lacking important skills, in contrast with the assumption that the affected children suffer from a lack of social skills and should be treated with social skills training (Cartwright-Hatton et al., 2005).

Wallace and Alden (1997) explained that negative interpersonal experiences were a result of an increase in anxiety self-assessment and other negative emotions, weak self-efficacy and heightened avoidance behaviours. As a result of operant conditioning, the development of undesirable social skills could be due to the excessive social avoidance behaviours during one's sensitive developmental stages of late childhood, which further enhance maladaptive cognitive biases. Rapee and Spence (2004) studied the social skills, social

outcomes, self-talk, outcome experiences and performance self-evaluation of children with SP during social evaluative tasks. They found lower than expected performance, with a higher level of negative self-talk on social evaluated tasks. Spence (2003) also compared social phobic children to matched non-anxious controls. Children with SP were rated by themselves and others as less socially competent with peers, less assertive, and less socially skilled. In addition, during behavioural observations, children with SP initiated fewer and shorter interactions with other children and spoke less. Social skills deficits can be both cause and effect in SP, although these studies could not establish an etiological direction because of their cross-sectional design. Either way, their recognition is important in devising intervention programmes, which often specifically target this aspect of social functioning.

1.3.1.2.5 Fear of negative evaluation

The innate and persistent fear of human interaction and performance in social situations, due mainly to the need to avoid embarrassment, humiliation and negative regard by others, is the crux of SP. According to Hirsch, Clark, and Mathews (2006), people with SP draw persistent fear from their own negative interpretation of social information, although in reality they are rarely regarded negatively by others in common social situations. Individuals with SP rated their performance as of poor quality in public speaking (Abbott & Rapee, 2004). For this reason, the Fear Negative Evaluation is widely used as a measure of changes in CBT, as demonstrated by Cox, Borger, and Enns (1999) in an earlier study of treatment outcomes.

SP patients are more likely to infer negative consequences, by excessively interpreting negative social events, compared with patients with other anxiety disorders and non-clinical controls (Lusia Stopa & Clark, 2000). Voncken, Bögels, and Peeters (2007) extended this in a study of social scenarios interpretations. People with SP were more likely than controls to make negative interpretations of social scenarios presented to them. These findings should, however, be interpreted with some caution because of methodological limitations of these studies, in particular the unequal sample size of the experimental and control groups, with much smaller control samples.

Musa, Lépine, Clark, Mansell, and Ehlers (2003) carried out a study to establish the association between SP and attention bias to social-threatening words, as well as to determine the effects of concurrent depressive disorder. They found that patients with SP tended to pay more attention to social threat words, while patients with SP and a concurrent depressive disorder preferred to avoid threat words. Moreover, there may be some connection between SP and one's attentional bias to physical threat, emphasizing the importance of co-morbidity assessment in the investigation of attentional biases.

1.3.2 Environmental factors

As personal characteristics interact with environmental factors from early life, children learn social behaviours, and about themselves in relation to other people. The family environment has a substantial impact on a child's development, which can mediate or moderate life events and other risk factors.

1.3.2.1 Parent/child interaction

This is particularly important in the development of SP. Several studies investigated the effect of perceived parenting style based on retrospective recall, which can be subject to memory bias. People with SP tended to describe both their parents as lacking in emotional warmth, and as being critical and overprotective (Arrindell, Emmelkamp, Monsma, & Brilman, 1983). Arrindell et al. (1989) reported that social phobic people tended to consider their parents more negatively in relation to perceived parenting style than people with agoraphobia. A substantial proportion of 21% reported negative or even neglectful parenting experiences (Shaw et al., 2006). Parental negative criticism/evaluation and the absence of positive evaluations can lead to children's expression of shame, as shown by a study of interactions between parents and their three-year-old children during performance tasks (Alessandri & Lewis, 1993).

Retrospective studies of child-rearing practices reveal that children with SP perceived their parents as socially isolated, avoidant, and deliberately shunning social activities with relatives and friends. Further, children may consider their parents to have SP and are overly concerned about the opinions of others (Bruch & Heimberg, 1994). Because of their parental worries and overprotection, the model of a maladaptive social interaction pattern proposed that the child is not being provided with an appropriate environment that promotes social growth (Brown, Craig, Harris, Handley, & Harvey, 2007).

The socializing patterns and habits of the family thus have a significant effect on the child. If a child is provided with limited opportunities for social interactions, they may find it harder to learn or anticipate that social situations are not necessarily harmful (Rapee, Schniering, & Hudson, 2009). Furthermore, they may be conditioned to avoid social situations, thereby reducing their chances to develop appropriate social skills and meaningful relationships with peers. Socially phobic adults may also condition in their children the notion that social interactions are unpleasant and should be avoided. Consequently, they may unknowingly reinforce their child's worries about the opinions of others, thus enhance their preoccupation with social approval (Hudson & Rapee, 2002).

Similar findings were reported by several Saudi studies, although these measured a range of parenting factors, which may have also been underpinned by cultural mechanisms. For example, 66% of SP adult patients described their father's parenting style as harsh, distant, physically abusive, and humiliating contrasted with 9% attributing similar characteristics to their mother (Chaleby & Raslan, 1990). Arafa et al. (1992) found that the negative effects of overprotection and criticism by fathers played an important role in the origins of social phobia. This indicates that, while generic mechanisms operate in all societies, these also interact with cultural factors. For example, Arab and Saudi societies have higher parental expectations for their firstborn. When these expectations are not perceived to have been met, children are more likely to become sensitized to failure, consequently less socially active and able to negotiate with their peers than their younger siblings (Dwairy et al., 2006).

1.3.2.2 Exposure to trauma (negative life events)

Traumatic experiences can significantly influence the lives of children and adolescents (Brown, 2002; Brown et al., 2007; J.-P. Glaser, van Os, Portegijs, & Myin-Germeys, 2006; Hovens et al., 2010; Sar et al., 2010). Trauma exposure is related to several factors, for example, this is higher in neighbourhoods that experience continuous family and community violence (Pine & Cohen, 2002). Further, trauma from a family member or close relative can be compounded by other risk factors for psychopathology (Fergusson, Horwood, & Lynskey, 1996). A large body of research has established the strong association between exposure to trauma and a number of mental health problems. For this reason, the next chapter is dedicated to exposure to trauma and how this impacts on children's mental health.

1.3.3 Cultural factors

Culture can be defined as the sum of a group or nation's way of thinking, believing, feeling, and acting (Swartz, 1997). It thus reflects the way of life for a group of people (Rozin, 2003). Culture can also be described as the mould of behaviours that is accredited to the members of any given society, learned and passed on from generation to generation. It includes the language, religion, and customs of a group of people, along with their feelings and attitudes. In general, it can be passed on by parents, the government, schools, and society. It should be noted that each culture has history, and everything that happens becomes part of its cumulative history (Pillai & Chaudhary, 2009). Ethnicity or the geopolitical boundaries of a particular nation or country are the terms referred to as culture, and these are the features that indicate the existence of a particular

distinct culture. Individualistic versus collective, industrialized versus agricultural, or simple versus complex are the polarized variables that often categorise the culture (Triandis & Suh, 2002).

Psychologists who try to reduce the cultural influences or at least to minimize the impact of these unwanted effects, are interested in the mechanisms that might have an effect on the applicability of psychological theory and practice (Berry, 1980; Lewis-Fernandez & Kleinman, 1994; Triandis & Brislin, 1984). The experience and expression of SP can also be affected by culture-related factors. There are worldwide psychobiological mechanisms that can be discerned across cultures (Matsunaga, Kiriike, Matsui, Iwasaki, & Stein, 2001; Rapee & Heimberg, 1997; Stein, 1993). Some researchers have described a disorder labelled the “offensive type” of SP, which is listed in the DSM-IV under its Japanese name, Taijin kyofusho, and which has been categorized as a culture-bound disorder. Its central feature is the fear that one will embarrass or cause offence to others through unpleasant odour, facial expressions, or movements (APA, 1994; Matsunaga et al., 2001).

Taijin kyofusho (TKS) has traditionally been considered as being closely related to a high level of interpersonal sensitivity, perceived as a cultural characteristic of Eastern communities (Kleinknecht, Dinnel, Kleinknecht, Hiruma, & Harada, 1997). Consideration of TKS has raised the possibility that the way in which basic SP is expressed may be related to fundamental features of the culture. A study suggested that the concerns of more collectivist communities may focus

on distress to others, while those of more individualistic communities may focus on distress to the self (Dinnel, Kleinknecht, & Tanaka-Matsumi, 2002).

In fact, TKS in the East and disorders such as DSM-IV SP in the West, have similarities in both phenomenological and psychobiological aspects, indicating that cultures shape the expression of particular fundamental mechanisms, in this instance perhaps involving self-perception and self-presentation in social situations (Matsunaga et al., 2001). There is some definitive evidence that SP is a universal disorder. Epidemiological studies state that this is highly prevalent in most countries (Weissman, Bland, Canino, Faravelli, et al., 1996), and some studies, such as by Stein (1993) and Hollander et al. (1998), found that several features of SP are similar (e.g., age of onset, gender, psychiatric sequelae).

While SP can be considered similar across cultures, the criteria for defining the disorder can differ. These differences reflect the variation of values between collectivist and individualistic cultures. While a relatively low level of social fear will be viewed as distressing and interfering in an individualistic society, social advantage is gained by asserting one's rights and acting as leader. In contrast, in a collectivist society, a high level of social fear is considered to be less dysfunctional, where some degree of SP would be viewed as normal. Concurring with this proposition, scholars identified that Thai parents viewed externalizing behaviours in their children as more problematic than internalizing, compared with American parents who did not show a strong differentiation (Lambert, Weisz, & Knight, 1989; Weisz, Sigman, Weiss, & Mosk, 1993; Weisz, Suwanlert, Chaiyasit, & Walter, 1987; Yeh & Weisz, 2001). Hence, internalizing

symptoms such as SP might be perceived as more impairing in some societies than others (Rapee & Spence, 2004).

Testing existing theories with individuals belonging to different cultures (i.e. cross-cultural studies) would overcome cultural bias or lack of validation in this field of research. This would strengthen the applications of psychology worldwide, and could accelerate the progress towards the universal understanding of the impact of trauma and a range of risk factors on child mental health. Unfortunately, such research is still rather limited, due to conceptual, methodological, measurement, pragmatic and economic constraints.

Notwithstanding this lack of mental health evidence, our understanding can be informed from sociological research findings. It is, for example, well established that the Saudi culture is heavily disciplined, with rigid moral codes and highly valued customs and rituals (Kraidy, 2007). Rules are often applied to even minor social rituals, according to social status, gender and age; while deviations from these rules are considered as not acceptable (Al-Hemaidi, 2001). It is thus plausible to consider that individual with personality traits or behaviours on the edges of societal norms can be more vulnerable in their social functioning and mental health domains, particularly to emotional maladjustment (Chaleby, 1987). At the same time, it is important to acknowledge that the Saudi society is undergoing an enormous and rapid process of socioeconomic development and change such as urbanization and upward social mobility (Dwairy & Achoui, 2006). As population groups have moved from Bedouin and rural areas to

expanding or newly constructed modern urban centers, their values can also be subject to subtle changes (Al-Saggaf, 2004). In a highly pressurised and aspiring socioeconomic environment, vulnerable individuals or those with existing mental health problems can struggle to perform according to expected norms and expectations, thus enter a cycle of further social avoidance and (Arafa, et al. 1992). Although the impact of these sociocultural factors on mental well-being is not definitive because of the lack of interdisciplinary research, their potential relevance should be kept in mind when considering mental health conditions, specifically those with a strong social context such as social phobia.

1.3.3.1 Social phobia in Saudi Arabia

The majority of studies in Saudi Arabia have been published in the Arabic language, with only a small amount published in English. Most of these studies investigated relationships between social phobia and factors such as parental rearing style; or variables such as age, gender, economic status, and academic achievement. Other authors studied the differences in personality between social phobia and other disorders. Some studies also evaluated therapeutic programs to mitigate or reduce the symptoms of social phobia. Their results mostly agreed with the findings of previous research in Western countries. To the researcher's knowledge, there has been no research published as yet with children or adolescents. Most studies published in English were presented in the previous section of this chapter, and only relevant findings will be mentioned in this section. The first study was published in English in 1987 by Chaleby, who found that adult social phobia constituted approximately 13% of all emotional disorders in an out-patient clinic sample. Most patients were young, unmarried

(51%), male (80%), and of relatively higher educational (28% University, 49% high school) and occupational (57% clerk and professional) status. A subsequent study by Chaleby and Raslan (1990) in Saudi Arabia, found that SP was highly comorbid with other mental health disorders. Like other service-based studies, a constraint was the self-selection of the sample, which was recruited from a private and a specialised hospital setting, i.e. whether the findings can be generalised to standard health services or indeed to the general population.

A third study was conducted by Arafa et al. (1992), and replicated the earlier finding on the high prevalence of SP in Saudi Arabia. Al-Khodair and Freeman (1997) completed a comparative study on social phobia across two cultures; i.e. Saudi Arabia and Scotland, and found differences in the profiles of the two groups. The age at assessment and the course of the disorder were different. Saudis were much younger with shorter period of illness; Scottish subjects had significantly higher anticipatory fears; the Saudi group felt more at ease when they were with younger people, while age had no effect on the Scottish group; the Scottish group reported more panic attacks, history of depression, agoraphobia, history of abusing alcohol and using psychiatric drugs. In conclusion, social and cultural differences appeared to have some effect on social phobia in terms of age at treatment, duration of illness, co-morbid panic disorder, depression, alcohol problems and in some social situations.

Social phobia is a disorder commonly associated with other anxiety and psychiatric disorders. In a predominantly clinical male sample, Bassiony (2005)

estimated the prevalence of depression in patients with SP, and the relationship between the severity of SP and depressive symptoms. The study found that 59% of SP patients had another psychiatric disorder. Of those, 41% had depression, 92.5% of whom developed it later than SP. The aim of the Al Zahrani (2007) study was to test out an aetiological model of SP and related phobias in a Saudi population. The study found that the development of social phobia, commencing in early life, during childhood, and developing in later life were significantly affected by fear of negative evaluation and victimization. El-Tantawy, Raya, Al-Yahya, and Zaki (2010) studied SP among Saudi psychiatric out-patients to investigate its prevalence, demographic and clinical characteristics. In out-patient attendees, the one-month prevalence of social phobia was 5.63%, with higher rates of dysthymic disorder than major depression among social phobia patients. These patients also had high levels of neuroticism and low levels of extroversion. The sample study was again recruited from a specialized service and was only followed-up over a short period of one month.

1.4 Outcome and prognosis

The prognosis of SP may include its duration, complications, symptomatic outcome, prospects of recovery, recovery period, and other outcomes. Early age of onset has been associated with poorer outcome and lower recovery rates (Davidson, Marshall, Tomarken, & Henriques, 2000; DeWit et al., 2005; Mersch, Emmelkamp, & Lips, 1991). Although the age of onset could be an epiphenomenon of the severity or duration of the illness, this has remained a significant predictor when these factors were controlled for.

Co-occurring personality disorders are frequent among adult patients with SP. Avoidant personality disorder has been negatively related to short-term outcome (Chambless, Tran, & Glass, 1997; Feske, Perry, Chambless, Renneberg, & Goldstein, 1996). Other anxiety (e.g. agoraphobia) (Angst, 1993) and mood disorders frequently co-occur with SP (Chartier et al., 2003). Clinically it appeared that co-occurring body dysmorphic disorder might hinder improvement, as it represents an additional reason for social avoidance. Both the short-term (Bruce et al., 2005) and long-term outcome (Borge, Hoffart, & Sexton, 2010) have been found to be related to the initial severity of illness in some studies (Chambless et al., 1997). Overall, the inconclusive status of these pre-treatment patient characteristics as outcome predictors does not justify specific aetiological hypotheses.

SP may be chronic over the life course, albeit with fluctuating severity (APA, 1994). This is supported by prospective clinical studies reporting that the probability of recovery is less than for other anxiety disorders (Bruce et al., 2005; Yonkers, Bruce, Dyck, & Keller, 2003). In addition, cross-sectional population studies, using retrospective data, support the view that SP has a chronic course (Chartier, Walker, & Stein, 2001; Davidson et al., 1993; Ruscio et al., 2008). In contrast, data from prospective population studies suggest a better prognosis of spontaneous recovery (Degonda, Wyss, & Angst, 1993; Vriends et al., 2007). To date, there has been no longitudinal research with children.

1.5 Treatment

There are various approaches to the treatment of SP that have been supported by empirical studies, including both psychological and pharmacological approaches. Evidence-based psychological interventions for SP include cognitive-behavioural therapy (individual or group), cognitive-behavioural therapy (CBT) plus medication, and attention training. Each of these treatment strategies and evidence for their effectiveness will be reviewed in this part, with a focus on children and adolescents studies as much as possible, because of this relatively limited evidence.

CBT is one of the most common treatments for SP. It frequently combines exposure with cognitive restructuring. Tsao, Mystkowski, Zucker, and Craske (2005) found that CBT reduced SP symptoms. It could be used individually or in groups (Albano & Kendall, 2002). In a study of children with SP, these were randomly assigned to either child-focused CBT or waiting list controls (WLC). At post-treatment, in comparison to the controls, children in the CBT group showed greater reduction in social phobic symptoms (Spence, Donovan, & Brechman-Toussaint, 2000). This result was supported by a later study with children and adolescents (Bögels & Siqueland, 2006).

Group approaches offer an important advantage over individual cognitive-behavioural group therapy (CBGT). The mere act of attending a group session is itself a powerful exposure exercise. Individuals with SP find attending the group challenging, but can benefit from being able to practice speaking in front of others and learning to manage their anxiety (Manassis et al., 2002). Hayward

et al. (2000) provided evidence on the effect of CBGT in treating female adolescents suffering from SP. Gallagher, Rabian, and McCloskey (2004) examined CBGT with children with the SP and waiting list controls. Significant improvement was observed in the SP group, but there were no differences between the individual and the group format. Therefore, CBT is already established in the treatment of CBT, although further evaluation is required on its specificity. It appears that both treatment modalities can lead to improvement in cases of social phobia. It is plausible that cognitive-behavioural therapy should be used individually with more severe cases of social phobia, while therapeutic groups can be used to replicate social situations.

The effectiveness of two pharmacological and non-pharmacological treatment options in SP was compared by Oosterbaan, Balkom, Spinhoven, Oppen, and Dyck (2001). Using a randomized, placebo-controlled clinical trial design to compare the impact of CBT with Moclobemide, better outcomes were found for CBT with Moclobemide but not with a placebo. In contrast, Fedoroff and Taylor (2001) found that medications such as benzodiazepines (BDZs) and selective serotonin reuptake inhibitors (SSRIs) provided the most effective treatment for SP, at least in the short-term.

Wells, White, and Carter (1997) examined the potential efficacy of attention training in a single case replication series. There was a decrease in anxiety and negative thoughts with the use of a reversal design, where attention training instructions were used to mitigate the effects of attention training by reinstating self-focus. When compared to the large number of studies of cognitive-

behavioural therapy, attention training has received relatively little research attention. Although it is incorporated into cognitive-behavioural treatment packages, it has yet to be established as a stand-alone treatment.

SP involves an intense fear of unfamiliar social situations or of being watched and evaluated by others. These social situations may be so frightening that they can result in anticipatory anxiety and avoidance. Using CBT can, therefore, help patients to overcome their difficulties by changing their thinking, behaviours, and emotional responses.

1.6 Conclusions

SP is a common psychiatric disorder. Individuals with SP have a strong fear of being humiliated or embarrassed in front of unfamiliar people. They also suffer from thoughts of being scrutinized and observed by others, which leads to physiological cognitive and emotional responses (APA, 1987). Social phobic people cannot adapt in social situations, as the internal and/or external factors that cause them anxiety also tend to disrupt their interactions in social situations.

Several factors appear to play an important role in the development of SP, and these were considered in detail. Internal factors such as genetic predisposition and temperamental traits can contribute to the development of social phobia. Environmental factors are also important, as children learn to socialize within their family, and any adverse experiences such as negative parenting or trauma can lead to dysfunctional patterns. Both individual and family factors can in turn interact with cultural factors in the development and maintenance of social

phobia. Although there are various approaches to the treatment of SP, a large body of empirical studies supports that the current treatment of choice for SP is CBT.

The literature review confirmed the importance of instruments in measuring mental disorders; many studies have shown vast differences in their findings, due to different instruments used in different cultures. In addition, there are no measures for childhood social phobias which are culturally appropriate for the Saudi society or other Arab communities. Previous studies could not counter the gender differences in SP generally, and there have been no epidemiological studies with children for SP in Saudi Arabia or other Arab countries. This supports the need for a research to address this gap of instruments, epidemiology, and gender differences. In addition, previous studies found that SP is associated with a number of disorders, but no studies aimed to determine this relationship, particularly between SP and post-traumatic stress disorders. Parents are the predominant environment faced by the child from early life and parent-child interaction styles significantly affect child development. The relationship between the child and their parents thus plays a crucial role in the development of the child's mental health, and the later emergence of disorders. Surprisingly, there is limited evidence on the role of parenting and trauma-focused factors in interventions for SP. In order to consider their role in this condition, before developing appropriate interventions, it is important to understand the potential impact of trauma. This will be considered in more detail in the next chapter in the wide context of child mental health problems.

Chapter Two

Impact of Trauma on Child Mental Health

2.1 Definitions and concepts of trauma

Trauma has been described by many health researchers and social scientists, who suggest that it consists of a number of components, following physical or psychological injury. The term 'trauma' originates from an ancient Greek word meaning 'to pierce'. In the context of physical injury, it indicates that the skin is broken. In relation to the psychological side, trauma is "an event that in a similar intense or violent way ruptures the protective layer surrounding the mind, with equally long-lasting consequences for psychic well-being" (Bentovim, 1992, p. 24).

Psychological trauma was developed as a concept more than a century ago by Janet (1889), who suggested that vehement emotions result from negative experiences which interfere with appropriate information processing and with appropriate actions following the evaluation of cognitive appraisal. Janet considered that continuous exposure to trauma would generate excessive physiological responses to the event experienced by the individual, which would trigger emotional mechanisms for coping with traumatic experiences. Freud expressed the belief in 1914 that the response to trauma was biologically based, labelling this response 'traumatic neurosis', which he claimed was a result of threatening stimuli that led to feelings of overwhelming helplessness (Hanna, 2008). Kardiner (1941), who was the first to define Post-Traumatic Stress Disorder (PTSD) in the USA, suggested that traumatized individuals continue to

live in the emotional environment of the traumatic event, with continuing attention for and sensitivity to any threat.

A critical step in this research and diagnostic process was the inclusion of the formal category of PTSD (which will be discussed in detail later), to help identify the effects of severe experiences on the psyche and the body (Van der Kolk, McFarlane, & Van Der Hart, 1996). The diagnostic classification system DSM-IV. (2000) defined trauma as resulting from exposure to actual or threatened events such as death or serious injury. The individual may be exposed directly or witness these events. McFarlane and Yehuda (1996) add that, notwithstanding concerns about stigmatizing individuals with psychiatric labels, the PTSD diagnosis appears to provide victims with legitimization and justification of the psychic distress, thus helping them make sense of their experiences. It has also helped to change societal attitudes and enhanced victim empathy (Van der Kolk et al., 1996). Scaer (2001) affirms that symptoms like re-experiencing, avoidance and arousal defined in the DSM-IV (1994) are not sufficient to identify traumatic stress, but should also include somatic and comorbid symptoms related to previous trauma.

Neurobiological and psycho-physiological approaches to trauma have been more closely aligned in recent years, for example by Van der Kolk et al. (1996), Levine and Frederick (1997), Scaer (2001) and Ross (2003), by holistically linking mind and the body. Scaer (2001, p. 6) defines trauma as “anything that represents a threat to our survival as human beings”, adding that “the mechanism by which traumatic stress occurs is by impinging upon or rupturing

that intangible but real perceptual boundary that separates our safe sense of self from the world around us". Levine and Frederick (1997) define trauma as an event that creates a physiological 'freeze'. Other researchers have commented on 'freeze' by referring to the individual's reaction to trauma. In addition, different definitions of trauma resources have been put forward. (Krystal (1978)) states that psychic surrender, observed as 'freezing of the affect', may represent an exact reaction to intense stress. (Hobfoll (2002)) considers the freeze response to be a reaction to exposure to extreme stress, sufficient to meet the criteria of traumatic stress. Ross (2003), referring to the response to a real threat to one's life, body and identity, affirms that its impact will remain in memory. Tedeschi, Calhoun, Linley, and Joseph (2004) adopt a broader characterization of trauma, suggesting that in the event of trauma, the person's adjustment skills are extremely challenged, as is their ability to make sense of and find meaning in life.

From the above mentioned, it becomes clear that the concept of trauma is defined in different ways, as some researchers described and determined trauma by the events themselves, while others described the results of exposure to trauma and its negative effects on the individual. In the next section, we will discuss the impact of trauma physiologically and psychologically.

2.2 Physical and psychological impacts of trauma

The impact of traumatic events on the lives of human beings is marked at different levels of the human experience, i.e. emotional, somatic-physiological, behavioural, cognitive, social and spiritual realms (Ross, 2003). People are

generally affected by traumatic events in a negative way, although the extent varies (C. Davis et al., 1995). Calhoun and Tedeschi (1999) list some common examples of the emotions evoked: worry and fear, shame and apprehension, guilt and terror, depression and anxiety, anger and irritability.

Cognitive domains are known as the most prevalent components of PTSD (Horowitz, 2001). Well established cognitive effects include numbness, disbelief, repetitive and intrusive ruminative thoughts, the belief that the world has changed or that life has become insecure and uncomfortable, lower self-esteem, and feeling that one is more exposed to harm. Behavioural impact includes the likelihood of the problematic use of legal and illegal drugs, alcohol abuse, sexual dysfunction, psychological difficulties and aggression (McCann & Pearlman, 1990). In addition, the tendency to withdraw socially is in part the result of feeling misunderstood by others.

The impact of trauma also varies in the somatic-physiological domain. After traumatic events, individuals are likely to suffer from physical and physiological symptoms expressed as physical illness and physical discomfort. Traumas such as domestic violence or sexual attacks can stimulate the nervous system. Psychological symptoms which can appear when trauma continues to stimulate the body for a period of time include being out of breath, muscular stress and frequent startle response (Scaer, 2001). In recent years, research has shown that trauma survivors commonly complain of physical conditions such as gastrointestinal symptoms, heart trouble, urinary tract infections, asthma, fibromyalgia and constant fatigue (Deighton, Gurriss, & Traue, 2007). These

symptoms and conditions are not necessarily caused but rather accentuated by traumatic stressors.

It is well established that trauma has significant impact on the lives of both adults and children, depending on how they process and deal with the event. In contrast, there has been limited research on certain aspects of this effect of trauma, what makes children withdraw from society and remain isolated from others, or on the relationship between trauma and social phobia.

2.3 Types of trauma

Developments in the field of trauma research in recent years have led many researchers to the conclusion that the term 'traumatic event' is broad and includes several components (Fullerton, Ursano, Norwood, & Holloway, 2003). This section presents brief information on the various types of trauma, including war, disaster, transportation accident, sexual assault and neglect, providing an overview of each type in terms of definition and key evidence on its psychosocial characteristics. The types of trauma are presented under three categories: human-induced, transportation accidents and natural disasters.

2.3.1 Human-induced

This section considers trauma caused by other people, within the family, school, neighbourhood or community. These causes range from neglect to warfare.

2.3.1.1 Physical abuse

Helfer, Kempe, and Mondale (1976) define physical abuse as being non-accidental and as causing or making an extensive threat of defacement, harm of bodily performance, or other severe physical injury. The Department of Health (2000: p. 5) in the UK defines physical abuse of a child as “hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child”. This definition does not determine whether physical abuse is accidental or deliberate. Corby (2003) considered a number of factors that need to be taken into account in establishing physical abuse: the seriousness of the injury, the intention of using violence and the child’s age, as it is usually the case that the younger the child the greater the likelihood that abuse will be officially reported (Durrant, 2008). Many child abuse cases are not reported. Sappington (2000) found that 5.7 cases of physical abuse for every 1,000 children were registered by child protection agencies, and 6% of pupils had been physically abused as children and were at risk of suffering from mental health problems. There is also a high possibility of inter-generational continuity (Doumas, Margolin, & John, 1994).

Attention to the impact of physical abuse has increased in recent years. Several studies have demonstrated that maltreatment is harmful for a child’s current quality of life and that it also has adverse effects on later development. Physical abuse may adversely affect children’s emotional and behavioural well-being. Silverman, Reinherz, and Giaconia (1996) found that abused males were more likely to report suicidal thoughts at age 15 and were more likely to suffer from depression, PTSD, anti-social behaviour and substance abuse at 21 years. In

Saudi Arabia, Al Ayed, Irfan Qureshi, Al Jarallah, and Al Saad (1998) studied children attending from the emergency service at King Khalid University Hospital in Riyadh over one year, and reported that four out of thirteen children in attendance had been physically abused, three of whom with serious injuries. Other studies were constrained by methodological problems, nevertheless also detected high rates of physical abuse. For example, Mansour et al. (2010) found that 12.2% of participating students from two Universities had been subjected to physical abuse as children. Their reports, as in other retrospective studies, may have been subjected to memory bias, but these have been triangulated from other samples and sources. Rates of physical abuse were, as expected, much higher within clinical populations. Al Eissa and Almuneef (2010) found that this was the most prevalent type of abuse, with 48.9% of children attending the psychiatric department at King Abdulaziz Medical City for the National Guard over eight years having experienced such trauma.

Child abuse occurs in all societies (Pereda, Guilera, Forns, & Gómez-Benito, 2009). In Arab countries such as Saudi Arabia it is important to consider several socio-cultural characteristics that may be relevant to the definitions of abuse, its implications, attitudes toward victims of abuse, and how communities deal with the problem (Muhammad M. Haj-Yahia & Safa Tamish, 2001). It has also been demonstrated that doctors do not have adequate knowledge or competencies to detect abuse and to implement appropriate legislation (Al Ayed et al., 1998). Many children had not been diagnosed as having suffered from abuse, hence not adequately protected, as reported by Kattan, Sakati, Abduljabbar, Al-Eisa, and Nou-Nou (1995), including the death of a child, which was not linked to

abuse until four years later when his sister made a disclosure. Despite some differences in research findings, it is well established that exposure to physical abuse universally affects children's mental health and development, whatever their sociocultural background. Consequently, child abuse has high costs for society across several public sectors such as providing investigations, protection, alternative care, judicial process, treatment or education (Geeraert, Van den Noortgate, Grietens, & Onghena, 2004).

2.3.1.2 Sexual abuse

Childhood sexual abuse has been defined as "... forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative and non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of pornographic material, watching sexual activities, or encouraging them to behave in sexually inappropriate ways" (Department of Health, 2000: p. 6).

Sexual harassment has the highest incidence when the child is around nine years of age. The offender is usually a male in his mid-20s or above (Briere, 1992; Briere & Elliott, 2003; Finkelhor & Browne, 1985). As with other types of child abuse, self-reported sexual abuse may not be taken seriously in court if not supported by other evidence from a social, psychological and medical perspective (Swahn et al., 2006).

(Walker, Carey, Mohr, Stein, and Seedat (2004)) report that the prevalence of child sexual abuse ranged from 6% to 62% in girls, and between 3% and 31% among boys. In the US National Comorbidity Survey, sexual abuse during childhood was retrospectively reported by 13.5% of women and 2.5% of men (Molnar, Buka, & Kessler, 2001). A recent study by Pereda et al. (2009), however, reviewed the prevalence of sexual abuse in 28 countries and concluded that up to 53% of women and 60% of men had suffered some form of sexual abuse.

In Saudi Arabia, there have been several on the occurrence of sexual abuse across different settings and samples. For example, among health professionals working in major hospitals in Riyadh 22.7% of abused children they had encountered over one year had been sexually abused, although the actual total number was low at the time, which indicated a high proportion of undetected cases (Al-Saud, 2000). Al-Zahrani (2005) interpreted such findings of low real or low detection rates as partly reflecting a traditional society with strong religious faith. In a more recent general population study by Al Eissa and Almuneef (2010), the incidence of child sexual abuse was established as 15%, which possibly indicates improvement in both measurement by such research and in wider attitudes that encouraged children and families to disclose such incidents. Research evidence in Arab societies is, however, still constrained by socio-cultural factors that affect the perceptions and definitions of sexual abuse, processes to facilitate disclosure, and methodological variation in sampling and instruments among the existing studies (Haj-Yahia & Tamish, 2001).

The association between sexual abuse and psychopathology is well established. Many studies of children who have been sexually abused support the relationship between sexual abuse and mental health problems (Horwitz, Widom, McLaughlin, & White, 2001; Mullen, Martin, Anderson, Romans, & Herbison, 1993; Spataro, Mullen, Burgess, Wells, & Moss, 2004). Follow-up studies of sexual abuse victims have also established a psychological impact in later life (Joiner et al., 2007; Kendler et al., 2000; Roberts, O'Connor, Dunn, & Golding, 2004).

2.3.1.3 Emotional abuse

Child emotional and psychological abuses are usually considered to be synonymous. Emotional abuse is increasingly recognised as a major risk factor that can significantly impede a child's growth and well-being, with long-term implications (D. Glaser, 2002). However, definitions are not consistent, for which reason policies and service responses still vary considerably. Countries differ in the disclosure of emotional abuse in the context of their civil and criminal liability; therefore, there are also extensive differences in the rates of detection and reporting (Hamarman, Pope, & Czaja, 2002).

A US survey found that 6% of children had reported emotional abuse and neglect (Health & Services, 2000). In England, the Child Protection Register records children's names under the categories of emotional, sexual and physical abuse, and neglect. The category of emotional abuse included 43.5% of all children on the Register (Department of Health, 2010). In Saudi Arabia Al-Zahrani (2005) found that the prevalence of emotional abuse was 22.8%. This

study also found that child emotional abuse was significantly associated with a family size of six or more children, which is the average family size in the Saudi society. This could be a proxy indicator of other risk factors associated with overcrowding. In all countries, the number of children documented as having been emotionally abused, hence in need of support and protection, is possibly an underestimate. It is also generally acknowledged that emotional abuse is usually an intrinsic element in all types of maltreatment (Carpenter et al., 2009). Although many studies established the importance of emotional abuse and its impact on child mental health, these have also acknowledged that this is the most difficult to prove or criminalize the perpetrator, by legally demonstrating negligence towards a child.

2.3.1.4 Neglect

Neglect is defined as the failure to provide for a child's physical and/or psychological needs, with likely adverse consequences on their health and growth. Furthermore, those unmet needs can be to provide adequate food, home and clothing, protection from physical harm or danger, and access to suitable health care or treatment (Department of Health, 2000: p. 6).

Measurement of child neglect is not easy, because it is not often observed directly outside the family; thus many cases are not reported. Available evidence, however, suggests that child neglect is common (U.S. Department of Health & Human Services, 2004, 2006). Although child neglect occurs in all religious, ethnic and cultural groups, there are substantial differences in regulations and child protection legislation among countries (Dubowitz &

Bennett, 2007). Neglect rarely has a single cause; multiple risk factors are usually involved (Molina, 1983; Wu et al., 2004). These include the child's disability (Kendall-Tackett, Lyon, Taliaferro, & Little, 2005), parental mental illness (S. L. Wilson, Kuebli, & Hughes, 2005), life conditions such as unsafe areas or poor leisure facilities (Korbin, 2003) and social factors such as poverty, with the associated burden (Sedlak & Broadhurst, 1996). Domestic violence is particularly likely to be a risk factor for child neglect, as for other types of abuse, so the mechanisms involved will be discussed in the next subsection.

2.3.1.5 Domestic violence

Domestic violence is defined as persistent physical and/or emotional aggression in the home that affects children, adults or any member of the family, through physical, emotional, sexual or economic abuse. It is usually committed by men against women within an intimate relationship, and is recognised by either self-reporting, observation, or witnessing by other people (Abramsky et al., 2011). Between 1995 and 2005 in England and Wales, domestic violence was the highest recorded offence (59%). It also has the highest rate (46%) of repeated victimization, i.e. when victims are attacked more than once (Nicholas, Povey, Walker, & Kershaw, 2005). Furthermore, in the UK, it is the offence most frequently reported to the police (Dobash, Dobash, Cavanagh, & Medina-Ariza, 2007). More than 5,000 children and one in nine women suffer from domestic violence (Stanko, 2006). In some situations, women can be violent towards their partners, but most of these are cases of self-defence (Hague, Thiara, & Mullender, 2011).

Exposure to domestic violence can lead to psychopathology in both adult victims and their children, with this association established in several studies of battered mothers (Briere & Jordan, 2004; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). Children may be involved in domestic violence in an active way by being subjected to abuse, or in a passive way by witnessing or overhearing it. In a study of children who had witnessed domestic violence, C. McGee (2000) found that the effects included fear, powerlessness, depression or sadness, antisocial behaviour, low self-esteem, negative mother-child and family relationships, low educational achievement and involvement in aggressive behaviour of their own.

2.3.1.5.1 Links between domestic violence and child abuse, and emerging services in Saudi Arabia

Saudi Arabia signed and ratified the United Nations Convention on the Rights of the Child in 1996 (Almuneef & Al Buhairan, 2012), which was subsequently adopted by all health facilities throughout the country. The lack of accurate statistics on incidence and prevalence rates has constrained the estimation of the real extent of the problem, despite the increased number of child abuse cases associated with exposure to domestic violence, who attended hospitals (Almuneef & Al Buhairan, 2012). Risk factors, indicators and categories of child maltreatment and domestic violence, as well as the interaction between the two traumatic situations, are not as yet well defined. This has hindered the development of multidisciplinary services for the victims of both domestic and child abuse and their families.

The increasing reports of abuse in recent years may reflect increased awareness and changes in public attitudes toward child abuse and neglect. These have frequently been highlighted by media campaigns since 2002. As a consequence, between 2000 and 2004 multidisciplinary teams were established at the main hospitals. In 2005, the National Family Safety Programme (NFSP) was developed and dedicated to the prevention of child abuse and domestic violence (Al-Khenaizan, Almuneef, & Kentab, 2005; Al Eissa & Almuneef, 2010; AlJasser & Al-Khenaizan, 2008) In 2007, the NFSP submitted a national project to establish Child Protection Centres (CPCs) in major hospitals throughout the Saudi Arabia. The project received full approval and support by the National Health Council (NHC), which is the highest health service authority in the Kingdom (Almuneef & Al Buhairan, 2012).

2.3.1.6 War

War is one of the greatest human disasters, affecting society dramatically, by destroying economies and communities over a long period. It is often accompanied by acts of terrorism, bombings, kidnappings and sniping. Civilians suffer from the scourge and effects of wars, with a substantial body of evidence on the emotional impact on children (Daniel S. Pine, Costello, & Masten, 2005; Thabet, Abed, & Vostanis, 2004), particularly in the forms of anxiety and PTSD (Thabet, Tawahina, El Sarraj, & Vostanis, 2008). As with other types of trauma, armed conflict can affect children through both direct and indirect mechanisms (Thabet, Karim, & Vostanis, 2006). A number of studies have found that children exposed to conflict experience a variety of stressors and that many develop both short-term and long-term post-traumatic stress reactions.

Common symptoms and reactions in the aftermath of a potentially traumatic event include sadness, anger, fear, numbness, feeling jumpy or jittery, moodiness or irritability, change in appetite, difficulty in sleeping, nightmares, avoidance of situations that are reminders of the trauma, impairment of concentration, and guilt because of survival or lack of harm during the event (Banyard, Rozelle, & Englund, 2001; Barenbaum, Ruchkin, & Schwab-Stone, 2004; Thabet et al., 2008; Thienkrue et al., 2006). Mental health problems are compounded by the lack of basic needs, collapse of community supports, migration or displacement, and resulting socioeconomic adversity (Reed, Fazel, Jones, Panter-Brick, & Stein, 2012).

Most of these studies were based on war exposed areas. Saudi Arabia has not experienced such devastating events of war conflict. Most research thus examined the effects of certain events such as the terrorist bombings in some areas, and the experience of the war to liberate Kuwait. The majority of these studies predominantly focused on security rather than on the psychological impact of trauma.

2.3.2 Transportation accidents

Road traffic accidents (RTAs) are daily events worldwide and their victims constitute one of the most frequently studied adult and child populations with regard to psychopathology and PTSD in particular. There have been many studies of RTAs, because of the frequency of these events and the relatively easy access to survivors through accident and emergency departments.

RTAs cause physical and mental health problems in children, for example PTSD, depression and anxiety, all of which affect the child's psychosocial functioning. Survivors of RTAs can be preoccupied with the traumatic incident for up to three months or longer, and may present with a number of PTSD symptoms (emotional, cognitive or physical) (Jones, Harvey, & Brewin, 2007). Four weeks after the RTA, 29.1% children fulfilled diagnostic criteria for PTSD, 20.3% reported significant levels of anxiety and 17.7% reported depressive symptoms. Girls were more likely than boys to develop PTSD (Bryant, Mayou, Wiggs, Ehlers, & Stores, 2004; Stallard, Salter, & Velleman, 2004).

Other incidents such as train crashes (Forsberg & Saveman, 2011) and sinking of ships are similar to RTAs in their impact on child mental health. Udwin, Boyle, Yule, Bolton, and O'Ryan (2000) examined risk factors for the development of PTSD in adolescents and young adults who were followed up 5 to 8 years after having survived a shipping disaster. Developing PTSD was associated with being female with learning and psychological difficulties before the disaster. As many as 51.5% of adolescents developed PTSD six months after the disaster, while 17.5% still suffered from PTSD after 5-8 years.

Previous studies found that survivors of all types of accidents continued to remember the traumatic events in the form of PTSD symptoms, which might also lead to anxiety and/or depression. Children were found to be affected through mechanisms similar to those which operate following exposure to other types of trauma.

2.3.3 Natural disasters

Research into natural disasters has significantly enhanced the understanding of children's reactions to trauma. The large numbers of children affected by natural disasters have provided the opportunity for cross-sectional and longitudinal research. Natural disasters are defined by the International Strategy for Disaster Reduction (2004) as "extensive events that affect the functional capacity of a nation or a community by causing individual, community, economic, or environmental effects that are beyond the capacity of the affected community or society to cope using its own resources" . In common with findings from studies of other types of trauma, survivors report high PTSD rates with comorbid psychopathology, according to evidence from research with children exposed to hurricanes, earthquakes and floods (Celebi Oncu & Metindogan Wise, 2010; Liu et al., 2011; Prawira et al., 2010; Wiguna, Guerrero, Kaligis, & Khamelia, 2010). The prevalence of PTSD varied considerably in these studies, depending on the extent of exposure to trauma, age, proximity to trauma, measures, design, length of time after the event and the nature of the disaster (Baddam, Russell, & Russell, 2007).

In summary, there are several types of human or environmental-induced trauma, whose impact on children has been reviewed in this section. A number of risk factors have been identified in the development and maintenance of mental health problems such as the nature, severity and proximity of the trauma; impact on parental mental health and parenting capacity; social and family support networks; and socioeconomic adversity;. The majority of these studies

have shown that exposure to trauma was associated with emotional disorders, predominantly post-traumatic stress disorders (PTSD). For this reason, the evolution and current criteria of PTSD will be discussed in more detail in the next section.

2.4 Post-traumatic stress disorder

PTSD is widely defined as an emotional condition that develops following exposure to events which result in psychological trauma. In children, these events involve the threat of death or serious injury to the child or to someone else, or some other threat to the child's own or someone else's physical or psychological integrity, and which weaken the child's ability to cope. Diagnostic symptoms of PTSD include persistently re-experiencing the original traumatic event(s) through images, thoughts or nightmares; avoidance; anything associated with the traumatic event; and increased arousal, like failure to sleep, continuation of anger and extreme vigilance (APA, 2000; Flannery, 2004; R. C. Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Ozer, Best, Lipsey, & Weiss, 2003; Ryan et al., 2008). The current DSM-IV-TR (APA, 2000) and ICD-10 (WHO, 1993) diagnostic criteria are presented in Table 2.1. In both cases PTSD is characterized by three clusters of symptoms, relating to re-experiencing the incident, arousal and a range of behavioural responses, including intrusive recollection, avoidant and hyper-arousal symptoms.

Table 2.1: Diagnostic criteria for PTSD according to DSM-IV-TR and ICD-10

Criteria	DSM-IV-TR	ICD-10
Stressor	√	√
Subjective	√	
Re-experience	√	√
Avoidant	√	√
Amnesia	√	√
Numbing	√	
Foreshortened future	√	
Arousal	√	√
Onset	one month	six months
Functional impairment	√	

At least three months after experiencing a traumatic event, PTSD tends to become chronic (Wickrama & Kaspar, 2007). The National Co-morbidity Survey in Germany found that more than 70% of adolescents experienced symptoms for more than a year, while over one third remained symptomatic for three years (Perkonig, Kessler, Storz, & Wittchen, 2000). Children exposed to direct trauma reported a high prevalence of PTSD. For instance, the PTSD prevalence following trauma was 11.2% at six months after the trauma and 13.4% at twelve months (Liu et al., 2011).

Overall, there is strong evidence that children's exposure to trauma can lead to the development of mental health problems, in particular PTSD. More recent studies have investigated in detail the factors that play a role in the development and maintenance of child psychopathology, and these have highlighted the importance of understanding the mechanisms involved. This research has been influential in identifying children who are at high risk of developing persistent

symptoms, therefore in need of prevention or treatment. The role of these risk factors is now discussed in more detail.

2.5 Responses to trauma

Many researchers have investigated why some children develop psychopathology when exposed to trauma, while others do not, and which factors account for the marked variation in the nature, severity and duration of responses. The establishment of risk factors would enhance the quality of assessment and interventions, with a more effective use of resources. The literature presents some evidence on mediating factors, which are usually grouped into three categories, related to the traumatic experience, to the individual child and to the trauma factors (family and the wider environment) (Green, Grace, & Gleser, 1985; Pfefferbaum, 1997; Tucker, Pfefferbaum, Nixon, & Dickson, 2000; Udwin et al., 2000).

Severity and proximity are dependent on exposure to the traumatic event and have emerged as a predictors in many studies (Keller, Herzog, Lavori, Bradburn, & Mahoney, 1992; Lonigan, Phillips, & Richey, 2003; Yule & Williams, 1990). Layne et al. (2001) found that children who were present at a school during a sniper attack reported higher levels of PTSD symptomatology than those who were exposed indirectly, such as by hearing about the attack. Anthony et al. (2005) found that the degree of exposure to a hurricane was associated with the intensity of anxiety symptoms. Other characteristics of natural disasters which have been less fully investigated include witnessing

death or injury and being separated from one's family (Van Hooff, McFarlane, Baur, Abraham, & Barnes, 2009).

Findings on the influence of individual characteristics like age, gender and ethnicity have been inconclusive. Some studies have found that girls are more likely than boys to report PTSD and other emotional disorders, but this pattern is not consistent across all research. Similarly, it is difficult to draw firm conclusions on the impact of age and ethnicity (Blom, 1986; Groome & Soureti, 2004; Pynoos et al., 1987; Schnurr & Green, 2004; Steinberg, Brymer, Decker, & Pynoos, 2004; Udwin et al., 2000). Koplewicz et al. (2002) indicate that a number of mediating age factors in response to the disaster might explain these contradictions. These include the variation with age in the evaluation of disasters, coping strategies and children's beliefs about the determinants of traumas.

In contrast, there have been few studies on the effects of pre-trauma temperament. Children with earlier physical or emotional vulnerabilities are more likely to develop PTSD symptoms (Buka et al., 2001; Kilpatrick et al., 2003; Terr, 1995; Yule et al., 2000). Tsui (1990) found that the survivors of the sinking of a ship (the Jupiter) who had higher academic skills pre-trauma were more likely to have better psychosocial outcomes.

As regards post-trauma factors, children's functioning after a traumatic event has been widely associated with parental adjustment (Punamäki, Qouta, & El-Sarraj, 2001; Scheeringa & Zeanah, 2001; Smith, Perrin, Yule, & Rabe-Hesketh,

2001). This could be explained by parents suffering from PTSD, and/or not providing emotional support. The survivors of the Buffalo Creek dam disaster were followed up for two years by Korol, Kramer, Grace, and Green (2002), who found that the strongest predictors of outcome were the parents' level of irritability and the family atmosphere. These parental factors will therefore be considered in the next section.

2.6 Parental psychopathology

The family is the first line of protection and safety following exposure to trauma; the quality of the parent-child interaction is particularly important. Conversely, parents who cannot cope with stress may adversely affect their children. Green et al. (2000), in a study of children exposed to a dam collapse, found that parental mental health symptoms such as irritability or depressed mood were predictive of children's PTSD symptomatology. Adolescents were more affected by the reactions of their parents. It is plausible that younger children were more likely to receive care from older siblings, who would thus adopt a parenting role which acted as an additional stressor. Korol, Green, and Gleser (1999) found that children living close to a nuclear waste reactor reported more PTSD symptoms than their parents.

Smith et al. (2001) studied children's and mothers' reactions to trauma in Bosnia and found that 58% of both children and their mothers suffered from high levels of PTSD, while a substantial proportion reported depression and anxiety. Laor and Wolmer (2000) assessed mothers and children for PTSD symptoms after a Scud missile attack in Israel. They found that a large number of children had

PTSD and that these symptoms were correlated with mothers' pathological reactions. Gurwitch, Sullivan, and Long (1998) established that a family's reaction could moderate the negative effects of trauma on children and thus help their children's coping and adjustment. Thabet, Ibraheem, Shivram, Winter, and Vostanis (2009) studied children in Gaza Strip a war zone a war zone and found an inverse association between parental support and children's PTSD reactions, confirming earlier findings on children exposed to various types of trauma (Gil-Rivas, Holman, & Silver, 2004; Khamis, 2005; Zahr, 1996). Parents provide safety zone, comfort and encouragement; children are influenced by their parental attitudes, emotional well-being and the help they provide to face adversity. When any of the parenting components is adversely affected by trauma, this is likely to impact on the child's well-being. Previous studies have been criticised for not eliciting gender effects among parents, or which parent may have more impact on girls or boys.

2.7 Co-morbidity with other mental health problems

PTSD can co-occur with psychosomatic complaints and somatization disorders (Clay-Warner & McMahon-Howard, 2009; Escalona, Achilles, Waitzkin, & Yager, 2004; McCarroll, Ursano, Fullerton, Liu, & Lundy, 2002), alcohol and substance abuse (J. M. Wallace & Muroff, 2002), conduct disorders (Famularo, Kinscherff, & Fenton, 1991; Spatz Widom, DuMont, & Czaja, 2007), or depression (Eksi & Braun, 2009; Vranceanu, Hobfoll, & Johnson, 2007).

The US National Comorbidity Survey found that 88% of male and 79% of female children diagnosed with PTSD also met criteria for other psychiatric diagnoses

(Kilpatrick et al., 2003). Several studies found that depression and anxiety were the most prevalent comorbid disorders (Breslau, 2009; Creamer, Burgess, & McFarlane, 2001; Goenjian et al., 2000; Kar & Bastia, 2006; Kessler et al., 1995; Nelson et al., 2002; O'Donnell et al., 2004; Rojas, Ariz & Kinder, Bill, 2009; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997; Udwin, Boyle, Yule, Bolton, & O'Ryan, 2000). Among children who had experienced war in Bosnia, those suffering from PTSD were also likely to report depression and anxiety (Papageorgiou et al., 2000). Similarly, after an earthquake in Armenia, high rates of comorbidity between PTSD, depression and anxiety were established, and these were particularly associated with separation from family members (Goenjian et al., 1995). Finally, many studies found long-term continuities in emotional disorders (Di Gallo & Barton; Di Gallo, Barton, & Parry-Jones, 1997; Gillies, Barton, & Gallo, 2003; Stallard et al., 2004)

This chapter has discussed the evidence on how exposure to different types of trauma can affect the quality of a child's life. A substantial proportion of survivors of trauma reported physical or psychological presentations, or both. A number of factors have been found to place children at risk or to protect them in the presence of trauma. Most research has demonstrated a direct link between exposure to trauma and PTSD, with some evidence on how trauma can lead to other emotional disorders such as anxiety or depression. However, there is also a gap in knowledge on the relationships between exposure to trauma and social phobia, and whether any mediating factors play a role in this association. The next chapter will formulate the questions, aims and hypotheses of this research project. This gap in the literature provides the rationale for the present study.

Chapter Three

Methods

3.1 Introduction

In this chapter, the research methods will be discussed in detail. The aims, sampling framework, measures, research procedure and statistical analysis are presented in the following sections.

3.2 Research aims and hypotheses

The study had three aims, each with an associated hypothesis:

Aim 1: To investigate the association between exposure to trauma and emotional disorders in children attending child mental health services in Riyadh, Saudi Arabia.

Hypothesis 1: Exposure to trauma is significantly associated with emotional disorders.

Aim 2: To investigate the association between exposure to trauma and social phobic disorders in the same sample.

Hypothesis 2: Exposure to trauma is significantly associated with social phobic disorders.

Aim 3: To investigate the role of mediating factors such as parental responses in the association between exposure to trauma and social phobic disorders.

Hypothesis 3: The association between exposure to trauma and social phobic disorders is mediated by parental responses, specifically by parents' own anxiety levels.

3.3 Research design

A cross-sectional design is commonly used in descriptive or observational studies. It can be applied to representative samples, which can help to establish

the relationship between different variables of interest in a specified sample at a particular time, as this design is relatively cost-effective. Furthermore, it can be completed over a short period and can be used to collect data in order to inform service planning (Susser, 2001). The current study adopts such a cross-sectional design, to investigate the relationship between exposure to trauma and social phobia in children.

In particular, a two-stage model was adopted. In the first stage, the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS; see section 3.8.2 for a detailed description) was used to determine whether children fulfilled the inclusion diagnostic criteria. All children who received the diagnosis of emotional disorder and their parents were included in the second stage (questionnaire rated).

3.4 Background of Saudi Arabia

The Kingdom of Saudi Arabia (Figure 3.1) occupies the largest part of the Arabian Peninsula (Al-Farsy, 1986) and attracts attention worldwide as the location of the two holiest sites of Islam: Makkah and Medina. The Prophet Mohammed began to preach Islam in Makkah. Saudi Arabia was founded as a religious state and its population is Muslim (Al-Rasheed, 2002). The population of Saudi Arabia according to the latest official report, issued in 2010, was 27,136,977, comprising 18,707,576 Saudis and 8,429,401 non-Saudis, with growth rate of 3.2% per annum (Ministry of Economy and Planning, 2010). The area of Saudi Arabia is 2,217,950 square kilometres (Niblock & Malik, 2007).

This provides the country with a wide geographic and climatic variety, and with a desert climate as the major characteristic (Niblock, 2006).

The extended family is the basis of Saudi society and is typically composed of a couple, their unmarried offspring, their married sons and daughters-in-law, and their grandchildren (Yamani, 2000). The Saudi society has experienced rapid development and changes in a relatively short period of time. Such social and economic changes have affected the family unit, and this has, in turn, had further effect on society (Almalki, FitzGerald, & Clark, 2011). One major example is the discovery and exploitation of oil. In the pre-oil period, extended families were dominant in society, but their status and influence has been on the decline, particularly in urban areas. While seeking education and employment opportunities, as well as access to better services, large parts of the population have moved from rural and Bedouin to inner-city areas. The implication of these geo demographic changes has been that smaller family units have set up new households in the emerging urban sites, but have been increasingly cut off from their traditional family and social support networks (Al-Khateed, 2008). The declining number of extended families has resulted in increased individual ownership of property (Rawas, Yates, Windsor, & Clark, 2012). Consequently, family functions in the educational, religious, and community domains have been seriously disrupted through the separation between home and work life, in contrast with the traditional integration of the past. In addition, the economic unite and productivity capacity of the family is not constituted as it was in one time (Al-Khateeb, 2008). Even though, the family name and status plays an important role in determining the individual's status in society, his acquisition of

a good education and job and individual's social networks and close connection to the patronage system (Esmaeili, 2009).



Figure 3.1: Saudi Arabia map

3.5 The role of women in the Saudi society: potential relevance to the development and presentation of social phobia

As social phobia is a condition with a particularly sociocultural underpinning in both its presentation (with symptoms such as shyness and avoidance of social places) and aetiology, and this is much more prevalent among females from adolescence to adult life, it is important to consider such factors that could be of relevance in the Saudi society. In Arab and Islamic societies, it appears that women have few opportunities in taking a leading role in politics and economics (Douki, Ben Zineb, Nacef, & Halbreich, 2007), despite assurances from Islam on their care, protection and attention, as illustrated by the holy Quran.

For example, Allah states: “They are a libaas (protection) for you and you are the same for them”. Furthermore: “And among his signs is this that he created for you wives from among yourselves that you may find repose in them, and he has put between you affection and mercy” (Al-Rum 21). These Quranic verses describe how men and women should come together, protect, and beautify one another. It is stipulated that each has to support, work and act on behalf of the other (Al-Sadlaan, 1996). This is the prescription of Islam with regard to the treatment of women. In a traditional Arab society, it is custom that men work outside the home and provide financial support to their family, while their wives take care of the house and children, while providing emotional support to their husbands (Fargues, 2003). As already discussed in previous chapters, recent years have seen significant socioeconomic changes, which have also influenced and often transformed these roles. In that respect, an increasing number of women work and share a larger proportion of the labour market with men than in the past (Metcalf, 2008).

In Saudi Arabia, social, political and economic factors have affected different spheres of the society. The labour recruitment from other Arabic and Western countries that followed the expansion of the oil economy, and which contributed significantly to the rapid development of Saudi Arabia by boosting its economy and the expansion of the construction, has also resulted in and the relative divergence of lifestyle (Hamdan, 2005). Other changes were initiated by the Gulf wars and the communications revolution such as satellite broadcasting and the internet. For example, the media constantly debate issues such as women's rights to drive and their inclusion in male-dominated jobs (Jamjoom, 2010).

Generally, in neighbouring Arab countries women have obtained some freedoms in life style; they can vote, drive their own cars and travel alone (Omair, 2008). Despite the fact that Saudi Arabia is slightly different than other Arab countries, it nevertheless endorses women's active role in religious and cultural activities. This often conflicts with social realities such as women not working with men unless there is a definite need – as banks, schools and the larger hospitals (Basaffar, 2012). Even in these environments they may have separate working areas, and contact their male colleagues via the internet, e-mail, or telephone. Although, gender segregation may not lead to the radical isolation of women from public life, their role remains largely peripheral ((Hilsdon & Rozario, 2006). This strict code and lack of freedom of movement for women has prevented many female from gaining employment, while the popular female occupations are over-subscribed (Omair, 2008).

In relation to social affairs, similar disparities apply, as women can visit each other at home or in shops, clubs, cafés and restaurants provided for them (Vogel, 2000). It is thus important to determine attributes or symptoms associated with social phobia to this sociocultural context. Islam and the Arab society consider shyness to be a positive quality in women, contrary to the Western media portrayal of Arab women as suppressed and underestimated (Al-Khodair & Freeman, 1997). However, the reality in some Arab communities is that boys are regarded as an asset to the family, whereas girls are regarded as a liability (Birenbaum & Nasser, 2006). Arab traditions emphasize submissiveness and dependency as important feminine attributes in the

upbringing of girls, while the belief that the function of the woman is to produce and care for children is widely held, particularly in the rural areas and among Bedouins (Hamdan, 2005). The rapid rise in the number of educated women is inevitably changing their traditionally limited roles within the family and the society as a whole, hence expectations on their social attributes (Doumato, 2003).

During this early transitional phase, Saudi women increasingly participate in senior management positions, consequently in the decision-making process in the public and private sectors, due to their increased enrolment at all levels of education, and in various fields of employment and aspects of public life (Al-Ahmadi, 2011). Women's right to education and employment are increasingly being recognised as a tool of empowerment and active participation (Hilsdon & Rozario, 2006). Gradually but steadily, Saudi women occupy high positions that comprise a Deputy Minister, a University President, Shura Council consultants, board members of Chambers of Commerce, and many other new and challenging positions (Basaffar, 2012).

Nevertheless the participation of Saudi and Arab women in these arenas (be it political, economic or social) continues to be compounded by a number of coded and unwritten social morals in a patriarchal, male-dominated society (Omair, 2008). Furthermore, there have not been significant changes in their domestic duties, which may include family tasks that were previously in the men's domain such as shopping or supervising the children's homework (Douki et al., 2007). Other significant constraints in some Arabic countries, including Saudi Arabia,

are posed by restrictions on women's mobility within their country (e.g. in public transport), or having to obtain permission to travel overseas from their husband or guardian (Metcalf, 2008). These roles are also being influenced though by factors such as the migration of large population groups from rural to urban areas (Calvert & Al-Shetaiwi, 2002).

Overall, one can conclude a number of often conflicting religious, sociocultural and economic factors that continuously impact on women's role within the Saudi society. These contradictions are reflected in societal attitudes and have been established by sociological research. For example, it is widely perceived within Arab communities that the most important decisions in the family are made by men, who hold this power from a patriarchal society and their tribe (Hamdan, 2005). However, women increasingly contribute to several of the decisions that were exclusive to men in the past (Al-Ahmadi, 2011). In the Saudi society, there are two broad attitudes towards women. Parts of the community see the need for women to take their full part in society under Islamic rules such as her right in education, employment, driving, and political participation. Consequently, several customs and traditions must change to that effect (Basaffar, 2012). In contrast, others believe that Saudi women are active family members, for which reason remaining at home is more important than working; and that they still need to be under the protection and guidance of men. Inevitably, there are ongoing debates on integrating these often opposed views in driving changes in legislation and implementation in everyday life (Jamjoom, 2010).

Linking these sociological perspectives with the mental health literature is important for the context of this study, since women in the Saudi society are viewed as shy, and are characterized by modesty and religiousness, it can be difficult to determine those who experience significant anxiety in social or interpersonal situations (Al-Khodair & Freeman, 1997). This is because many women do not have a great deal of exposure to these situations, thus anxiety may be interpreted as part of their feminine shyness. Indeed, those women who do experience significant anxiety may not find that it impacts greatly on their day-to-day functioning (Ahmed M & Alansari, 2004). Therefore, little is known about the experience of social anxiety in women compared to men in this culture. This is an important consideration arising from the research evidence, both in relation to the psychopathology of social phobia and parenting capacity, which are central variables in the conceptualization of the design of this study. For those reasons, we may need to revisit these issues in the interpretation of the findings.

3.6 Child mental health problems and services in Saudi Arabia

In order to understand the context of mental health services provided for children in Saudi Arabia, it is essential to consider a number of issues. Mental health services in Saudi Arabia have developed slowly and many Saudis, like others in Arab societies, have limited mental health awareness (Abolfotouh, 1997; Al-Krenawi & Graham, 2000; El-Islam, 1982). Children are not routinely referred to psychiatric services. Common reasons for referral are behavioural and emotional problems; lack of established organic causes for physical

symptoms; difficulties in adjusting to chronic or recurrent illness; family history of mental illness; and suspected abuse or neglect (Al-Haidar, 2003).

The development of mental health services requires rational planning, with sound epidemiological evidence of the prevalence of mental health problems. In the UK, approximately 1 in 10 children have a mental health problem (Ford, Goodman, & Meltzer, 2003), while in Australia, one in six (18%) of secondary school students were reported to suffer psychological distress (Van de Ven et al., 2002). In general, the prevalence of mental health problems among children has been investigated in many studies in both developed and developing countries. While prevalence figures vary considerably between studies, apparently 10 to 20% of all children have at least one mental health problem (WHO, 2002). Many researchers have shown that up to 50% of adult sufferers of anxiety disorders identify the onset of their symptoms in childhood; and that stress levels are escalating at an alarming rate among adolescents (Al-Gelban, 2007; Brooks, Harris, Thrall, & Woods, 2002; Pollock, Rosenbaum, Marrs, Miller, & Biederman, 1995).

The socioeconomic changes which have already been discussed, have inevitably affected children and young people as well. The current population is predominantly young, with 60% of Saudis under the age of 30 years and 47% under 15 years (Ministry of Economy and Planning, 2010). In a recent study, Abdel-Fattah et al. (2004) found that 8.3% of pupils (94.4% being children and 5.6% adolescents) suffered from emotional and behavioural problems, which is consistent with epidemiological research from western and low/middle income

countries. In Saudi study a high prevalence of mental health problems was established among young patients attending primary health care settings (Al-Faris et al., 1997), two-thirds of which were not detected (Al-Fakeeh, 1994), there is no evidence for children attending primary care. The main reasons were a shortage of psychiatrists and lack of necessary mental health training to General Practitioners (Al-Faris et al., 1997).

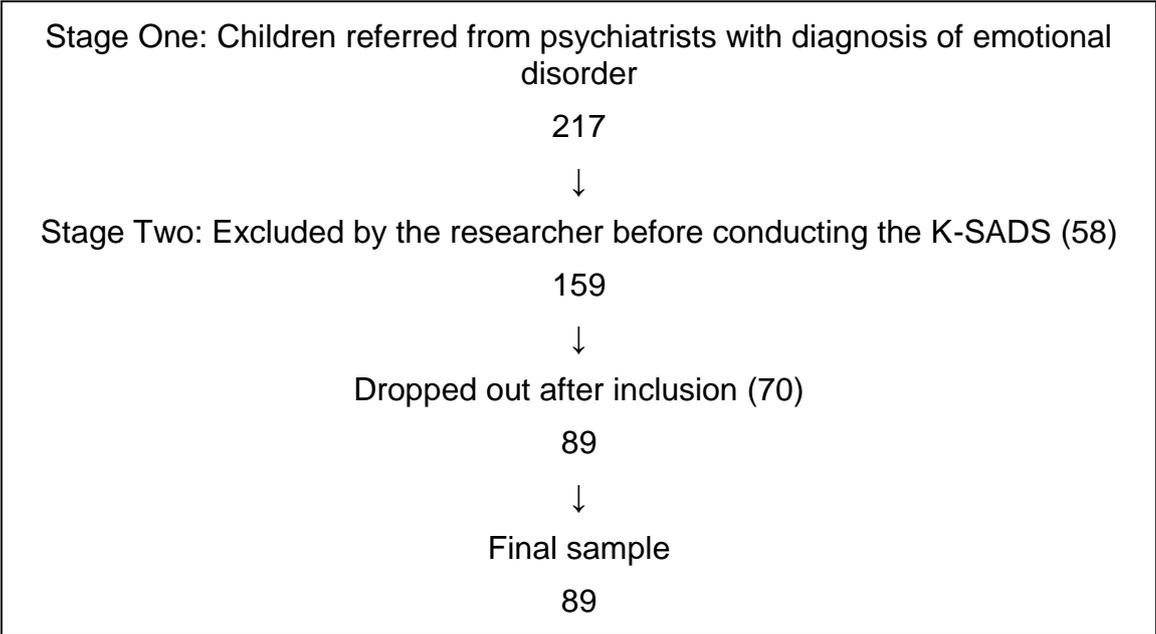
The Ministry of Health in Saudi Arabia has prioritised the development of primary health centres, since these constitute the first level of health care, before processing referrals to general or specialist hospitals, to diagnose and treat health conditions, especially chronic and widespread ones such as cancer, heart disease, diabetes, obesity and psychiatric disorders. The number of primary health centres has expanded in all areas of Saudi Arabia, to a total of 2,094 (MOH, 2009), with trained doctors and health staff. Scholarships have been awarded for the required specialties, and specialists from other countries have been recruited where necessary. In a related context, with regard to mental health, similar improvements have led to the establishment of 21 specialized mental health hospitals across the Kingdom (MOH, 2009). Children and adolescents are referred to the same Psychiatry departments as adults, there being no specialist child and adolescent mental health services as yet.

3.7 Sample

The sample consisted of children aged 9-16 years referred during a six-month period to psychiatrists, who had initially made a diagnosis of emotional disorder following a clinical interview, according to the researcher's request to use ICD-

10 or DSM-IV criteria. The selection of the participants for stage one of this study was confined to first-time referrals, before the initiation of treatment. The recruitment sources were out-patient clinics at the three main hospitals in Riyadh city. Each hospital has a psychiatric department and its patients were referred from a variety of sources, such as primary care clinics or schools. Over a period of six months (April to September 2008) the researcher recruited 217 participants. All were seeking treatment for the first time, and most of them completed the diagnostic interview. Figure 3.2 presents the sampling framework. Children were subsequently selected for stage two according to an independent diagnostic assessment using the K-SADS.

Figure 3.2: Sampling framework



The instruments used in the study were self-administered. Therefore, the age group was limited to 9 to 16 years, to ensure that children would be able to read and have sufficient cognitive capacity to complete the instruments. Consequently, the researcher excluded children unable to complete the self-rated questionnaires if they had moderate to profound learning disability.

Children who could not read and those with illiterate parents were also excluded. This partly affected the sampling frame, as the majority of participants came from the Al Badu area or the villages around Riyadh, which have high rates of illiteracy. Although the exclusion criteria including inability to complete the instruments, the sample still included participants from the Al Badu area and the villages. Some participants dropped out because they lived outside the city and had difficulty in returning to complete the study instruments; while others dropped out for unknown reasons, failing to return the questionnaires or to answer the researcher's calls. Maybe initially agreeing but then refusing to send the forms back was a passive way of declining to take part, which can be culturally prominent when people do not like to directly decline to someone of perceived higher status. The researcher engaged the participants by encouraging them to complete the instruments at the clinic, by providing a comfortable place for them, and by offering drinks and snacks. Thus the total number of children not included in the sample was 128 (Table 3.1), leaving a total of 89 subjects who consented to participate in the study. All participants were aged between 9 and 16 years ($M=13.09$, $SD=2.53$); 47 were male (52.8%) and 42 female (47.2%).

Table 3.1: Reasons for non-participation in the study

	Reasons		Number
Excluded by the researcher	Learning disability		16
	Illiteracy	Children	10
		Parents	32
Dropped out	Living outside Riyadh		22
	Withdrew		48
Total			128

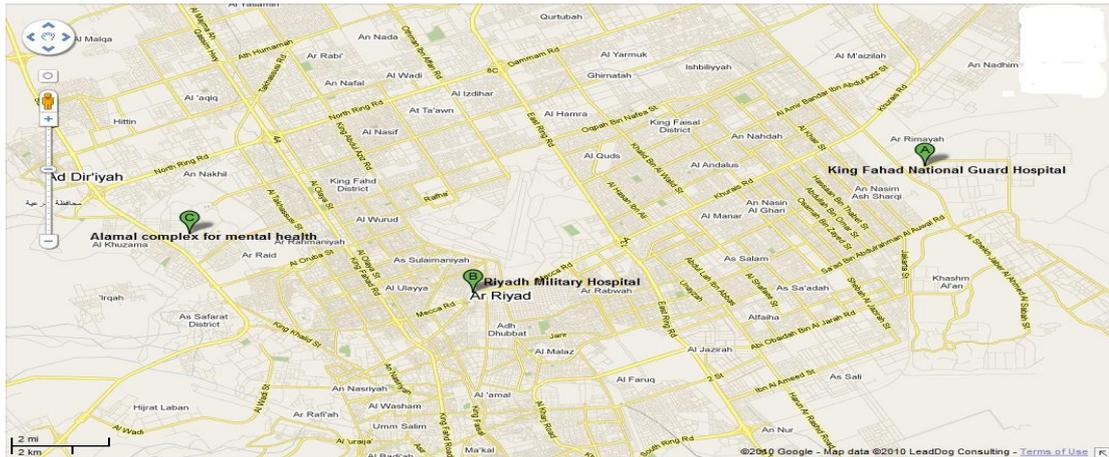
Several governmental and private hospitals and clinics provide mental health services in Riyadh city. The study was conducted at the three main hospitals (Figure 3.3), due to the availability of the majority of cases from these settings. Other services were excluded, as these were provided by other departments such as paediatrics or internal medicine. Some hospitals and clinics had psychiatric specialties, such as adult psychiatry and addiction, but not for children.

The selected hospitals were the Riyadh Military Hospital (RMH), the Al-Amal Complex for Mental Health (ACFMH) and the King Fahad National Guard Hospital (KFNGH). The largest number of participants were referred from the KFNGH (n=40, 44.9%), because of its participation in the National Family Safety Programme, followed by the ACFMH (n=30, 33.7%) and the RMH (n=19, 21.3%). After stage one, the researcher interviewed these children, and found that the majority suffered from one or more of the main emotional disorders, i.e. social phobia, post-traumatic stress disorder (PTSD) or anxiety disorder. The focus was on the main diagnostic categories of emotional disorders, as previous studies had found trauma exposure to have a predominant impact on emotional symptoms. This association was found to be mediated by several factors. The only type of emotional disorder that had not been studied was social phobia, which was the rationale for this study, as discussed in previous chapters. Table 3.2 lists the diagnoses of cases selected from each hospital.

Table 3.2: Referral source and diagnosis

Hospital	K-SADS Diagnosis						Total
	Social phobia	Social phobia and anxiety	Social phobia, anxiety and PTSD	Anxiety	Anxiety and PTSD	PTSD	
KFNGH	1	2	2	6	19	10	40
ACFMH	5	3	3	14	4	1	30
RMH	12	1	1	2	3	0	19
Total	18	6	6	22	26	11	89

As seen in the table above, the number of children diagnosed with SP and PTSD were few, however, this reflects that psychopathology is not pure, with high co-morbidity between SP, PTSD and other disorders.



A. King Fahad National Guard Hospital



B. Riyadh Military Hospital



C. Al-Amal Complex for Mental Health

Figure 3.3: The selected hospitals and their locations in Riyadh

3.8 Measures

To test the hypotheses set out in section 3.2, a total of 11 instruments were selected to measure four broad groups of variables (Table 3.3). The first

instrument elicited socio-demographic information from the participants and the second was the semi-structured diagnostic interview to select the sample. The third group consisted of rating scales of the main types of emotional disorders, and the fourth comprised questionnaires on potential mediating / risk factors according to the research literature.

Table 3.3: Research measures

1	Socio-demographic information checklist	
2	Semi-structured diagnostic interview (K-SADS-IVR)	
3	Ratings of emotional symptoms	Impact of Event Scale (IES) Revised Children's Manifest Anxiety Scale (RCMAS) Children's Depression Inventory (CDI) Social Phobia Questionnaire (SPQ) Strengths and Difficulties Questionnaire (SDQ)
4	Potential mediating/ risk factors	Exposure to Trauma (ET) Parenting Rearing Style (EMBU-C) Parenting Stress Index (PSI) Short Form (SF) General Health Questionnaire (GHQ)

The following subsections describe each measure in detail.

3.8.1 Socio-demographic checklist

The initial checklist consisted of 11 questions for the child and the parent, which were developed according to the existing literature. It elicited the following data on the child: gender, age, educational status, number of siblings, child order and referring hospital. The questions about the participant's parents were as follows: father's and mother's educational status, standard of living and parents' marital status (Appendix 3.1). During the statistical analysis, the researcher reduced variables if these overlapped or were significantly associated, i.e. the child's and

parents' educational status; the child's age and educational status; and the parents' educational status, which also reflected the family's standard of living.

3.8.2 K-SADS-IVR

The K-SADS is a semi-structured diagnostic interview tool designed to assess current psychopathology in children and adolescents. The K-SADS-P was initially developed by Puig-Antich and Chambers (Ambrosini & Dixon, 2000). The K-SADS-IVR is a revision of the K-SADS-IIIR, which was DSM-IIIR and DSM-III compatible. This edition of the K-SADS-IVR is consistent with DSM-IV and DSM-IIIR criteria. The major changes in the current edition are that diagnoses have been updated to include generalized anxiety disorder, which was new to the DSM-IV for children and adolescents. Post-traumatic stress disorder (PTSD) has also been added. All of the diagnoses assessed by the K-SADS-IVR are listed in Table 3.4.

Table 3.4: K-SADS diagnostic categories

EMOTIONAL DISORDERS	Avoidant Generalized anxiety Overanxious Separation anxiety Obsessive-compulsive	Simple phobia Social phobia Panic disorder Post-traumatic stress disorder
AFFECTIVE DISORDERS	Major depression a) non-endogenous b) endogenous c) psychotic Minor depression Dysthymia	Bipolar disorder a) Mania b) Bipolar I c) Hypomania d) Bipolar II Cyclothymia
BEHAVIOURAL DISORDERS	Attention deficit-hyperactivity Oppositional defiant Conduct Substance abuse/dependence	
EATING DISORDERS	Anorexia nervosa Bulimia nervosa	
PSYCHOSES	Schizophrenia Schizoaffective	
OTHER DISORDERS	Schizotypal Paranoid	

The researcher used the emotional disorders section of the K-SADS, consistent with the aims of study. The remaining sections of the K-SADS were not included, as they were not required for the selection of the sample.

The tool was first administered to the parent(s) alone, then to the child alone, finally achieving summary ratings which included all sources of information. In each case, the authors recommend that raters use their best clinical judgment when there are discrepancies between different sources. The interviewer should rate the signs and symptoms first, then use this information to arrive at an overall severity rating; the severity ratings for the K-SADS-P are scaled either 0 to 4, or 0 to 6. When a symptom has been scored as 3 or more, this indicates a positive diagnosis. There are also several items which refer to the absence or presence of symptoms, and which are scored 0 to 2 (0=No information,

1=symptom absent, 2=symptom present). For symptoms scored from 0 to 6, the coding is 0=No information, 1=Not at all, 2=Slight, 3=Mild, 4=Moderate, 5=Severe, 6=Extreme. For symptoms scored from 0 to 4, the coding is 0=No information, 1=Not at all, 2=Slight, 3=Mild to Moderate, 4=Severe to Extreme.

Validity of the K-SADS

The K-SADS has been validated against several established diagnostic instruments. For example, one study compared it to the Beck Depression Inventory (BDI) for adolescents, the Children's Depression Inventory (CDI) for pre-adolescents and the clinician-rated Hamilton Depression Rating Scale (HDRS) in 356 adolescents and 116 children attending psychiatric out-patient clinics. Patients with major depressive, minor depressive and dysthymic disorder were compared with non-depressed psychiatric controls. The findings supported satisfactory validity (McConville, Ambrosini, Somoza, Bianchi, & Minnery, 1995; McLaughlin, Ambrosini, Fallon, Bianchi, & Metz, 1997). Table 3.5 summarizes some of these findings.

Similar results were established by Kaufman, Birmaher, Brent, Ryan, and Rao (2000), who compared the K-SADS to the internalizing and externalizing subscales of the Child Behavior Checklist, the Conners Parent Rating Scale for ADHD and the Screen for Child Anxiety Related Emotional Disorders.

Table 3.5: Validity, sensitivity and specificity of the K-SADS compared to the BDI, HDRS and CDI

Measure	N	Cronbach's α	Sensitivity	Specificity
BDI	356	0.90	92	71
HDRS	144	0.82	93	95
CDI	116	0.89	41*	87

BDI: Beck Depression Inventory; HDRS: Hamilton Depression Rating Scale; CDI: Children's Depression Inventory.

*The low established sensitivity was not related to the K-SADS but to the CDI. In the prepubertal sample, the CDI was not very sensitive in identifying affective disorders, nor did it differentiate between major depressive and dysthymic disorders. Authors in this field have argued that the CDI measures a broader depressive construct than other instruments (Jensen et al., 1993).

Reliability of the K-SADS

The test-retest reliability of the K-SADS was investigated by W. J. Chambers et al. (1985) in 52 children aged 6-17 years; they found that the majority of the symptoms were reliably assessed in test-retest format for depressive, conduct, oppositional defiant and attention deficit-hyperactivity disorders. Similar results of inter-rater reliability using videotaped interviews were established by Ambrosini, Metz, Prabucki, and Lee (1989). Reliability scores have consistently improved in recent editions of the K-SADS. Inter-rater reliability has been higher in major depressive, minor depressive/dysthymic, generalized anxiety, separation anxiety and oppositional defiant disorders (Ambrosini, 2000). The inter-rater kappa coefficients for six diagnoses using the IV version are presented in Table 3.6.

Table 3.6: K-SADS inter-rater reliability data scores (kappa)

Diagnosis	K-SADS (n=20)
Major depression	0.90
Minor depression	0.88
Generalized anxiety disorder	0.78
Separation anxiety disorder	0.85
Oppositional defiant disorder	0.80
ADHD	0.80

Training for the use and scoring of the K-SADS

Although there used to be some formal training available in the UK, this is no longer the case. Professor Ambrosini, the author and developer of the K-SADS in the USA, confirmed that no training courses were available in the USA or the UK, in spite of recommendations that training should be undertaken before using this tool. Professor Ambrosini sent the latest version of the K-SADS and its scoring forms. The researcher was in regular communication with Professor Ambrosini, who kindly provided support and offered guidance and advice on how to use the K-SADS. Any doubts in relation to the K-SADS were discussed with and supervised by Professor Ambrosini through e-mail (Appendix 3.2).

Before the research took place, in order to become familiar with the K-SADS, the researcher also received informal training from a clinician (Professor Jon Arcelus) who had used the K-SADS in a previous PhD study in primary care (Arcelus, Gale, & Vostanis, 2001; Arcelus & Vostanis, 2003). The researcher also remained in regular contact with Dr. Sajida Hassan, who had used the instrument in her own PhD study with schoolchildren in Karachi, Pakistan (Hassan, 2010; Hussein, Hussein, & Vostanis, 2008).

3.8.3 Measures of emotional problems

The measures of emotional problems listed in Appendix 3.3 were selected predominantly to measure the severity of the emotional symptoms of three disorders: anxiety, PTSD and social phobia. Because of co-morbidity in children, they were also used to measure other mental health problems such as behavioural disorders, hyperactivity and depression.

3.8.3.1 Impact of Event Scale

The IES was originally developed by M. Horowitz, Wilner, and Alvarez (1979) to measure the main PTSD phenomena of re-experiencing or avoiding the traumatic event and the feelings to which it gave rise. Hence, its 13 items, each rated on a four-point scale, are grouped into the subscales of Intrusion and Avoidance. The IES was not initially designed for children, but it has since been successfully used in a number of studies with children aged eight years and older. Two studies with adolescent survivors of a shipping disaster (Yule, Bruggencate, & Joseph, 1994) and children exposed to war trauma in Croatia (Dyregrov, Kuterovac, & Barath, 1996) found that a number of items were being misinterpreted by children. These separate studies identified identical factor structures of the IES, which resulted in the selection of eight items that best reflected the underlying factor structure, thus producing a shortened version: the IES-8 for children.

With the establishment of DSM-IV, Zatzick et al. (1997) added items to reflect adult symptoms of increased physiological arousal, although Horowitz had found that these did not form a separate factor. Therefore, Yule et al. (1994)

developed five items to reflect the five DSM-IV Cluster D symptoms of arousal. The present version is designed for use with children aged eight years and above, who are able to read independently. It consists of four items measuring intrusion (e.g. Do you think about it even when you do not mean to?), four items measuring avoidance (e.g. Do you try not to talk about it?) and five items measuring arousal (e.g. Do you have sleep problems?). This is called the CRIES-13. Each item is scored on a four-point scale: Not at all = 0, Rarely = 1, Sometimes = 3, Often = 5. The maximum total IES score is 65. A cut-off score of 30 and above has been found to indicate the likely presence of post-traumatic stress disorders (Appendix 3.3.1).

Validity

Joseph, Williams, and Yule (1997) used the 13-item version of the IES to explore its validity and reported that the total score of the eight-item version correlated highly with the total score on the 13-item version of which it was part ($r = +0.95$, $p < 0.001$). The two versions correlated with a symptom count based on the number of DSM symptoms reported by adolescents following an acute trauma, as follows: 13-IES: $r = 0.76$; 8-IES: $r = 0.70$.

Reliability

P. Smith, Perrin, Yule, Hacam, and Stuvland (2002) used the 13-item version in a survey of 2,976 children aged 9-14 years who had experienced war trauma in Mostar, Bosnia. The scale was translated into Bosnian and back-translated by a separate Bosnian speaker to establish the cultural accuracy of the questions. No major differences were found between boys and girls in respect of the factors

identified, so only the overall results are presented here. The scales had satisfactory internal consistency. Cronbach's alpha values were as follows: intrusion = 0.70; avoidance = 0.73; arousal = 0.60; total = 0.80. The analysis revealed a three-factor solution corresponding to the three hypothesised subscales and accounting for 49.3% of the total variance.

The IES has been widely used internationally (Elhai, Gray, Kashdan, & Franklin, 2005; Paton, 1990); it has been translated into Arabic for previous studies and applied to Arab child populations such as in the Gaza Strip, Lebanon and Iraq (Aroian, Norris, González de Chávez Fernández, & García Averasturi, 2008; Dyregrov & Raundalen, 1992; Saigh, 1991; Thabet, Abed, & Vostanis, 2001; Thabet et al., 2008)

3.8.3.2 Revised Children's Manifest Anxiety Scale

The RCMAS is a self-report instrument designed to measure anxiety in children and adolescents. It was developed by Reynolds and Richmond (1978) to assess "the degree and quality of anxiety experienced by children and adolescents" (Gerard & Reynolds, 1999, p. 323). It is based on the Children's Manifest Anxiety Scale (CMAS), which was devised by Castaneda, McCandless, and Palermo (1956). The revised version of the CMAS omitted, added, and amended items to meet psychometric standards. Reynolds and Richmond (1978) renamed the instrument "What I Think and Feel", although subsequent papers primarily refer to it as the Revised Children's Manifest Anxiety Scale. There are five subscales: The Physiological, Worry/Oversensitivity, Concentration, Anxiety and Lie Scales (Lie 1, Lie 2). The RCMAS is suitable for

individual or group administration, by clinicians, researchers or teachers, with 6 to 19 year-old children. Each item is given a score of one for a 'Yes' response, yielding a total anxiety score. An overall cut-off point of 19 out of 28 has been found to identify children who are like to be experiencing clinically significant levels of anxiety (Gerard & Reynolds, 1999) (Appendix 3.3.2).

Validity

Reynolds and Richmond (1979) conducted a factor analysis with the Anxiety Scale items, in a test development sample. Three anxiety factors were identified and were named according to their item content: physiological, worry /oversensitivity and concentration. However, there were a number of anomalies with the results, attributed to the small sample size of 329 subjects, compared with the 28 variables.

Reliability

Wisniewski, James, Genshaft, and Daniel (1987) examined the test-retest reliability of the RCMAS in 161 children. Analyses of re-testing after one and five weeks indicated satisfactory reliability (Pearson correlations from 0.60 to 0.88, significant at $p \leq 0.01$) and a non-significant difference between test and re-test mean raw scores. These results would support the stability of the scale over brief periods. The RCMAS has been widely used internationally (Chorpita, Moffitt, & Gray, 2005; Muris, Merckelbach, Ollendick, King, & Bogie, 2002; Turgeon & Chartrand, 2003; Williams et al., 2003). It has been translated into Arabic and has been applied in Arab child populations such as in the Gaza Strip (Thabet et al., 2001; Thabet, Abed, & Vostanis, 2002; Thabet et al., 2008).

3.8.3.3 Children's Depression Inventory

The CDI is used to measure depressive symptoms in young life. It is a self-report inventory designed for the assessment of children and adolescents aged 7 to 17 (Kovacs, 1985, 1992), initially developed because of concerns regarding the use of the Beck Depression Inventory with young people. The CDI has 27 sets of items. Respondents are asked to choose which of three sentences in each set best describes his or her thoughts and feelings over the last two weeks. It yields a total score (ranging from 0-54) as well as five sub-scores: Mood, Interpersonal Problems, Ineffectiveness, Anhedonia and Negative Self-Esteem. Scores of 19 and above are thought to be clinically significant and to indicate a likely depressive episode (Saylor, Finch, Spirito, & Bennett, 1984). The administration of the CDI takes approximately 10-15 minutes (Appendix 3.3.3).

Validity

In a normative sample of youths, the CDI suicidal ideation item was correlated with the total scores from the remaining CDI items $r=0.45$ (Kovacs, 1992). In an out-patient psychiatric sample, a sample of youths newly diagnosed with diabetes and a sample of school children, the CDI suicidal ideation item was correlated with CDI total scores ($r=0.52$, $r=0.22$ and $r=0.49$ respectively) (Kovacs, 1992). In a study with sexually abused youths, the CDI item regarding suicidal ideation was correlated with the rest of the CDI score ($r=0.27$) (Wozencraft, Wagner, & Pellegrin, 1991). In a different sample of schoolchildren, endorsement of the CDI ideation item was significantly related to

scoring above the cut-off for clinically significant depression scores (Larsson & Melin, 1992).

Reliability

In the same sample of schoolchildren, it was found that 50% of those who rated the CDI suicidal ideation item at initial screening continued to endorse the suicidal ideation item at a second testing 6 to 9 weeks later (Larsson & Melin, 1992). The CDI has been widely used internationally (Cole & Martin, 2005; Honjo et al., 2001; Ivarsson, Svalander, & Litle, 2006). It has been translated into Arabic for previous studies and used in Arab countries such as Egypt, Kuwait and the Gaza Strip (Abou et al., 1991; Ghareeb & Beshai, 1989; Hadi, Llabre, & Spitzer, 2006; Llabre & Hadi, 1997; Thabet, Vostanis, & Karim, 2005).

3.8.3.4 Measures of social phobia symptoms

Western and Arab studies were searched for tools designed to measure social phobic disorders in children. Unlike all other instruments measuring emotional disorders, where up to two or three in each category have dominated the literature, this was not found to apply to the measurement of social phobia in children. A number of measures were considered but were not found to be appropriate for the current study because of either cultural or psychometric constraints (Beidel, Turner, & Morris, 1995; Gauer, Picon, Vasconcellos, Turner, & Beidel, 2005; Levin, Hermesh, & Marom, 2001; Neal & Edelman, 2003; Osman, Gutierrez, Barrios, Kopper, & Chiros, 1998; Ranta, Kaltiala-Heino, Koivisto, et al., 2007; Ranta, Kaltiala-Heino, Rantanen, Tuomisto, & Marttunen,

2007; Rheingold, Herbert, & Franklin, 2003; M. B. Stein, Torgrud, & Walker, 2000; Stemberger et al., 1995; L. Stopa & Clark, 2001).

The cultural factors that prevented the researcher from using these measures were that they were designed for different cultures and /or conflicted with the religion of the chosen population. Unlike other internalizing disorders such as PTSD or depression, which are largely based on reporting emotions and cognitions, social phobias always manifest in a social context and are consequently more strongly influenced by cultural factors. Existing measures contained several items that described mixed gender situations, activities like dancing, and/or religious activities like singing in a place of worship, which would have been inappropriate for the Saudi culture and religion. Any attempt to resolve these issues by omitting items from the tools or adding new ones might well have altered their psychometric properties, i.e. their reliability, validity, age and administrative procedures.

Therefore, it was decided that it was necessary to develop a new questionnaire to measure social phobia in Saudi children, with reference to a checklist based on earlier measures and DSM-IV-TR criteria (Table 3.7) (APA, 2000). These criteria differentiate between adults and children. By covering the main factors in earlier studies and measures such as assertiveness, general conversation, traditional social encounters, public performance, physical and cognitive symptoms and avoidance, the researcher used the most suitable items for the Saudi culture, such as the statement describing assertiveness (afraid when becoming the centre of attention), general conversation (afraid when I start to

talk to someone), or physical symptoms (when I am in social situation, I feel somatic symptoms).

Table 3.7: DSM-IV-TR criteria of social phobic disorders

Criteria	
1	A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or possible scrutiny by others.
2	Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situational bound or situational predisposed panic attack. In children, this may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.
3	The person recognizes that the fear is excessive or unreasonable. In children this feature may be absent.
4	The feared social or performance situations are avoided, or else are endured with intense anxiety or distress
5	The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships; or there is marked distress about having the phobia.
6	In individuals under the age 18 years, the duration is at least six months.
7	The fear or avoidance is not due to the direct physiological effects of a substance (e.g. drug abuse) or a general medical condition, and is not better accounted for by another mental disorder (e.g. panic disorder with or without agoraphobia, separation anxiety disorder, body dysmorphic disorder, pervasive developmental disorder or schizoid personality disorder).
8	If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g. the fear is not of stuttering, trembling in Parkinson's disease; or exhibiting abnormal eating behaviour in anorexia or bulimia nervosa.

The resulting Social Phobia measure (SP) covered most social situations, such as in schools and parties or public places like restaurants, parks and clubs. It comprised 25 items and used clear language designed for the age group of 9-16 years. Following the format of measures described in the literature, each item was scored on a three-point scale: Not at all = 0, Sometimes = 1, Often = 2. The maximum total score on the SP was 50. As this measure was developed by the researcher, it required further psychometric evaluations. Some of these are presented below, predominantly factor analysis and the correlation of the items

with the total score, so that the reader can understand how to interpret the instrument in the later statistical analysis. As factor analysis requires a large sample size, the correlation between items and total score provides only a general indication of its psychometric properties, which was nonetheless considered sufficient for the objectives of this research. Future studies could focus on the further development and standardization of this instrument (Appendix 3.3.4).

At the beginning, SP parent and child items were found to be correlated with the total score, with values ranging from 0.40 to 0.90. The alpha value for social phobia symptoms (parent and child) was $\alpha = 0.96$. Children's and parents' responses were also analyzed by means of factor analysis, despite the constraints of the sample size. Bartlett's test of sphericity was significant for both children ($\chi^2 = 187.7 (300), p < 0.000$) and parents ($\chi^2 = 165.4 (300), p < 0.000$).

In terms of the factorial structure obtained, five factors with eigenvalues greater than one were extracted in the parents' sample, explaining a total of 69.45% of the variance. However, the scree plot shown in Figure 3.4 clearly indicated a one-factor solution; therefore, the analysis was re-run, restricting the number of factors to one. The resultant factor had an eigenvalue of 12.17 and explained around 48.68% of the variance. As displayed in Table 3.8, all items loaded significantly (i.e. greater than 0.30) on this factor.

Regarding the children's sample, the same procedure resulted in five initial factors with eigenvalues above one and explaining an overall of 71.77% of the

variance. As in the parents' group, the scree plot shown in Figure 3.5 suggested a one-factor model and the analysis was re-run, again limiting the number of factors to be extracted to one. This factor had an eigenvalue of 13 and explained 52.01% of the variance. High and significant items loadings were obtained on this factor, as shown in Table 3.8.

Table 3.8: Item loadings for Social Phobia measure (children and parents)

No	Items	Factor Extracted	
		Children	Parents
1	Afraid when joining a large group such as at a party	.81	.76
2	Afraid when becoming the centre of attention	.62	.49
3	Afraid when I have to do something such as writing while others watch me	.59	.69
4	Afraid when speaking or reading out loud in front of a group	.85	.76
5	Afraid when answering questions in class or at group meetings	.80	.76
6	Afraid at parties, dances, school... And go home early	.81	.72
7	Afraid to meet new kids	.88	.79
8	Too afraid to ask questions in class	.60	.52
9	Afraid of eating in front of others	.73	.73
10	Afraid if someone starts arguing	.40	.54
11	Afraid if someone asks me to do something that I don't want to do	.40	.41
12	Afraid in an embarrassing situation	.47	.45
13	Afraid if someone says something that is wrong or bad	.45	.48
14	Afraid when I start to talk to someone	.88	.83
15	Afraid if I have to talk for longer than a few minutes	.85	.84
16	Afraid when speaking with other young people around, or in class	.85	.85
17	Afraid when in a school play, choir, music, or dance recital	.87	.82
18	Afraid when ignored or made fun of by others	.75	.56
19	I avoid social situations (parties, school, playing with others)	.84	.81
20	I leave social situations	.82	.74
21	Before going to a party, I think about what might go wrong	.58	.63
22	My voice leaves me or sounds funny when I am talking to others	.80	.80
23	When I am with other people, I think of 'scary' thoughts	.74	.70
24	Before going someplace, I feel (somatic symptoms)	.53	.73
25	When I am in a social situation, I feel (somatic symptoms)	.69	.73
Eigenvalue		13.00	12.17
Variance explained (%)		52.01	48.68

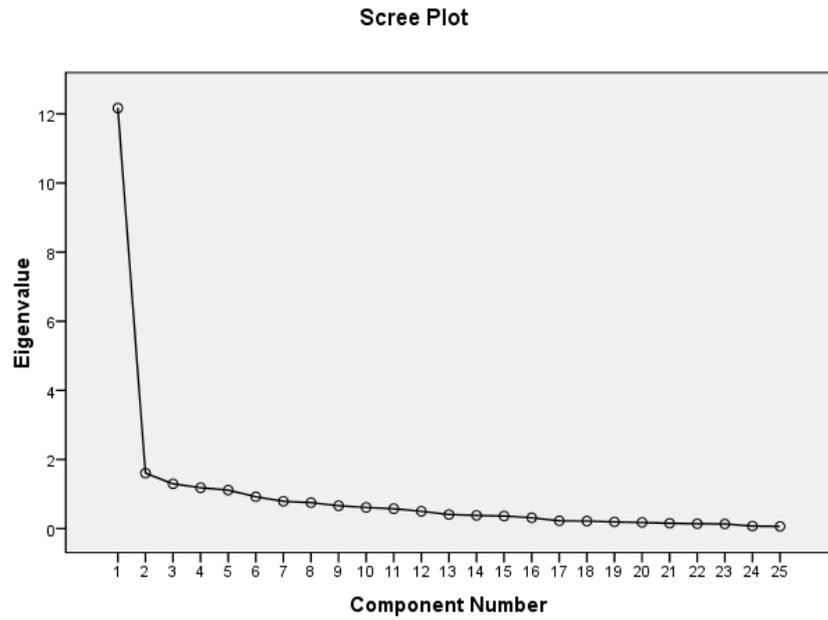


Figure 3.4: Scree plot of the SPQ for the parents' sample

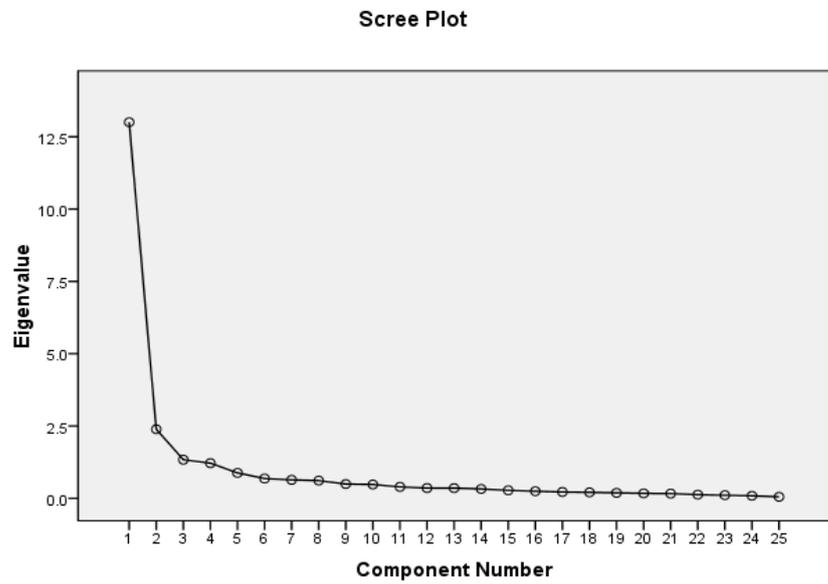


Figure 3.5: Scree plot of the SPQ for the children's sample

3.8.3.5 Strengths and Difficulties Questionnaire

The SDQ is a questionnaire for 3-16 year-olds which measures general emotional and behavioural problems. It exists in several versions to meet the needs of researchers, clinicians and educationalists. All versions of the SDQ ask about 25 attributes, five positive and 20 negative. The 25 items are grouped in five subscales of five items each, generating scores for conduct, hyperactivity/inattention, emotional and peer problems and prosocial behaviour (Goodman, 1997, 2001) (Appendix 3.3.5).

The answer for each item is scored as 0 = Not true, 1 = Somewhat true, 2 = Certainly true. If the item is phrased positively, these scores are reversed. Item scores are summed to provide a score for each problem category. The score for each category ranges from 0 to 10. To generate a total mental health difficulties score, the scores of the four problem categories (conduct, emotional, hyperactivity and peer problems) are summed without including the prosocial score. The total difficulties score can therefore range from 0 to 40.

Category bands and total difficulties scores can be classified as normal, borderline or abnormal. These bands, which are not adjusted for age or gender, have been chosen so that approximately 80% of children in the community are considered to be in the normal category and 10% in each of the borderline and abnormal bands (Goodman, 1997). The total difficulties score can also be classified into normal, borderline and abnormal bands. Scores ranging from 0 to 13 are considered to be normal, between 14 and 16 borderline and between 17

and 40 abnormal, i.e. indicating that a clinical assessment would be beneficial for likely mental health problems.

Validity and reliability

Goodman (1997) initially validated this screening questionnaire in 5-15 year-old children living in the community (N=467) and children attending a psychiatric clinic (N=232). The SDQ scores were highly correlated ($r=0.74$) with the ratings of a standardized interview (Goodman, 1999). Goodman and Scott (1999) subsequently compared the properties of the SDQ with the established but lengthier Child Behaviour Checklist (CBCL) (Achenbach, 1991), by asking mothers of 132 children aged 4-7 years to complete both. SDQ and CBCL scores were highly correlated and were equally able to discriminate psychiatric from non-psychiatric cases. The SDQ was more sensitive than the CBCL in detecting inattention and hyperactivity problems.

The SDQ has been widely used internationally (Goodman & Goodman, 2009; Matsushita et al., 2008; Samad, Hollis, Prince, & Goodman, 2005; Woerner et al., 2004). It has been translated into Arabic for earlier studies and has been applied in Arab countries such as Yemen and the Gaza Strip (Almaqrabi & Shuwail, 2004; Alyahri & Goodman, 2006; Thabet et al., 2008; Thabet & Vostanis, 2000).

3.8.4 Exposure to Trauma

Several previous studies have examined children's experience of traumatic events, especially in natural disasters such as floods, earthquakes or volcanic eruptions, as well as in situations of community violence and war (Breslau,

Peterson, Kessler, & Schultz, 1999; Demir et al., 2010; Forsberg & Saveman, 2011; Gold et al., 2000; Johnson & Thompson, 2008; Liu et al., 2011; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997). These studies concentrated on measuring psychological disorders post trauma, for a certain population exposed to one or more disasters or events. They were not designed to measure the event itself and/or did not include any measurement of the daily life events that may have affected the individuals. For this reason, a wide variation of instruments is reported in the literature.

As was the case for social phobia, measures used in previous studies were not compatible with Saudi culture; for example, strikes and demonstrations are illegal in Saudi Arabia and racial discrimination is prohibited by Islam. The same applies to questions on war and natural disasters, as some are not compatible with the geography of Riyadh, where there are no volcanoes and where no earthquake has been experienced for many years. Consequently, the measures used in these studies were not considered appropriate for the current study.

In this study, it was important to measure the adverse life events and trauma experienced by children at different stages of their lives such as illness, accidents, thefts and rape. For this reason, the researcher developed a measure of Exposure to Trauma (ET), based on the literature, the UK National Survey checklist (DOH, 2005) and previous studies (Briere, 2005, 2010; Briere et al., 2001; Briere & Runtz, 1989; Evans, Briere, Boggiano, & Barrett, 1994). The ET was designed to measure the trauma associated with life events such as family problems, including domestic violence and divorce; neglect; economic hardship;

clashes with authority (police, courts); criminal attacks; exposure to parental mental illness; chronic disease; disability and accidents on public or private transport. It also covered events like armed violence and floods.

The ET consisted of 19 items (Appendix 3.4) and its purpose was to assess the effects of trauma through the child's self-report. The measure was simplified to suit the children's understanding. Each child was asked about life events or problems that s/he may have faced directly, those involving another family member and being affected by others' experiences. Responses to each item were on a two-point scale (Yes or No). Since this was a purposefully designed measure, three methods of scoring and analysis were used, based on individual item scores, factor scores (groups of items) and total scores. All children and their parents completed this scale individually. Their responses were found to be identical across the entire sample, as the correlation between the child's and parent's response was $r = 1$. For this reason, the final measure represented both. As this measure was developed by the researcher, it required further psychometric investigation and factor analysis, as with the Social Phobia questionnaire.

The ET items were associated with total scores, with correlation values ranging from 0.20 to 0.70. Items of the newly developed ET measure were entered into a principal components analysis (PCA) with varimax rotation. A criterion of 0.30 was used to determine item loadings and an eigenvalue equal to or greater than 0.1 was used to decide the number of factors to be retained. A scree test was also used. The sample size was found to be adequate, as indicated by Bartlett's

test of sphericity ($\chi^2 = 507.30$ (171), $p < 0.000$). A seven-factor solution was extracted. Eigenvalues of the seven factors were 2.80, 2.07, 1.86, 1.82, 1.69, 1.54 and 1.22. The overall solution explained 68.47% of the total variance. The scree plot was not interpretable, so it was decided to retain and rotate the seven factors. Item loadings on the extracted factors are shown in Table 3.9.

Although factor analysis was the preferred method, this was constrained by the sample size. For this reason, an alternative method of scoring was used whereby the researcher classified the items into six trauma categories according to the literature, then dichotomized the scoring according to whether respondents had experienced trauma in any of the items within each category. These categories and their constituent items are presented in Table 3.10.

Table 3.9: Item loadings of the Exposure to Trauma measure

No	Items	Factors						
		1	2	3	4	5	6	7
1	Have had a separation due to marital difficulties or broken off a steady relationship?	.85						
2	Have you witnessed severe domestic violence, e.g. seen your mother badly beaten up at home?	.87						
3	Have you (or someone close to you) had a major financial crisis, such as losing the equivalent of three months income?				.93			
4	Have you (or someone close to you) had a problem with the police involving a court appearance?	.62						
5	Have you experienced a severe attack or threat, e.g. by a mugger or gang?						.84	
6	Have you (or someone close to you) had a serious physical illness such as cancer or heart attack?					.77		
7	Have you (or someone close to you) had a serious mental illness such as schizophrenia or major depression?					.76		
8	Now turning to things that have happened to her/him. At any stage in his/her life, has a parent, brother or sister of his/hers died?		.52			.47		
9	Has s/he ever had a serious injury which required a stay in hospital?	.42						
10	Has s/he ever been in a serious accident or badly hurt in an accident?		.82					
11	Have you been exposed to something frightening or dangerous, e.g. an accident on a ferry or a train crash?		.83					
12	Have you (or someone close to you) experienced a serious fire, e.g. trapped in a burning house or car?				.91			
13	Have you (or someone close to you) experienced other disasters, e.g. kidnapping, earthquake, explosions, or war?						.85	
14	In the past year, has s/he ended a close friendship, for example, permanently falling out with a best friend?							.66
15	Has s/he (or someone close to her/him) experienced severe physical abuse?			.55		.46		
16	Have you (or someone close to you) experienced sexual abuse?			.83				.38
17	Have you (or someone close to you) experienced rape?							.69
18	Have you ever lost something that was dear to you, like a doll or a toy?			.91				
19	Has s/he experienced an embarrassing situation (for example, insults and humiliation) by his/her family or colleagues that s/he still remembers?		-.35					-.31
Eigenvalue		2.80	2.07	1.86	1.82	1.69	1.55	1.2
Variance explained		14.72	10.91	9.79	9.59	8.91	8.13	6.43

Table 3.10: Exposure to trauma – Categories and items

Family problems (ETS1)	
ET1	Have had a separation due to marital difficulties or broken off a steady relationship?
ET2	Have you witnessed severe domestic violence, e.g. saw mother badly beaten up at home?
ET3	Have you (or someone close to you) had a major financial crisis, such as losing the equivalent of 3 months income?
ET4	Have you (or someone close to you) had a problem with the police involving a court appearance?
Violence/Abuse (ETS2)	
ET5	Have you experienced a severe attack or threat, e.g. by a mugger or gang?
ET15	Has s/he experienced (or someone close to here/him) severe physical abuse?
ET16	Have you (or someone close to you) experienced sexual abuse?
ET17	Have you (or someone close to you) experienced rape?
Illness/Death (ETS3)	
ET6	Have you (or someone close to you) had a serious physical illness such as cancer or heart attack?
ET7	Have you (or someone close to you) had a serious mental illness such as schizophrenia or major depression?
ET8	Now turning to things that have happened to her/him. At any stage in his/her life, has a parent, brother or sister of his/hers died?
ET9	Has s/he ever had a serious illness which required a stay in hospital?
Accident/Disaster (ETS4)	
ET10	Has s/he ever been in a serious accident or badly hurt in an accident?
ET11	Have you been exposed to something frightening or dangerous, e.g. being in an accident on a ferry or a train crash?
ET12	Have you (or someone close to you) experienced a bad fire, e.g. trapped in a burning house or car?
ET13	Have you (or someone close to you) experienced other disasters, e.g. kidnapping, earthquake, explosions, war?
Peer relationships (ETS5)	
ET14	In the past year, has s/he ended a close friendship, for example, permanently falling out with a best friend?
ET19	Has s/he experienced an embarrassing situation (for example, insults and humiliation) by his/her family or colleagues that s/he still remembers?
Loss (ETS6)	
ET18	Have you ever lost something that was dear to you, like a doll or a toy?

3.8.5 Parental factors

3.8.5.1 Parental Rearing Style

Parental responses (Appendix 3.5) were measured by the Parental Rearing Style (EMBU-C) tool. The modified version included 52 items of the pool of 81 items of the original Dutch Egena Minnen Beträffande Uppfostran (Markus, Lindhout, Boer, Hoogendijk, & Arrindell, 2003), which was developed to assess perceptions of parents' rearing practices by children and young adolescents. Each item was presented to both the father and the mother and was scored on a four-point Likert-scale (1 = No, never; 2 = Yes, but seldom; 3 = Yes, often; 4 = Yes, most of the time). The EMBU-C assesses four factors: Emotional Warmth (19 items), Rejection (17 items), Overprotection (12 items) and Favouring Subject (4 items) (Appendix 3.5.1).

Validity

The EMBU-C scales have been found to be little to moderately inter-correlated. A joint higher order analysis (PCA with varimax rotation) of the mothers' and fathers' scales yielded three factors with eigenvalues greater than 1. Cumulatively, these explained 80.8% of the total variance (Markus et al., 2003).

Reliability

Reliability analysis revealed that the alpha coefficients for the Emotional Warmth and Rejection scales were high. In accordance with previous research with the EMBU, the alpha coefficients for Overprotection and Favouring Subject were smaller in magnitude. The mean inter-item *rs* for the four item-sets, for both the fathers' and mothers' ratings, were acceptable according to the criteria of Briggs

and Cheek (1986). In view of the magnitudes of the homogeneity figures, the alpha coefficients may be considered to have attained acceptable values. In that same study, Pearson correlations were determined between each EMBU-C scale and the trait anxiety scale of the State-Trait Anxiety Inventory for Children (STAIC) for 37 children. The correlations of trait anxiety with Rejection (F: 0.41, $P=0.006$; M: 0.27; $P<0.05$, one-tailed, $n= 37$) and with Overprotection (F: 0.29, $P=0.04$; M: 0.38; $P<0.01$, one-tailed, $n= 37$) indicated that anxious children had higher scores. The correlations between trait anxiety and Emotional Warmth were not significant.

Despite the wide use of the EMBU-C in different countries such as Spain, South Africa and Japan (Castro, Toro, Van der Ende, & Arrindell, 1993; Mofrad, Abdollah, & Samah, 2009; Niditch & Varela, 2011; Van Gastel, Legerstee, & Ferdinand, 2009), the researcher could find no study of Arabic speakers that had used it. However, the positive evidence on its psychometric properties justified using it in the current study. The instrument investigates parenting styles and parent-child relations, which in general have similarities across cultures. Besides, the instrument had been used in several cultures and languages, making it flexible for further use.

3.8.5.2 Parenting Stress Index / Short Form

The PSI/SF is a direct derivative of the full-length Parenting Stress Index test. All items of the short form are included in the long form, with identical wording (Abidin, 1995). The PSI is a measure of relative magnitude of stress in parent and child interactions (Loyd & Abidin, 1985). The PSI/SF was based on the

theory that the total stress which a parent experiences is a function of certain salient child characteristics, parent characteristics and situations that are directly related to the role of being a parent. The PSI identifies dysfunctional parenting and predicts the potential for parental and child adjustment difficulties within the family system (Abidin, 1995).

The PSI/SF assesses three factors: Parental Distress (PD), Parent-Child Dysfunctional Interaction (P-CDI) and Difficult Child (DC). Each is measured by 12 items, making a total of 36 items, which together take ten minutes for the parent to complete. Each item is scored by circling SA (strongly agree), A (agree), NS (not sure), D (disagree) or SD (strongly disagree). It yields a Total Stress Score, plus scale scores for both child and parent characteristics, which pinpoint sources of stress within the family (Appendix 3.5.2).

Validity

The correlations between the PSI/SF and the full-length PSI were estimated in a sample of 530 mothers and their children who attended a paediatric clinic in Virginia City, USA. Total Stress on the full-length PSI correlated at 0.94 with the PSI/SF Total Stress, which is exceptionally high and comparable to the two-week test-retest reliability of the full-length PSI, which is 0.95. Examination of the pattern of correlations suggests that the PD subscale score was highly correlated with the Parent Domain score of the full-length PSI ($r=0.92$), which was expected, as the PD Subscale consists of items derived from the Parent Domain subscale. Similarly, the score on the DC subscale, derived from the Child Domain subscale of the full-length PSI, was strongly correlated with it

($r=0.87$), as was expected. The correlation of the P-CDI score with the Child Domain and Parent Domain scores of the full-length PSI were lower, at 0.73 and 0.50 respectively. These lower correlations were also expected, because the P-CDI subscale contains items from both the Child and Parent Domains of the full-length tool (Abidin, 1995).

Reliability

Test-retest reliability was established at 0.84 for PD, 0.68 for P-CDI, 0.78 for DC and 0.84 for Total Stress. Reliability was assessed by a re-test at an interval of six months. Coefficient alpha was calculated as 0.87 for the PD, 0.80 for the P-CDI, 0.85 for the DC and 0.91 for Total Stress, based on a normative sample of 800 subjects. In addition, Roggman, Moe, Hart, and Forthun (1994) studied 103 parents attending the Head Start parenting programme in the USA and reported PSI/SF alpha reliabilities of 0.79 for the PD, 0.80 for the P-CDI, 0.78 for the DC and 0.90 for Total Stress.

The PSI has been widely used internationally, including with Chinese, Italian, Portuguese, Latin American and French Canadian families (Abidin, 1995; Davis & Carter, 2008; Hassall, Rose, & McDonald, 2005; Lecavalier, Leone, & Wiltz, 2006). These studies demonstrate that the PSI maintains its validity in diverse non-English speaking cultures. The measure has been translated into Arabic, and studies have been carried out in Arab countries such as Lebanon, Jordan and the United Arab Emirates (Azar & Badr, 2006, 2010; Khamis, 2000, 2007; Krulik, Turner-Henson, Kanematsu, & Al-Ma'aitah, 1999).

3.8.5.3 General Health Questionnaire

The GHQ is a measure of generic adult mental health problems, which since its development by Goldberg in the 1970s has been widely used by researchers in various fields (occupational health, medicine, and psychology) and clinicians who wish to screen individuals for psychiatric disorders. The questionnaire was originally developed as a 60-item instrument, but at present a range of shortened versions are available, including the GHQ-12, the GHQ-20, the GHQ-28 and the GHQ-30. One advantage of using the GHQ-12 over the GHQ-30 is that it can be completed more quickly (2-3 minutes). The scale asks whether the respondent has recently experienced a particular symptom or behaviour. Each item is rated on a four-point scale (0 = Less than usual, 1 = No more than usual, 2 = Rather more than usual, or 3 = Much more than usual). The GHQ-12 gives a maximum total score of 36 based on Likert scoring styles (0-1-2-3) (Gao et al., 2004; Hu, Stewart-Brown, Twigg, & Weich, 2007; Montazeri, Harirchi, et al., 2003; Montazeri, Vahdaninia, Ebrahimi, & Jarvandi, 2003; Sanchez-Lopez & Dresch; Toyabe et al., 2007; Ye, 2009) (Appendix 3.5.3).

Validity

A study of 748 young people aged 18-25 years investigated the correlation between the GHQ-12 and Global Quality of Life Questionnaire scores; a significant negative correlation emerged ($r = -0.56$, $p < 0.0001$), indicating that those who were more distressed showed lower levels of quality of life (Montazeri, Harirchi, et al., 2003). An earlier study in Germany investigated the screening properties of the GHQ-12 in primary care patients compared with the Symptom CheckList (SCL-90-R), finding a correlation between the instruments

of 0.64 and no difference in the performance of the general scores; both questionnaires were able to identify symptoms (Schmitz, Kruse, Heckrath, Alberti, & Tress, 1999).

Reliability

The internal consistency of the questionnaire was measured using Cronbach's alpha. The coefficient for the whole sample was found to be 0.87 for both males and females (Montazeri, Harirchi, et al., 2003). The measure has been translated into Arabic, and used in studies carried out in Arab countries such as the Gaza Strip and the United Arab Emirates (El-Rufaie & Daradkeh, 1996; Thabet et al., 2001; WHO, 2002).

3.9 Translating the measures into Arabic

Psychological tests can be affected by cultural contexts, to an extent which varies from measure to measure, depending in part on the targeted construct (Anastasi & Urbina, 1997). Tests of affective and emotional aspects, personality traits and self-related variables have been found to be highly influenced by culture, compared to these of cognitive performance. Therefore, it is vital to ensure that these measures are characterized by sufficient psychometric properties before using them with samples derived from different cultures; otherwise, the interpretation of data will be difficult, as it will not be clear whether the scores can be attributed to the targeted phenomena or whether they are just measurement errors. All tools in this study were translated into Arabic, using the back-translation process (Anastasi & Urbina, 1997; Gregory, 2004; Kaplan & Saccuzzo, 1993, 2008) as follows:

1. Each tool was translated into Arabic by the author and three bilingual Arabic-speaking clinical psychologists. Every care was taken to ensure that the Arabic items reflected the meaning conveyed by the original English items, taking into account their linguistic contexts.

2. The different versions produced at the previous stage were compared against each other to ensure that the meaning of each item did not differ significantly between the English and Arabic versions, taking into account their linguistic and psychological context. This step produced the first draft of the Arabic version of each tool.

3. The second version was given to bilingual Clinical Psychologists, who were asked to translate the questionnaires back into English. A final decision regarding the similarities between the English and Arabic versions was reached during this stage and the final Arabic versions were produced.

Although some of the tools listed above had already been translated into Arabic by other researchers, they were included in this process, because they required further psychometric investigation. In addition, children's developmental ability to understand the terms used was taken into account in the previous procedures.

3.10 Research procedure

The researcher contacted the three main hospitals in Riyadh to enquire about their ethical approval procedures; and to obtain initial information on the number of patients attending out-patient clinics and the approximate nature of their cases, in particular emotional disorders, including social phobia. On average,

about 30 children with emotional disorders as well as social phobia were found to attend the three hospitals daily. However, no exact figures or statistics were available, due to the lack of systematic recording. The researcher applied for official approval from the Ministry of Health and presented the project to its Ethics Committee, which gave approval for the ACFMH. The KFNGH and the RMH then gave their agreement, based on the Ministry's decision (Appendix 3.6).

In the second phase, the researcher met the head of the Psychology Department and/or the person in charge of the out-patient clinics to explain the research protocol and the sample target of emotional disorders. The researcher arranged to liaise directly with the psychiatrists, so that any cases with the initial clinical diagnosis of emotional disorders were referred to the researcher directly or after the first appointment. The researcher met with each child and his/her father/mother, explained the aims of the study, and provided an information letter and consent form. If they consented to participate in the study, the researcher conducted an interview with the parent, then interviewed the child to confirm the diagnosis. According to standardized K-SADS criteria, children with a confirmed diagnosis of emotional disorder were included in the study. Parents and children completed the questionnaires in the next phase.

There were some minor differences among hospitals in the process of accepting patients, but these had no impact on the course of the research. For example, some hospitals required the patient to be registered before the date of the screening by a physician, for which reason cases seen in the emergency

departments were not referred to the researcher. In order to cover the three hospitals, the researcher attended each daily. He arranged to be contacted to determine the age and initial diagnosis of each referred child; if the case was appropriate, he then booked an appointment with the family. At the beginning of the research, many participants asked to complete the questionnaires at home, but because of limited returns and parents' non-response to telephone calls, they were subsequently encouraged to complete the questionnaires before leaving the hospital.

3.11 Ethical considerations

Research ethics are increasingly taken into consideration in developing countries, many of which are trying to reach clear milestones for research ethics as a result of increased interest in research and attention to human rights (Dixon-Woods, Young, & Heney, 1999). Organizations that regulate the relationship between researchers and participants have thus become increasingly concerned to observe the ethics of research for adults and children alike (Benatar, 2002; Hyder et al., 2004). Ethically there is a difference between research conducted with adults, who can express their views freely and independently (Punch, 2002), and research with children, because of their inability to make informed decisions to participate in research. They are, nevertheless, independent individuals, with their own views and experiences. Ethical guidelines are established to protect these children, respect their views and opinions, and distance them from potential harm (Keddie, 2000). Therefore, the purpose and content of the research should be explained to the child and parent in developmentally appropriate ways. When their understanding and

approval are ensured, consent should be sought from the parent or guardian (Christensen & Prout, 2002; Keddie, 2000).

The present research project was designed in line with the British Psychological Society (BPS) guidelines (2004). Potential participants were given detailed written information about the study prior to giving their written consent. Due to the nature of this project, participants were not expected to experience problems or significant distress resulting from the research procedures. They were informed about their rights to receive an explanation of the research from the beginning and to ask questions and request clarifications at the outset or during the study. They were also told that they had the right to withdraw from the study at any time, without any effect on their future treatment. Moreover, since the local supervisor of this research was a psychiatrist, it was possible to provide rapid access to suitable clinical services when needed.

The researcher faced some difficulties in obtaining ethical approval for the research, as this had to be given by three different hospitals. In general, all hospitals required the researcher to present a summary of his research and copies of the tools to be used in data collection and of the consent forms to be signed by participants. In addition, each requested a letter from the authority responsible for the research and from the researcher. The study was approved by the Commission delegated by the Ministry of Health. The King Fahd National Guard Hospital accepted that approval, which was sufficient for the application of research in that setting. Since the majority of its patients served in the armed forces, the RMH took additional measures to protect any military information

divulged during the research, and to ensure the integrity of research and the tools used for security purposes.

The researcher met the parents and children, introduced himself and thanked them, before explaining the research and its objectives. He assured them that all information would be treated confidentially, would not exceed the limits of the research, and would not affect or exceed their personal freedom. Whether they wished to participate or not would not affect the service they received, and they had the right to withdraw from the study at any time. The researcher offered to answer any questions the families had about the study. He then explained how to complete the questionnaires and the estimated time required. When the researcher was sure that the participants, especially the children, had understood the information, he asked the parents to sign the consent form. In some cases, participants asked to leave after the interview, because the child was bored, and to be allowed to complete the instruments at home. However, because of the initial difficulties of non-response noted above, the researcher encouraged participants to complete the instruments before leaving the clinic, by providing them with soft drinks or beverages and a place to rest.

3.12 Statistical analysis

The researcher scored and coded the data, then entered it in the SPSS program, version 18. Following the recommendation of Tabachnick and Fidell (2007), any missing values were replaced by the mean for the item concerned in the remaining sample. The researcher worked closely with a statistician, discussing the various options in the programme to determine the

descriptive statistics and frequencies, and to establish data such as totals for each subscale and each instrument.

The measurement of exposure to trauma was initially used to divide subjects into two groups, i.e. children who had been subjected to trauma and those who had not. The bivariate correlations between the variables were then calculated between exposure to trauma (total score) and each of the psychopathology scores. Linear regression analyses were also performed, to identify which total ET score predicted each of the psychopathology variables. An alternative analysis examined the cross-sectional differences between the two groups (children with at least one self-reported traumatic event and those without any such experiences) on the psychopathological variables. These analyses were carried out by means of a t-test. As a final step, analysis of covariance was used to establish whether social phobia and other psychopathologies were predicted by any mediating variables.

All of these procedures and their results will be detailed in chapters five and six (Results 1-2). The next chapter (four) will discuss the psychometric properties of the research instruments in the pilot study.

Chapter Four

Pilot study and psychometric properties of research instruments

4.1 Introduction

The previous chapter described the instruments selected for this study and reported previous evidence of their psychometric properties. Overall, most of these tools had been widely used in different cultures, including Arab countries. A set of psychometric tests were completed following the translation of the instruments into Arabic. These tests were selected in accordance with the published literature; that is, whenever possible, each tool was psychometrically tested using the same indicators as reported in the original studies. Taking into account the small sample size of the pilot study, which was not large enough for psychometric tests on their sub-scales, and its clinical nature, the researcher estimated the psychometric properties according to the total scores of selected measures.

Two of these instruments, measuring social phobia symptoms and exposure to trauma, were purposefully developed for this study, because of the lack of available tools. Their development was based on the literature and on similar measures. These two instruments are described in chapter three, while the present chapter reports the required further evaluation, such as validity and reliability tests. The aim of the pilot study presented here was to establish the validity and reliability of the translated versions of the measures. To assess reliability, the widely used Cronbach's alpha coefficient (α) was employed, while validity was tested by means of construct validity, internal validity and the Pearson correlation between the scores of children and parents. The new

instruments were subjected to factor analysis, as described in chapter three (Anastasi & Urbina, 1997; Gregory, 2004). The K-SADS-IVR semi-structured interview tool was used to independently confirm the diagnostic criteria of the selected sample, following the initial clinical assessment by the physician. This interview was not included in the following procedures, as it was not related to the research hypotheses of this study.

Furthermore, the pilot study gave an indication of how children understood and responded to items within the instruments, allowing potentially problematic items to be corrected, replaced or amended before administering them to the main sample. The pilot study also provided the researcher with a good opportunity to become familiar with aspects of the research procedure such as the administration, the time required and the scoring of the instruments.

4.2 Method

4.2.1 Sample

The sample for the pilot study comprised 20 children and was not included in the final sample. Children were referred by the three Riyadh hospitals identified in chapter three. They had been diagnosed with various emotional disorders by the referring psychiatrists. Their ages ranged from 9 to 16 years, with a mean age of 12.90 (SD = 2.61). There were 12 male (60%) and eight (40%) female children. Recruitment and data collection took place during March 2008. Eight of the children (40%) were referred by the Al-Amal Complex for Mental Health, six (30%) by the King Fahd National Guard Hospital and six (30%) by the Riyadh Military Hospital. According to the clinicians and the K-SADS, most children

suffered from one or more of the selected emotional disorders: social phobia, post-traumatic stress disorder, and/ or anxiety disorders. Table 4.1 shows the diagnoses for each hospital, including their comorbidity.

Table 4.1: Referral sources of the pilot study sample and their diagnoses

Hospitals	K-SADS Diagnosis						Total
	Social phobia	Social phobia and anxiety	Social phobia, anxiety and PTSD	Anxiety	Anxiety and PTSD	PTSD	
KFNGH	0	0	1	2	1	2	6
ACFMH	0	2	1	3	1	1	8
RMH	3	1	0	1	1	0	6
Total	3	3	2	6	3	3	20

4.2.2. Measures

Nine measures were used, as described in the previous chapter. The majority of these tools had already been translated into Arabic and had been used in Arab countries. Only the Parental Rearing Style (EMBU-C) had not been translated into Arabic, but it had been used in several countries and translated into a number of languages.

4.2.3 Research procedure

The researcher contacted the three hospitals to obtain ethical approval and to gather information on the number of patients and the mental health problems presented. After approval had been obtained, the researcher recruited a sample of children diagnosed with emotional disorders attending outpatient clinics. He met with each child and the father or mother, explained the aims of the study and gave them copies of the information letter and the consent form. If they consented to participate in the study, the researcher conducted an interview with

the father or mother. He then interviewed the child to confirm the diagnosis. According to the standardized criteria of the K-SADS, children with a confirmed diagnosis of emotional disorders were included in the study. Parents and children completed the questionnaires in the next phase.

4.3 Results

4.3.1 Descriptive statistic and alpha values of total scores

This section presents the descriptive statistics of total scores for each tool, as well as their alpha values.

Table 4.2: Descriptive statistics and alpha values

Variable	Item No	Mean	SD	α
Impact of Event Scale-Parent	13	20.85	14.46	0.91
Impact of Event Scale-Child		21.45	14.33	0.92
Revised Children's Manifest Anxiety Scale-Parent	37	18.50	6.53	0.86
Revised Children's Manifest Anxiety Scale-Child		21.20	5.70	0.77
Children's Depression Inventory-Parent	27	13.95	5.43	0.70
Children's Depression Inventory-Child		13.85	4.83	0.52
Social Phobia symptoms-Parent	25	24.35	13.73	0.96
Social Phobia symptoms-Child		23.45	13.93	0.96
Strengths and Difficulties Questionnaire-Parent	25	23.40	3.72	0.32
Strengths and Difficulties Questionnaire-Child		22.90	5.00	0.58
Exposure to Trauma	19	1.90	1.52	0.32
Parenting Stress Index	36	1.08	18.09	0.67
General Health Questionnaire	13	16.90	3.89	0.43

The Cronbach's alpha values contrasted with those of previous studies. P. Smith et al. (2002) report a value of $\alpha=0.80$ for the total score of the Impact of Event Scale. While Kendall, Safford, Flannery-Schroeder, and Webb (2004)

found alpha scores of 0.82 for the Revised Children’s Manifest Anxiety Scale and 0.93 for the Children’s Depression Inventory. Furthermore, $\alpha=0.71$ was established for the Strengths and Difficulties Questionnaire (Mellor, 2004). Roggman et al. (1994) reported PSI/SF alpha values of 0.90 for the total score and the Cronbach’s alpha coefficient of the General Health Questionnaire has been estimated at 0.87 (Montazeri, Harirchi, et al., 2003).

The descriptive statistics of subscales scores of the Parental Rearing Style are presented in Table 4.3, which show means, standard deviations and alpha values for the pilot study variables. As mentioned in Chapter three, total scores were not estimated for this instrument (Markus et al., 2003).

Table 4.3: Descriptive statistics and alpha values of Parental Rearing Style (EMBU-C) subscales

Variable	Item No	Mean	SD	α
EMBU-C-Parent-father-Emotional warmth	19	51.39	10.47	0.91
EMBU-C-Parent-father-Rejection	17	34.10	5.08	0.62
EMBU-C-Parent-father-Overprotection	12	27.27	4.40	0.64
EMBU-C-Parent-father-Favouring subject	4	8.30	2.36	0.55
EMBU-C-Parent-mother-Emotional warmth	19	56.58	10.72	0.92
EMBU-C-Parent-mother-Rejection	17	33.08	4.73	0.63
EMBU-C-Parent-mother-Overprotection	12	31.56	4.28	0.67
EMBU-C-Parent-mother-Favouring subject	4	8.30	2.30	0.54
EMBU-C-Child-father-Emotional warmth	19	50.82	10.80	0.87
EMBU-C-Child-father-Rejection	17	34.80	9.62	0.88
EMBU-C-Child-father-Overprotection	12	28.10	6.77	0.79
EMBU-C-Child-father-Favouring subject	4	7.40	1.90	0.37
EMBU-C-Child-mother-Emotional warmth	19	56.85	7.57	0.77
EMBU-C-Child-mother-Rejection	17	31.35	6.30	0.73
EMBU-C-Child-mother-Overprotection	12	30.60	6.50	0.33
EMBU-C-Child-mother-Favouring subject	4	9.10	2.57	0.53

C. Wilson et al. (2011) used the EMBU-C and found Cronbach's alphas of 0.87 for Emotional warmth, 0.78 for Rejection, 0.56 for Overprotection and 0.77 for Favouring Subject. These results suggests that the instruments are reliable enough for the purpose of this study (Cronbach, 1951).

4.3.2 Association between subscales and total scores

4.3.2.1 Impact of Event Scale

The IES-Parent items were significantly associated with the IES total scores, with correlation values ranging from 0.56 ($p < 0.01$) to 0.86 ($p < 0.01$). Table 4.4 shows that the associations between the subscales, and those between subscales and total scores were also statistically significant. These findings provide support for the internal validity of this measure.

Table 4.4: Bivariate correlations between IES-P subscales and total scores

	IES-Parent Avoidance	IES-Parent Arousal	IES-Parent Total score
IES-Parent Intrusion	.73**	.79**	.93**
IES-Parent Avoidance		.68**	.88**
IES-Parent Arousal			.91**

** Correlation is significant at 0.01 level

IES-Child items were found to be associated with the total score by values ranging from 0.47 to 0.83. Table 4.5 also displays significant associations between subscales, and between total score and subscales.

Table 4.5: Bivariate correlations between IES-C subscales and total scores

	IES- Child Avoidance	IES- Child Arousal	IES- Child total score
IES-Child Intrusion	.90**	.64**	.93**
IES-Child Avoidance		.71**	.95**
IES-Child Arousal			.85**

** Correlation is significant at 0.01 level

Table 4.6 presents the associations of subscales and total scores between children and parents.

Table: 4.6 SDQ Child-Parent associations

	IES-Child-Intrusion	IES-Child-Avoidance	IES-Child-Arousal	IES-Child total score
IES-Parent-Intrusion	.87**	.72**	.57**	.79**
IES-Parent-Avoidance	.74**	.68**	.42	.68**
IES-Arousal	.65**	.68**	.50*	.67**
IES-Parent-total score	.83**	.76**	.55*	.79**

*Correlation is significant at 0.05 level

** Correlation is significant at 0.01 level

4.3.2.2 Revised Children’s Manifest Anxiety Scale

RCMAS-P items were associated with the total scores by values ranging from 0.24 to 0.74. Table 4.7 indicates that none of the correlations between RCMAS-Parent-Physiological, RCMAS-Parent-Worry/Oversensitivity and RCMAS-Parent-Concentration Anxiety were significant, despite all subscale scores being significantly correlated with the total scores.

Table 4.7: Bivariate correlations between RCMAS-P subscales and total scores

	RCMAS-Parent-Worry/Oversensitivity	RCMAS-Parent-Concentration Anxiety	RCMAS-Parent total score
RCMAS-Parent-Physiological	.32	.40	.78**
RCMAS-Parent-Worry/Oversensitivity		.57**	.50*
RCMAS-Parent-Concentration Anxiety			.72**

*Correlation is significant at 0.05 level

** Correlation is significant at 0.01 level

The items of RCMAS–Child were correlated with total scores, with values ranging from 0.21 to 0.82. The correlation between RCMAS–Child-Physiological

and RCMAS-Child-Concentration Anxiety was not significant; however, all subscales were associated significantly with the total score (Table 4.8).

Table 4.8: Bivariate correlations between RCMAS-C subscales and total scores

	RCMAS Child - Worry/Oversensitivity	RCMAS Child Concentration Anxiety	RCMAS Child total score
RCMAS-Child-Physiological	.55*	.44	.73**
RCMAS-Child-Worry/Oversensitivity		.48*	.83**
RCMAS-Child Concentration Anxiety			.67**

*Correlation is significant at 0.05 level

** Correlation is significant at 0.01 level

Table 4.9 displays the association of subscales and total scores between children and parents.

Table: 4.9 RCMAS Child-Parent associations

	RCMAS-Child-Physiological	RCMAS-Child-Worry/Oversensitivity	RCMAS-Child-Concentration Anxiety	RCMAS-Child total score
RCMAS-Parent-Physiological	.67**	.69**	.53*	.77**
RCMAS-Parent-Worry/Oversensitivity	.70**	.56*	.32	.74**
RCMAS-Parent-Concentration Anxiety	.43	.35	.57**	.56*
RCMAS-Parent total score	.66**	.70**	.50*	.85**

*Correlation is significant at 0.05 level

** Correlation is significant at 0.01 level

4.3.2.3 Children's Depression Inventory

When total CDI scores were calculated, items for children and parents were found to be associated with the total scores, with values ranging from 0.23 to 0.79. In this study, the correlation between the CDI-Child and CDI-Parent scores was 0.36.

4.3.2.4 Strengths and Difficulties Questionnaire

SDQ-Parent items were associated with total scores, with values ranging from 0.21 to 0.65. Table 4.10 shows that correlations between subscales and total scores were moderate, even though most of the subscales were not significantly associated with total scores. The association between SDQ-P Prosocial behaviour and SDQ-P-Conduct problems was not consistent with previous studies.

Table 4.10: Bivariate correlations between SDQ-P subscales and total scores

	SDQ-P Emotional Symptoms	SDQ-P Conduct Problems	SDQ-P Hyperactivity	SDQ-P Peer Problems	SDQ-P Prosocial Behaviour
SDQ-P-Total Score	.66**	.53*	.43	.43	.22
SDQ-P-Emotional Symptoms		-.03	.27	.23	-.09
SDQ-P-Conduct Problems			.19	-.20	.37
SDQ-P-Hyperactivity				-.12	-.28
SDQ-P-Peer Problems					-.19

*Correlation is significant at 0.05 level

** Correlation is significant at 0.01 level

SDQ-Child items were associated with SDQ total scores, with values ranging from 0.23 to 0.77. In the same way as for the SDQ-Parent, correlations between subscales and total scores were moderate, and some of the subscales were not significantly associated (Table 4.11).

Table 4.11: Bivariate correlations between SDQ-C subscales and total scores

	SDQ-C Emotional Symptoms	SDQ-C Conduct Problems	SDQ-C Hyperactivity	SDQ-C Peer Problems	SDQ-C Prosocial Behaviour
SDQ-C-Total Score	.65 ^{***}	.71 ^{***}	.52 [*]	.35	.32
SDQ-C-Emotional Symptoms		.25	.42	.37	-.33
SDQ-C-Conduct Problems			.59 [*]	-.03	.14
SDQ-C-Hyperactivity				-.32	-.10
SDQ-C-Peer Problems					-.16

* Correlation is significant at 0.05 level

** Correlation is significant at 0.01 level

Table 4.12 presents the association of subscales and total scores between children and parents. Associations between subscales varied from strong to weak.

Table: 4.12 SDQ Child-Parent associations

	SDQ-C- Emotional Symptoms	SDQ-C- Conduct Problems	SDQ-C- Hyperactivity	SDQ-C- Peer Problems	SDQ-C- Prosocial Behaviour	SDQ-C Total Score
SDQ-P- Emotional Symptoms	.12	-.04	-.20	.46 [*]	-.16	.07
SDQ-P- Conduct Problems	.12	.82 ^{**}	.43	-.15	.32	.59 ^{**}
SDQ-P- Hyperactivity	-.27	-.25	-.06	-.24	.10	-.27
SDQ -P- Peer problems	.18	-.03	-.14	.23	-.42	-.09
SDQ-P- Prosocial Behaviour	.14	.50 [*]	.40	.08	.58 ^{**}	.68 ^{**}
SDQ-P Total Score	.15	.41	.13	.21	.06	.36

*Correlation is significant at 0.05 level

** Correlation is significant at 0.01 level

4.3.2.5 Parental Rearing Style

EMBU-C-Parent items were found to be associated with subscales, with values ranging from 0.20 to 0.88. Table 4.13 shows that the associations between subscales varied from strong to weak, as did the associations between mothers and fathers. However, as has already been discussed, correlations between these subscales could not all be strong, since they measured different constructs.

Table 4.13: Bivariate correlations for EMBU-C-Parent subscales

		Emotional Warmth	Rejection		Over-protection		Favouring Subject	
		Mother	Father	Mother	Father	Mother	Father	Mother
Emotional Warmth	Father	.20	-.25	-.35	.55*	-.21	.08	-.14
	Mother		-.25	-.35	-.21	.47*	-.03	.32
Rejection	Father			.92**	.04	-.10	-.30	-.16
	Mother				.12	-.02	-.18	-.04
Over-protection	Father					.27	.34	.15
	Mother						.29	.51*
Favouring Subject	Father							.75**

*Correlation is significant at 0.05 level

** Correlation is significant at 0.01 level

Similarly, EMBU-C-Child items were associated with the subscales, with values ranging from 0.23 to 0.84. Table 4.14 presents the associations between subscales, and the associations between mothers and fathers, which again varied from strong to weak.

Table 4.14: Bivariate correlations for EMBU-C-Child subscales

		Emotional warmth		Rejection		Over-protection		Favouring Subject	
		Mother	Father	Mother	Father	Mother	Father	Mother	
Emotional Warmth	Father	.16	-.39	-.19	.42	-.12	.04	-.48*	
	Mother		-.01	.14	.15	.53*	-.28	-.33	
Rejection	Father			.48*	.56**	.34	-.01	.49*	
	Mother				.11	.50*	-.25	.07	
Over-protection	Father					.07	.09	.23	
	Mother						-.23	-.19	
Favouring Subject	Father							.50*	

*Correlation is significant at 0.05 level

** Correlation is significant at 0.01 level

Table 4.15 shows that the associations of subscales between children and parents also varied from strong to weak.

Table: 4.15 EMBU-C Child-Parent associations

Child		Emotional Warmth		Rejection		Over-protection		Favouring Subject	
		Father	Mother	Father	Mother	Father	Mother	Father	Mother
Emotional Warmth	Father	.12	-.09	.46*	-.08	.53*	.08	.26	.14
	Mother	.04	.21	.13	-.18	.28	-.34	-.12	-.12
Rejection	Father	.52*	.13	-.19	.32	.04	.20	-.25	-.42
	Mother	.46*	.03	-.19	.38	-.04	.15	-.19	-.37
Over-protection	Father	.07	-.45*	.35	.13	.37	-.16	.35	.48*
	Mother	-.22	-.29	.01	-.01	-.09	-.50*	-.01	.29
Favouring Subject	Father	-.39	.08	.44	.26	.10	.19	.38	.57**
	Mother	-.25	.15	.44	.33	.26	-.03	.36	.51*

*Correlation is significant at 0.05 level

** Correlation is significant at 0.01 level

4.3.2.6 Parenting Stress Index - Short Form

PSI items were associated with total scores, with values ranging from 0.27 to 0.71. Table 4.16 presents the relationship between the subscales, and between subscales and total scores. These were significant, although the correlation between PSI-Difficult Child (DC) and PSI-Parental Distress (PD) was weak.

Table 4.16: Bivariate correlations between PSI subscales and total scores

	PSI-Parental Distress	PSI-Child Dysfunctional Interaction	PSI-Difficult Child
PSI-total score	.85**	.91**	.57**
PSI-PD		.63**	.09
PSI-P-CDI			.64**

** Correlation is significant at 0.01 level

4.3.2.7 General Health Questionnaire

GHQ items were correlated with total scores, with values ranging from 0.24 to 0.65. This scale applied to parents only.

4.3.2.8 Social Phobia symptoms

SP-Parent and Child items were found to be correlated with the total score, with values ranging from 0.40 to 0.90. The correlation of total Social Phobia scores between children and parents was 0.92 ($p=0.01$). As was mentioned earlier, this measure was developed by the researcher; therefore the factor analysis which was presented in the previous chapter should be taken in consideration.

4.3.2.9 Exposure to Trauma (ET)

In this scale, children's and parents' responses were identical, as the correlation between the child's and parent's response was $p=1$. In addition, the ET items

were associated with total scores, with values ranging from 0.20 to 0.70. The correlations between ET and IES total scores were 0.66 and 0.70 for children and parents respectively (both $p < 0.01$).

4.4 Conclusions from the pilot study

The aim of the pilot study was to evaluate the psychometric properties of the Arabic versions of the self-report tools measuring a wide variety of emotional and behavioural variables, in order to use them in the main study. Every care was taken to ensure that these versions were conceptually and linguistically equivalent to the original (English) ones, which led to the use of a combined procedure of back-translation and committee techniques. This was followed by an empirical investigation to allow statistical testing of the translated tools.

The results can be divided into three groups of instruments, the first consisting of the Impact of Event Scale, Revised Children's Manifest Anxiety Scale, Children's Depression Inventory and General Health Questionnaire. All these tools had high alpha values, and high Pearson correlations between their subscales and total scores. In addition, the associations between the subscales were strong.

The second group of tools consisted of the Strengths and Difficulties Questionnaire, Parental Rearing Style and Parenting Stress Index; their alpha values were high and their subscales were strongly associated with total scores. However, associations were moderate between their subscales. Although such weak associations between subscales might be anticipated, the high alpha

values were satisfactory for the purpose of scientific research, as were the relationships between the items and the total scores.

The final group comprised the Social Phobia symptoms and Exposure to Trauma measures. Their alpha values were high, as was the strength of association between their items and total scores, indicating satisfactory psychometric properties. However, given that these two instruments are new, having been developed by the researcher for the purpose of this study, they will require further evaluation in future research.

In conclusion, to the level of precision allowed by the data, it appears that the translated versions were generally suitable for this study, taking into consideration the small size of this clinical sample. In addition, more detailed evaluation was performed on the two new measures, based on the large sample of the main study, and this will be presented in the next chapter.

Chapter Five

Results 1: Association between trauma and child psychopathology

5.1 Introduction

This chapter is dedicated to describing the characteristics of the sample and to establishing the relationship between exposure to trauma and child psychopathology, through univariate models.

5.2 Missing data and normality

Once returned, questionnaires were checked for completion and respondents were then asked to supply any missing answers. Most children's (96.93%) and parents' (93.26%) measures had no missing values. Three children missed one item each on the Parental Rearing Style (EMBU-C) scale, while four parents missed two items and two parents missed one item, each on the same measure. Following the recommendation of Tabachnick and Fidell (2007), missing values were replaced by the mean of that item in the remaining sample. The normality of distributions was checked by looking at the histograms of the individual scores. These suggested that scores were distributed normally.

5.3 Descriptive statistics for the study variables

Having dealt with missing data and established normality, the researcher calculated descriptive statistics for the variables involved in the analysis. Table 5.1 shows the mean, median and standard deviation scores for all the measures. For ease of presentation, variables are divided into four tables: Table 5.1 presents the child psychopathology instruments of Social Phobia, Impact of Event Scale, Revised Children's Manifest Anxiety Scale, Children's Depression

Inventory, and Strengths and Difficulties Questionnaire; Table 5.2 presents the parent instruments, i.e. the Parental Rearing Style, Parenting Stress Index, and General Health Questionnaire; Table 5.3 presents the frequencies of different types of trauma (subscales); and Table 5.4 presents frequencies of Exposure to Trauma items.

Table 5.1: Descriptive statistics of child psychopathology measures

Variables	Mean	Median	Std. deviation
Social Phobia (Parent)	23.25	22	12.40
Social Phobia (Child)	23.74	23	13.63
Impact of Event Scale (Parent)	21.84	20	15.02
Impact of Event Scale (Child)	22.35	19	15.45
Revised Children's Manifest Anxiety Scale (Parent)	20.42	21	6.20
Revised Children's Manifest Anxiety Scale (Child)	21.05	22	6.86
Children's Depression Inventory (Parent)	13.94	14	5.67
Children's Depression Inventory (Child)	14.46	15	5.98
Strengths and Difficulties Questionnaire (Parent)	23.74	24	3.87
Strengths and Difficulties Questionnaire (Child)	23.63	23	5.51

These scores can be contrasted with those reported in previous studies. In a clinical sample of children suffering from chronic PTSD, Amdur and Liberzon (2001) found that the mean score for the total IES was 56.97, with a standard deviation of 10.46. In a general population study, the mean IES score was 10.66 (SD=13.79) (Andrews, Shevlin, Troop, & Joseph, 2004). The mean score on the Revised Children's Manifest Anxiety Scale was 18.00 (SD=5.87) in a sample consisting of children fulfilling PTSD diagnostic criteria (Chemtob, Nakashima, &

Carlson, 2002), while in a group of schoolchildren it was 12.42 (SD=6.76) (Pina, Silverman, Saavedra, & Weems, 2001). The mean score of the Children's Depression Inventory was 10.09 (SD=6.24) in a clinical sample (Kendall et al., 2004), while the respective mean score in a community sample was 9.40 (SD=7.70) (Stark & Laurent, 2001). Becker et al. (2006) report a mean total score of the Strengths and Difficulties Questionnaire of 20.4 (SD=6.00) in a clinical sample, while Palmieri and Smith (2007) estimated a mean score of 12.05 (SD=92) in the general population.

Table 5.2: Descriptive statistics of the parental measures

Variables	Mean	Median	Std. Deviation
EMBU-C*-P-F- Emotional Warmth	52.29	51	9.53
EMBU-C-P-M- Emotional Warmth	56.47	56	7.94
EMBU-C-P-F- Rejection	34.06	32	12.82
EMBU-C-P-M- Rejection	32.63	32	11.58
EMBU-C-P-F- Overprotection	30.39	31	4.61
EMBU-C-P-M- Overprotection	32.21	33	3.40
EMBU-C-P-F- Favouring Subject	8.08	8	2.36
EMBU-C-P-M- Favouring Subject	8.46	9	2.52
EMBU-C-C-F- Emotional Warmth	49.79	51	9.55
EMBU-C-C-M- Emotional Warmth	56.11	55	7.61
EMBU-C-C-F- Rejection	34.85	34	7.92
EMBU-C-C-M- Rejection	32.99	32	6.44
EMBU-C-C-F- Overprotection	30.78	30	11.90
EMBU-C-C-M- Overprotection	33.03	32	11.34
EMBU-C-C-F- Favouring Subject	7.56	7	1.90
EMBU-C-C-M- Favouring Subject	8.52	8	2.46
Parenting Stress Index	109.30	108	13.96
General Health Questionnaire	16.43	16	3.25

* EMBU-C (Parental Rearing Style): P=Parent; C=Child; F=Father; M=Mother

In relation to the parental measures presented in Table 5.2, Lindhout et al. (2006) report the following mean EMBU-C subscale scores in a clinical sample: emotional warmth 64.7 (SD=8.8), rejection 23.9 (SD=3.4), overprotection 22.7

(SD=4.5) and favouring subject 7.1 (SD=1.9). Respective scores in a general population study were emotional warmth 32.01 (SD=6.59), rejection 15.10 (SD=4.91), overprotection 24.74 (SD=5.14) and favouring subject 23.84 (SD=8.48) (Zlomke & Young, 2009). In another general population study, Chartrand, Frank, White, and Shope (2008) used the PSI-SF and found that the mean total score was 65.0 (SD=18.5), contrasted with a clinical sample mean of 100.33 (SD=18.69) (Epstein, Saltzman-Benaiah, O'Hare, Goll, & Tuck, 2008). The respective total GHQ mean scores were 4.54 (SD=1.25) in a sample of University students Ye (2009) and 18.6 (SD=6.1) in a clinical sample (C. Smith, Hancock, Blake-Mortimer, & Eckert, 2007).

Table 5.3: Frequencies of Exposure to Trauma subscales

ET subscales	Response	N = 89	%
Family problems	Yes	36	40.4
	No	53	59.6
Violence/Abuse	Yes	15	16.9
	No	74	83.1
Illness/Death	Yes	28	31.5
	No	61	68.5
Accident/Disasters	Yes	29	32.6
	No	60	67.4
Peer relationships	Yes	12	13.5
	No	77	86.5
Loss	Yes	1	1.1
	No	88	98.9
Exposure to any type of trauma	Yes	75	84.3
	No	14	15.7

Table 5.4: Frequencies of Exposure to Trauma items

	Item	Yes/ No	N = 89	%
1	Have you had a separation due to marital difficulties or broken off a steady relationship?	No Yes	66 23	74.2 25.8
2	Have you witnessed severe domestic violence, e.g. seen your mother badly beaten up at home?	No Yes	64 25	71.9 28.1
3	Have you (or someone close to you) had a major financial crisis, such as losing the equivalent of three months' income?	No Yes	87 2	97.8 2.2
4	Have you (or someone close to you) had a problem with the police involving a court appearance?	No Yes	67 22	75.3 24.7
5	Have you experienced a severe attack or threat, e.g. by a mugger or gang?	No Yes	87 2	97.8 2.2
6	Have you (or someone close to you) had a serious physical illness such as cancer or heart attack?	No Yes	84 5	94.4 5.6
7	Have you (or someone close to you) had a serious mental illness such as schizophrenia or major depression?	No Yes	84 5	94.4 5.6
8	Now turning to things that have happened to her/him. At any stage in his/her life, has a parent, brother or sister of his/hers died?	No Yes	69 20	77.5 22.5
9	Has s/he ever had a serious illness which required a stay in hospital?	No Yes	81 8	91.0 9.0
10	Has s/he ever been in a serious accident or badly hurt in an accident?	No Yes	65 24	73.0 27.0
11	Have you been exposed to something frightening or dangerous, e.g. an accident in a ferry or a train crash?	No Yes	73 16	82.0 18.0
12	Have you (or someone close to you) experienced a serious fire, e.g. trapped in a burning house or car?	No Yes	88 1	98.9 1.1
13	Have you (or someone close to you) experienced other disasters, e.g. kidnapping, earthquake, explosions or war?	No Yes	87 2	97.8 2.2
14	In the past year, has s/he ended a close friendship, for example, permanently falling out with a best friend?	No Yes	82 7	92.1 7.9
15	Has s/he (or someone close to her/him) experienced severe physical abuse?	No Yes	81 8	91.0 9.0
16	Have you (or someone close to you) experienced sexual abuse?	No Yes	87 2	97.8 2.2
17	Have you (or someone close to you) experienced rape?	No Yes	84 5	94.4 5.6
18	Have you ever lost something that was dear to yourself, like a doll or toy?	No Yes	88 1	98.9 1.1
19	Has s/he experienced an embarrassing situation (for example, insults and humiliation) by his/her family or colleagues that he/she still remembers?	No Yes	84 5	94.4 5.6

5.4 Association between trauma and child psychopathology

In this section, the association between exposure to trauma and child psychopathology is presented, through two types of analysis. The first shows the Pearson's correlation between exposure to trauma (total score) and each of the child psychopathology scores: social phobia, depression, anxiety, PTSD and overall mental health problems.

The second analysis examines the differences between two groups: one with at least one self-reported traumatic experience and the other with no such experience, on the child psychopathology variables. These analyses were carried out by means of a t-test. The t-tests quoted have 87 degrees of freedom.

5.4.1 Correlation tests

There was no significant correlation between the Exposure to Trauma (ET) total score and most of the psychopathology scores (social phobia, anxiety, depression and overall mental health problems).

However, there was a significant association between ET and Impact of Event Scale (IES) total and subscale scores for both parent (P) and child (C). Of particular importance is the significant correlation between ET and IES-P total scores ($r = 0.64$, $p < 0.01$). Similarly, there was a significant association between the ET and IES-C total scores ($r = 0.60$, $p < 0.01$). Table 5.5 shows the significant associations between the ET and IES variables.

Table 5.5: Significant bivariate associations between ET and psychopathology variables

Psychopathology variables	<i>r</i>	<i>p</i>
IES-P Intrusion	0.59	< 0.01
IES-P Avoidance	0.57	< 0.01
IES-P Arousal	0.52	< 0.01
IES-P Total score	0.64	< 0.01
IES-C Intrusion	0.59	< 0.01
IES-C Avoidance	0.57	< 0.01
IES-C Arousal	0.52	< 0.01
IES-C Total score	0.64	< 0.01

5.4.2 Between-groups comparison of child psychopathology

Two groups were identified on the basis of children’s reports on the ET checklist. The ‘trauma’ group had experienced at least one positive item on an ET subscale, while the ‘without trauma’ group had not responded ‘Yes’ to any ET item. The two groups were compared on all psychopathology measures, of which only those that were significantly different are presented below.

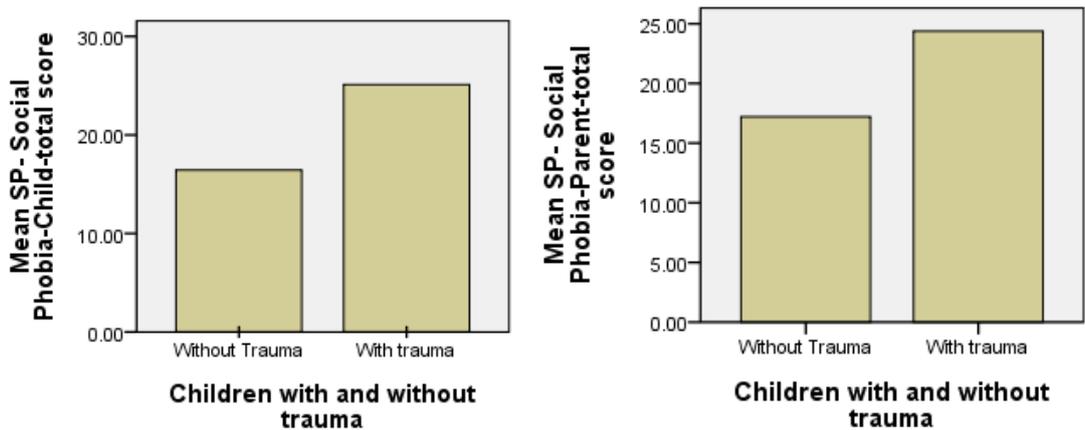
5.4.2.1 Groups with and without exposure to trauma

The trauma group scored significantly higher on two psychopathology measures: on social phobia (parent) ($t = 2.02, p < 0.05$) and social phobia (child) ($t = 2.23, p < 0.05$), and on IES-P total score ($t = 7.30, p < 0.01$) and IES-C total score ($t = -8.01, p < 0.01$), as well as on IES subscales. Table 5.6 shows the positive findings of the between-groups comparison. Figure 5.1 illustrates the comparison between children with and without trauma on social phobia scores.

Table: 5.6: Psychopathology measures that differentiated between children with and without trauma

Psychopathology variable	With trauma (n=75)		Without trauma (n=14)		t	p
	mean	SD	mean	SD		
Social Phobia Parent	24.37	12.10	17.21	12.68	-2.02	0.05
Social Phobia Child	25.11	13.29	16.43	13.61	-2.23	0.03
IES-P total score	24.63	14.52	6.93	6.56	-7.30	0.00
IES-C total score	25.33	14.83	6.36	6.12	-8.01	0.00

Figure 5.1: Comparison between children with and without trauma on social phobia scores



5.4.3 Between-subscales comparison of child psychopathology

Children were then divided into two groups according to whether or not they had experienced each type of trauma. These groups were compared by t-test on the psychopathology scores.

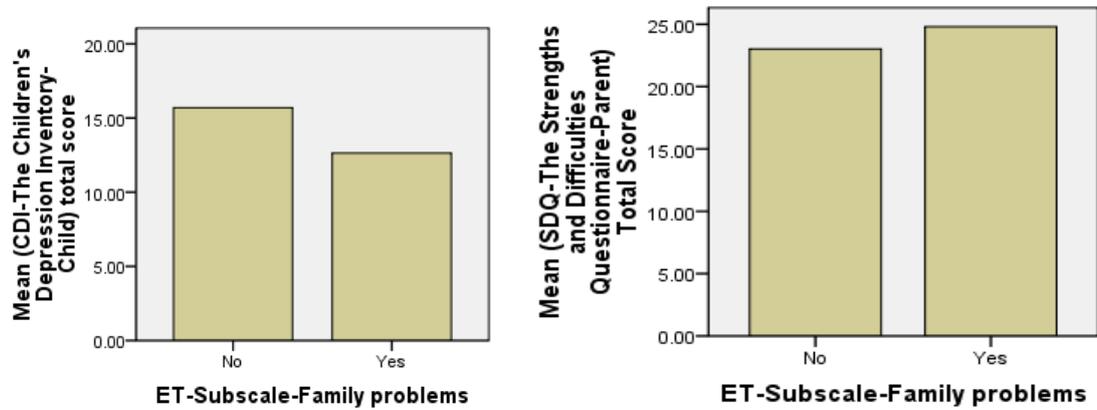
5.4.3.1 Exposure to family problems

The family problems group (ETS1) scored significantly higher on the following psychopathology measures: IES-P total score ($t = -4.64, p < 0.01$), IES-C total score ($t = -4.33, p < 0.01$) and all IES subscales for parent and child; SDQ-P total score ($t = -2.18, p < 0.05$) and SDQ-P Emotional Symptoms subscale. In contrast, the group without family problems scored significantly higher on the CDI-Child ($t = 2.43, p < 0.05$), which is not compatible with the literature review or the findings of previous studies. Table 5.7 shows the significant findings of the comparisons between the two groups, while Figure 5.2 compares children with and without family problems on the total SDQ score.

Table 5.7: Significant psychopathology differences between children with and without exposure to family problems

Psychopathology variable	With family problems (n=36)		Without family problems (n=53)		t	p
	mean	SD	mean	SD		
IES-P total score	29.92	12.92	16.36	13.92	-4.62	0.000
IES-C total score	30.19	13.80	17.02	14.29	-4.33	0.000
SDQ-P Emotional Symptoms	6.92	1.63	6.02	1.90	-2.32	0.023
SDQ-P total score	24.81	3.24	23.02	4.11	-2.18	0.032

Figure 5.2: Comparison between children with and without exposure to family problems on SDQ total scores



5.4.3.2 Exposure to violence/abuse (ETS2)

The exposure to violence or abuse group (ETS2) scored significantly higher on the following psychopathology measures: IES-P total score ($t = -4.50$, $p < 0.01$), IES-C total score ($t = -6.77$, $p < 0.01$) and all IES subscales for parent and child; RCMAS (parent) physiological subscale ($t = -2.95$, $p < 0.01$) and RCMAS (child) physiological subscale ($t = -2.01$, $p < 0.05$); SDQ-P emotional symptoms ($t = -2.25$, $p < 0.05$), SDQ-P Hyperactivity ($t = -2.13$, $p < 0.05$), SDQ-C emotional problems ($t = -2.56$, $p < 0.01$) and SDQ-C hyperactivity problems ($t = -2.02$, $p < 0.05$). Table 5.8 shows the significant findings of the comparison between the two groups.

Table 5.8: Psychopathology measures that differentiated between children with and without exposure to violence/abuse

Psychopathology variable	Exposed to violence/abuse (n=15)		Not exposed to violence/abuse (n=74)		t	p
	mean	SD	mean	SD		
IES-P total score	36.27	12.72	18.92	13.77	-4.50	0.000
IES-C total score	40.07	10.50	18.76	13.75	-6.77	0.000
RCMAS-P Physiological	6.13	2.61	4.03	2.50	-2.95	0.004
RCMAS-C Physiological	6.07	2.28	4.58	2.67	-2.01	0.048
SDQ-P Emotional symptoms	7.33	1.88	6.19	1.78	-2.25	0.027
SDQ-P Hyperactivity	6.20	1.66	5.12	1.81	-2.13	0.036
SDQ-C Emotional symptoms	7.20	2.01	5.58	2.30	-2.56	0.012
SDQ-C Hyperactivity	5.93	2.05	4.85	1.86	-2.02	0.046

5.4.3.3 Exposure to accidents or disasters

It was found that children without exposure to accidents or disasters (ETS4) scored significantly higher on two psychopathology measures: RCMAS-C total score ($t = 2.38, p < 0.05$), RCMAS-C worry/oversensitivity ($t = 1.99, p = 0.05$); SDQ-C total score ($t = 2.10, p < 0.05$) and SDQ-C conduct problems subscale ($t = 2.18, p < 0.05$). These results are not compatible with the literature review or previous findings.

5.4.3.4 Other ET subscales

No significant differences were established for any psychopathology variables on the illness/death, peer relationships or loss subscales.

5.5 Summary

The findings so far are summarized below, in order to inform the next stage of the analysis. No significant association was found between total trauma and social phobia scores or any other types of psychopathology such as depression,

anxiety or overall mental health problems, as rated by parents and children, in contrast with the consistent association between trauma and PTSD symptoms (total and subscales scores). However, when children were divided into two groups by exposure to trauma, the group with exposure to trauma reported significantly higher levels of social phobia and PTSD scores, than children without exposure to trauma. On the contrary, no differences were found when comparing the two groups in regard to the rest of psychopathology like depression, anxiety and overall mental health problems, as rated by both parents and children.

Children's exposure to family problems was associated with higher IES scores (child and parent), SDQ total and SDQ emotional scores, whereas there were no differences between the exposed group and non-exposed group for SP, anxiety and depression. Furthermore, children exposed to violence or abuse had significantly higher scores on PTSD, anxiety-physiological, SDQ emotional and SDQ hyperactivity symptoms than children without exposure to violence or abuse; but no significant differences were reported on SP and depression, scores according to both parents and children.

The impact of accidents or disasters was not compatible with the literature review or previous findings. Similarly, the illness/death, peer relationships and loss subscales did not differentiate between any of the psychopathology variables. Table 5.9 presents an overview of the significant differences.

Table 5.9: Summary of significant associations

Psychopathology variables	High mean	Low mean
Social Phobia	With trauma	Without trauma
Impact of Event scales	With trauma	Without trauma
	With family problems	Without family problems
	With violence/abuse	Without violence/abuse
Strengths and Difficulties Questionnaire	With family problems	Without family problems
SDQ-emotional symptoms and hyperactivity	With violence/abuse	Without violence/abuse
RCMAS Anxiety-physiological	With violence/abuse	Without violence/abuse
Correlation: Exposure to Trauma correlated with Impact of Event Scales scores		

These univariate associations informed the next stage of the analysis, i.e. the multivariable model, which also included potentially mediating factors such as parenting problems. This analysis will be presented in the next chapter.

Chapter Six

Results 2:

Multivariate model of the relationship between exposure to trauma and child psychopathology

6.1 Introduction

This chapter reports the statistical analysis undertaken to establish whether social phobia was predicted by a combination of trauma, mediating and demographics variables, and to test whether other types of psychopathology were predicted in the same way. The main aim of the analysis was to determine which independent and mediating variables significantly predicted outcome variables. This study was mainly interested in social phobia as the dependent variable, but also had some interest in PTSD, anxiety, depression and general mental health problems and in their relationships with trauma and parenting variables. The independent variables entered in the model, therefore, were emotional trauma, demographic variables, EMBU-C, GHQ and PSI scores. As in the univariate analysis, trauma was considered in terms of a total score (ET), of the total score on each subscale (ETS 1-6), or of the dichotomous variable of having experienced any trauma or not (groups ET1 and ET2) in separate analyses.

The potential mediating variables consisted of demographic (the participant's gender, age, and standard of living for the family) and parental variables. The latter consisted of the following instruments: 1) Parental Rearing Style (EMBU-C), including the subscales of Emotional Warmth, Rejection, Overprotection, and Favouring Subject (the researcher combined EMBUC fathers' with mothers' responses, resulting in four subscales scores for each child and parent). 2) Parenting Stress Index (PSI) - Short Form (SF) with total scores and three

subscales of Parental Distress (PD), Parent-Child Dysfunctional Interaction (P-CDI), and Difficult Child (DC). In the statistical analysis, both total and subscales scores were included. 3) General Health Questionnaire (GHQ) total scores. The outcome (dependent) variables consisted of the psychopathology scores: Social Phobia (SP), Impact of Event Scale (IES), Revised Children's Manifest Anxiety Scale (RCMAS), Children's Depression Inventory (CDI), and Strengths and Difficulties Questionnaire (SDQ). Only the total scores of these measures were used.

6.2 Primary analyses

As reported in the previous chapter, univariate associations were first identified. In the multivariate model, the aim was to look at the independent and mediating variables simultaneously with the outcome variables. In other words, using analysis of covariance (ANCOVA), the purpose was to determine whether trauma was associated with child psychopathology, taking into consideration demographic and parental variables. The results are presented separately for each type of psychopathology.

6.2.1 Social phobia

The findings are presented in three sections, according to the method of measuring exposure to trauma.

6.2.1.1 Exposure to trauma measured as a total score

Table 6.1 presents the association between ET total scores and social phobia symptoms (child scores). Increasing age ($F=41.23$, $p=000$), low EMBU-C-Child-

Emotional Warmth scores ($F=12.54$, $p=001$), and PSI total scores ($F=4.37$, $p=040$) were significantly associated with SP scores. The ANCOVA was repeated with age, EMBU-C-Child-Emotional Warmth and PSI total scores as the only covariates, because although the ET total score was not significantly associated with SP scores, it was the variable of primary interest; therefore, it was essential to verify whether it predicted SP in the presence of age, EMBU-C-Child-Emotional Warmth and PSI total scores. Parameter estimates (Table 6.2) show that ET total scores did not make a significant contribution; furthermore, the correlation of age with PSI total score and SP remained positive, which means that SP scores increased with age and PSI total scores. The correlation between EMBU-C-Child-Emotional Warmth and SP was negative, i.e. lack of parental warmth was a significant predictor. In summary, age, lack of parental warmth and parenting stress predicted social phobia symptoms, but not children's exposure to trauma. Parameter estimates are presented in detail in Table 6.2, but in subsequent analyses only the positive findings are quoted.

Table 6.1: ANCOVA between ET total scores, SP-Child scores covariates

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Gender	4.128	1	4.128	.038	.845
Age	4422.511	1	4422.511	41.226	.000
Standard of living for the family	.294	1	.294	.003	.958
ET-total score	12.867	1	12.867	.120	.730
EMBU-C-Parent-Emotional Warmth	16.243	1	16.243	.151	.698
EMBU-C- Parent-Rejection	234.520	1	234.520	2.186	.144
EMBU-C- Parent-Overprotection	11.438	1	11.438	.107	.745
EMBU-C- Parent-Favouring Subject	13.455	1	13.455	.125	.724
EMBU-C-Child-Emotional Warmth	1345.341	1	1345.341	12.541	.001
EMBU-C-Child-Rejection	.002	1	.002	.000	.997
EMBU-C-Child-Overprotection	1.576	1	1.576	.015	.904
EMBU-C-Child-Favouring Subject	20.683	1	20.683	.193	.662
Parental Stress Index total score	468.468	1	468.468	4.367	.040
General Health Questionnaire	63.146	1	63.146	.589	.445

Table 6.2: Parameter estimates of model including ET total scores

Parameter	B	Std. Error	t	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Age	2.921	.426	6.857	.000	2.074	3.769
ET-total score	.329	.712	.462	.645	-1.086	1.744
EMBU-C-Child-Emotional Warmth	-.384	.079	-4.866	.000	-.541	-.227
PSI-total	.172	.077	2.227	.029	.018	.326

As the PSI has three subscales, the analyses were repeated with the PSI total scores being replaced by subscale scores; only positive findings are presented.

The same tests were repeated for social phobia scores as rated by the parent. Table 6.3 shows that age ($F=55.30$, $p=000$), EMBU-C-Parent-Rejection ($F=4.33$, $p=041$) and lack of EMBU-C-Child-Emotional Warmth ($F=8.67$, $p=004$) were significantly associated with SP scores. In particular, ET (total) scores did not make a significant contribution in predicting SP symptoms when age, EMBU-C-Parent-Rejection and EMBU-C-Child-Emotional Warmth were taken into account.

Table 6.3: ANCOVA between ET total scores, SP-Parent scores covariates

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Gender	11.025	1	11.025	.131	.718
Age	4638.407	1	4638.407	55.298	.000
Standard of living for the family	.009	1	.009	.000	.992
ET-total score	16.330	1	16.330	.195	.660
EMBU-C-Parent-Emotional Warmth	23.012	1	23.012	.274	.602
EMBU-C- Parent-Rejection	363.378	1	363.378	4.332	.041
EMBU-C- Parent-Overprotection	5.395	1	5.395	.064	.801
EMBU-C- Parent-Favouring Subject	8.254	1	8.254	.098	.755
EMBU-C-Child-Emotional Warmth	727.639	1	727.639	8.675	.004
EMBU-C-Child-Rejection	29.039	1	29.039	.346	.558
EMBU-C-Child-Overprotection	62.512	1	62.512	.745	.391
EMBU-C-Child-Favouring Subject	125.671	1	125.671	1.498	.225
Parental Stress Index total score	148.956	1	148.956	1.776	.187
General Health Questionnaire	10.895	1	10.895	.130	.720

6.2.1.2 Exposure to trauma measured as a category (any exposure vs. no exposure)

In the next step, the ET total scores were replaced by a dichotomous variable: whether or not the child had been exposed to any trauma (ET groups). The findings with SP-Child scores as the dependent variable are presented in Table 6.4. Age ($F=39.94$, $p=000$), lack of EMBU-C-Child-Emotional Warmth ($F=14.01$, $p=000$) and PSI-total scores ($F=4.05$, $p=048$) again significantly contributed to the association with total SP scores. The ANCOVA was repeated with significant variables and ET group status. Parameter estimates (Table 6.5) show that exposure to any trauma was significant ($p<0.05$), in addition to the previous variables (age, EMBU-C-Child-Emotional Warmth and PSI total score), in predicting SP scores. Table 6.6, using the estimated marginal means test, also shows the significant difference in SP scores depending on whether the child had been exposed to any trauma. This analysis suggests that although the severity of trauma was not found to predict social phobia symptoms, exposure to trauma made some contribution, together with the child's age, parental lack of warmth and parental stress.

Table 6.4: ANCOVA between groups of any or no exposure to trauma, SP-Child score covariates

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Gender	16.816	1	16.816	.162	.688
Age	4135.601	1	4135.601	39.938	.000
Standard of living for the family	.850	1	.850	.008	.928
EMBU-C-Parent-Emotional Warmth	27.830	1	27.830	.269	.606
EMBU-C- Parent-Rejection	122.139	1	122.139	1.180	.281
EMBU-C- Parent-Overprotection	28.317	1	28.317	.273	.603
EMBU-C- Parent-Favouring Subject	13.780	1	13.780	.133	.716
EMBU-C-Child-Emotional Warmth	1450.595	1	1450.595	14.008	.000
EMBU-C-Child-Rejection	.222	1	.222	.002	.963
EMBU-C-Child-Overprotection	16.493	1	16.493	.159	.691
EMBU-C-Child-Favouring Subject	15.217	1	15.217	.147	.703
ET group status	284.612	1	284.612	2.749	.102
Parental Stress Index total score	418.998	1	418.998	4.046	.048
General Health Questionnaire	47.781	1	47.781	.461	.499

Table 6.5: Parameter estimates of model including exposure to any trauma

Parameter	B	Std. Error	t	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
[Without Trauma=.00]	-5.743	2.855	-2.012	.047	-11.421	-.066
[With Trauma=1.00]	0a	.	.	.	.	.
Age	2.811	.417	6.745	.000	1.982	3.640
EMBU-C-Child-Emotional Warmth	-.377	.077	-4.909	.000	-.529	-.224
Parental Stress Index total score	.163	.076	2.161	.034	.013	.314

Table 6.6: Estimated marginal means test on social phobia scores between groups of any or no exposure to trauma

Exposure to trauma category	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Any exposure to trauma	18.90 2 ^a	2.617	13.697	24.107
No exposure to trauma	24.64 5 ^a	1.125	22.408	26.882

Table 6.7 shows that two of the above variables were significantly associated with SP-Parent scores, i.e. age ($F=55.18$, $p=000$) and lack of EMBU-C-Child-Emotional Warmth ($F=10.25$, $p=002$).

Table 6.7: ANCOVA between groups of any or no exposure to trauma, SP-Parent scores covariates

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Gender	2.154	1	2.154	.026	.873
Age	4593.066	1	4593.066	55.183	.000
Standard of living for the family	.034	1	.034	.000	.984
EMBU-C-Parent-Emotional Warmth	34.876	1	34.876	.419	.519
EMBU-C- Parent-Rejection	251.488	1	251.488	3.021	.086
EMBU-C- Parent-Overprotection	18.182	1	18.182	.218	.642
EMBU-C- Parent-Favouring Subject	11.047	1	11.047	.133	.717
EMBU-C-Child-Emotional Warmth	853.495	1	853.495	10.254	.002
EMBU-C-Child-Rejection	48.947	1	48.947	.588	.446
EMBU-C-Child-Overprotection	30.984	1	30.984	.372	.544
EMBU-C-Child-Favouring Subject	109.292	1	109.292	1.313	.256
ET group status	63.560	1	63.560	.764	.385
Parental Stress Index total score	140.726	1	140.726	1.691	.198
General Health Questionnaire	5.295	1	5.295	.064	.802

Although the PSI total scores were not significant in this model, the analysis was repeated with PSI total scores being replaced by PSI subscales scores. Table 6.8 shows that PSI-Parental Distress ($F=11.12$, $p=001$) was significantly associated with SP scores.

Table 6.8: ANCOVA between SP-Parent include groups of any or no exposure to trauma and PSI subscales

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Gender	.248	1	.248	.003	.953
Age	4058.054	1	4058.054	56.679	.000
Standard of living for the family	2.870	1	2.870	.040	.842
EMBU-C-Parent-Emotional Warmth	22.285	1	22.285	.311	.579
EMBU-C- Parent-Rejection	245.144	1	245.144	3.424	.068
EMBU-C- Parent-Overprotection	20.829	1	20.829	.291	.591
EMBU-C- Parent-Favouring Subject	106.135	1	106.135	1.482	.227
EMBU-C-Child-Emotional Warmth	668.062	1	668.062	9.331	.003
EMBU-C-Child-Rejection	11.861	1	11.861	.166	.685
EMBU-C-Child-Overprotection	11.624	1	11.624	.162	.688
EMBU-C-Child-Favouring Subject	300.977	1	300.977	4.204	.044
ET group status	48.546	1	48.546	.678	.413
PSI-Parental Distress	796.119	1	796.119	11.119	.001
PSI-Parent-Child Dysfunctional Interaction	94.479	1	94.479	1.320	.255
PSI-Difficult Child	64.624	1	64.624	.903	.345
General Health Questionnaire	8.160	1	8.160	.114	.737

6.2.1.3 Exposure to different types of trauma (ET subscales category)

At the last step of this analysis, exposure to trauma was measured by ET subscales scores. Table 6.9 shows that age ($F=36.36$, $p=000$), lack of EMBU-C-Child-Emotional Warmth ($F=12.81$, $p=000$), PSI total score ($F=4.70$, $p=034$) and ET-Subscale-Loss ($F=4.97$, $p=029$) all contributed significantly to the prediction of SP symptoms.

The ANCOVA was repeated with significant variables and ET subscales scores. Parameter estimates (Table 6.10) show that these variables remained significant. In contrast, Table 6.11 shows that the loss item had significantly differentiated SP-Child scores, but in the opposite direction than expected, which casts doubts on the validity of the item, or this could be a random finding.

Table 6.9: ANCOVA between ET subscales scores, SP-Child scores covariates

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Gender	2.206	1	2.206	.021	.885
Age	3808.684	1	3808.684	36.357	.000
Standard of living for the family	14.196	1	14.196	.136	.714
EMBU-C-Parent-Emotional Warmth	50.070	1	50.070	.478	.492
EMBU-C- Parent-Rejection	266.600	1	266.600	2.545	.115
EMBU-C- Parent-Overprotection	31.424	1	31.424	.300	.586
EMBU-C- Parent-Favouring Subject	.297	1	.297	.003	.958
EMBU-C-Child-Emotional Warmth	1342.426	1	1342.426	12.815	.001
EMBU-C-Child-Rejection	7.481	1	7.481	.071	.790
EMBU-C-Child-Overprotection	.331	1	.331	.003	.955
EMBU-C-Child-Favouring Subject	11.909	1	11.909	.114	.737
Parental Stress Index total score	492.742	1	492.742	4.704	.034
General Health Questionnaire	52.376	1	52.376	.500	.482
ET-Subscale-Family problems	22.115	1	22.115	.211	.647
ET-Subscale-Violence/Abuse	12.331	1	12.331	.118	.733
ET-Subscale-Illness/Death	7.433	1	7.433	.071	.791
ET-Subscale-Accident/Disasters	.155	1	.155	.001	.969
ET-Subscale-Peers relationships	106.202	1	106.202	1.014	.318
ET-Subscale-Loss	520.773	1	520.773	4.971	.029

Table 6.10: Parameter estimates of the model, including ET subscales scores

Parameter	B	Std. Error	t	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Age	3.015	.414	7.278	.000	2.191	3.839
EMBU-C-Child-Emotional Warmth	-.378	.076	-4.958	.000	-.529	-.226
PSI total score	.173	.075	2.306	.024	.024	.322
[without loss=.00]	22.617	9.788	2.311	.023	3.151	42.082
[with loss=1.00]	0 ^a	.	.	.	.	.

Table 6.11: Estimated marginal means test comparison of children who had experienced loss or not on SP scores

ET-Subscale-Loss	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Without loss	23.996 ^a	1.030	21.948	26.043
With loss	1.379 ^a	9.732	-17.975	20.733

In addition, Table 6.13 shows that age ($F=44.14$, $p=000$), EMBU-C-Parent-Rejection ($F=4.42$, $p=039$) and lack of EMBU-C-Child-Emotional Warmth ($F=7.15$, $p=009$) contributed significantly to the prediction of SP-Parent scores.

Table 6.12: ANCOVA between ET subscales scores, SP-Parent scores covariates

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Gender	46.549	1	46.549	.543	.464
Age	3782.368	1	3782.368	44.145	.000
Standard of living for the family	7.036	1	7.036	.082	.775
EMBU-C-Parent-Emotional Warmth	50.694	1	50.694	.592	.444
EMBU-C- Parent-Rejection	378.899	1	378.899	4.422	.039
EMBU-C- Parent-Overprotection	6.219	1	6.219	.073	.788
EMBU-C- Parent-Favouring Subject	1.536	1	1.536	.018	.894
EMBU-C-Child-Emotional Warmth	612.300	1	612.300	7.146	.009
EMBU-C-Child-Rejection	11.280	1	11.280	.132	.718
EMBU-C-Child-Overprotection	86.868	1	86.868	1.014	.318
EMBU-C-Child-Favouring Subject	93.537	1	93.537	1.092	.300
ET-Subscale-Family problems	30.501	1	30.501	.356	.553
ET-Subscale-Violence/Abuse	10.044	1	10.044	.117	.733
ET-Subscale-Illness/Death	42.885	1	42.885	.501	.482
ET-Subscale-Accident/Disasters	.836	1	.836	.010	.922
ET-Subscale-Peers relationships	19.492	1	19.492	.228	.635
ET-Subscale-Loss	203.768	1	203.768	2.378	.128
Parental Stress Index total score	144.834	1	144.834	1.690	.198
General Health Questionnaire	9.456	1	9.456	.110	.741

In the above analysis, PSI total scores were not significantly associated with SP scores. When tests were replaced with PSI subscales scores, Table 6.13 shows that age ($F=47.77$, $p=000$), EMBU-C- Parent-Rejection ($F=4.35$, $p=041$), lack of EMBU-C-Child-Emotional Warmth ($F=6.40$, $p=014$) and PSI-Parental Distress ($F=11.93$, $p=001$) contributed significantly to the prediction of SP scores.

Table 6.13: ANCOVA between ET subscales scores, SP-Parent scores covariates and PSI subscales

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Gender	28.852	1	28.852	.393	.533
Age	3506.760	1	3506.760	47.766	.000
Standard of living for the family	30.147	1	30.147	.411	.524
EMBU-C-Parent-Emotional Warmth	16.804	1	16.804	.229	.634
EMBU-C- Parent-Rejection	319.101	1	319.101	4.347	.041
EMBU-C- Parent-Overprotection	3.484	1	3.484	.047	.828
EMBU-C- Parent-Favouring Subject	37.390	1	37.390	.509	.478
EMBU-C-Child-Emotional Warmth	470.253	1	470.253	6.405	.014
EMBU-C-Child-Rejection	1.664	1	1.664	.023	.881
EMBU-C-Child-Overprotection	42.260	1	42.260	.576	.451
EMBU-C-Child-Favouring Subject	274.562	1	274.562	3.740	.057
ET-Subscale-Family problems	19.553	1	19.553	.266	.608
ET-Subscale-Violence/Abuse	62.861	1	62.861	.856	.358
ET-Subscale-Illness/Death	126.394	1	126.394	1.722	.194
ET-Subscale-Accident/Disasters	.423	1	.423	.006	.940
ET-Subscale-Peers relationships	9.271	1	9.271	.126	.723
ET-Subscale-Loss	99.377	1	99.377	1.354	.249
PSI-Parental Distress	875.961	1	875.961	11.932	.001
PSI-Parent-Child Dysfunctional Interaction	130.754	1	130.754	1.781	.187
PSI-Difficult Child	49.206	1	49.206	.670	.416
General Health Questionnaire	15.873	1	15.873	.216	.643

6.2.2 Multivariate models with other child mental health measure scores as the dependent variables

Similar procedures of statistical analysis were carried out for the remaining child mental health outcomes. The key findings are summarised below.

6.2.2.1 Impact of Event Scale

The child's age ($F=7.55$, $p=008$) and ET-total score ($F=39.98$, $p=000$) were significantly associated with IES-Parent scores. When ET total scores were replaced by any exposure vs. no exposure to trauma, age ($F=12.87$, $p=001$), EMBU-C-Child-Rejection ($F=5.29$, $p=024$) and ET group status ($F=17.42$, $p=000$) contributed significantly to the prediction of IES-Parent scores. The

group exposed to trauma had significantly higher mean IES scores than the group not exposed to trauma ($p=000$). When exposure to trauma was measured according to ET subscales, ET-Subscale-Family Problems ($F=15.45$, $p=000$), ET-Subscale-Violence or Abuse ($F=17.23$, $p=000$) and ET-Subscale-Illness/Death ($F=4.64$, $p=035$) were associated significantly with IES-Parent scores. The groups exposed to specific types of trauma also had significantly higher IES scores than the respective groups without subscales trauma.

The child's age ($F=8.96$, $p=004$), EMBU-C-Child-Favouring Subject ($F=5.94$, $p=017$), GHQ total scores ($F=4.50$, $p=037$) and ET total scores ($F=5.96$, $p=000$) were significantly associated with IES-Child scores. When ET total scores were replaced by ET group status, age ($F=13.87$, $p=000$), lack of EMBU-C-Child-Emotional Warmth ($F=5.20$, $p=026$), EMBU-C-Child-Rejection ($F=7.20$, $p=009$), EMBU-C-Child-Favouring Subject ($F=8.16$, $p=006$) and exposure to any trauma ($F=23.62$, $p=000$) contributed significantly to the prediction of IES-Child scores. The analysis was repeated for the ET subscales. GHQ total ($F=7.02$, $p=010$), ET-Subscale-Family Problems ($F=18.29$, $p=000$), ET-Subscale-Violence or Abuse ($F=30.31$, $p=000$) and ET-Subscale-Illness or Death ($F=6.27$, $p=015$) were significantly associated with IES-Child scores. The groups exposed to a specific type of trauma also had significantly higher IES scores than the respective groups without subscales trauma.

6.2.2.2 Revised Children's Manifest Anxiety Scale

RCMAS scores were predicted only by the child's age, irrespective of how exposure to trauma was measured; for example, for ET total scores, the contribution of age was $F=5.69$, $p=020$.

6.2.2.3 Children's Depression Inventory

The child's age ($F=6.84$, $p=011$) and lack of EMBU-C-Parent-Emotional Warmth ($F=7.93$, $p=006$) were significantly associated with CDI-Parent scores, when ET was measured by total scores. These variables remained significant when ET was included as a category.

Furthermore, only the child's age ($F=4.35$, $p=041$) was significantly associated with CDI-Child scores, when ET was measured by total scores. ET group status age ($F=5.60$, $p=021$), EMBU-C-Parent-Favouring Subject ($F=8.74$, $p=004$) and GHQ total scores ($F=4.17$, $p=045$) contributed significantly to the prediction of CDI-Child scores. When ET was measured by ET subscales, EMBU-C-Parent-Favouring Subject ($F=6.87$, $p=011$) and GHQ total scores ($F=4.31$, $p=042$) were significantly associated with CDI-Child scores.

6.2.2.4 Strengths and Difficulties Questionnaire

The child's age was significantly associated with SDQ-Parent scores ($F=5.65$, $p=020$), with ET measured as total score. This was the only significant predictor, irrespective of how ET was measured, and remained significant for SDQ-Child scores.

6.3 Summary of key findings

This section summarizes the key findings reported above in relation to social phobia, PTSD and the remaining types of child psychopathology. These results indicate that the child's increasing age, lack of parental warmth and parental stress were related to social phobia symptoms. In contrast, the results did not demonstrate any differences according to the family standard of living and children's gender. Exposure to trauma had a strong association with PTSD symptoms, which, as in previous studies, indicated a dose-effect relationship. Parental rearing (lack of parental warmth, rejection and favouring subject) and mental health contributed to this model. The child's increasing age was the only significant predictor of anxiety and overall mental health problems. The same variables, as well as lack of parental warmth, were significantly associated with depressive symptoms. Once more, the family standard of living and children's gender were not associated with this type of psychopathology.

Table 6.14: Key findings

	Psychopathology	Significantly associated variables
1	Social phobia	Age, lack of parental warmth, parental stress
2	PTSD	Age, parental rearing style, exposure to and severity of trauma, parental mental health problems
3	Anxiety	Age
4	Depression	Age, lack of parental warmth
5	Overall mental health problems	Age

Chapter Seven

Discussion

7.1 Introduction

This chapter presents a critical overview of the findings by revisiting the research hypotheses, and then discusses their methodological and clinical implications. The researcher's reflections on the research process are followed by conclusions drawn from the study.

7.2 Critical overview of findings

The findings of this study indicate that, although the extent of exposure to trauma is not directly associated with social phobia symptoms, it can act as a risk factor in conjunction with the child's age, parental stress and reduced emotional warmth, which all contributed to the model. These findings partially support the research hypothesis. In other words, exposure to any trauma was significantly associated with social phobic disorder, although no dose effect was established. This supports an earlier finding by Alnaes and Torgersen (1988) that exposure to trauma in childhood is not directly linked with social phobia, although this study concentrated on stressful events such as loss of family members and financial problems. The findings are not, however, consistent with studies which have indicated a direct relationship between exposure to trauma and emotional disorders in general, nor with those suggesting that trauma may escalate into a clinically significant form of emotional disorder. It is also worth noting that these studies, unlike the present research, did not focus on social phobia as a separate condition, but rather targeted the entire group of emotional disorders; nor did they aim to establish an explanatory mechanism to account for the assumed link between social phobia and exposure to trauma (Brozovich

& Heimberg, 2011; Erwin, Heimberg, Marx, & Franklin, 2006; Manfro et al., 2003; Meiser-Stedman, Smith, Glucksman, Yule, & Dalgleish, 2007). In addition, the results did not indicate any differences according to the socioeconomic status of the family or according to the child's gender.

In contrast, the association between level of exposure to trauma and PTSD symptoms is compatible with previous studies that established such a dose effect (Beech & Leather, 2006; N. Breslau, 2009; Flannery, 2004; Ryan et al., 2008; Wykes & Whittington, 1998). The current findings suggest that the likelihood of exhibiting PTSD symptoms increased in the presence of a history of trauma,, particularly if parents had mental health problems and a negative parental rearing style.

The bivariate correlations revealed significant associations of two types of traumatic events, namely exposure to family problems and violence or abuse, with both anxiety and overall mental health problems, which is in line with findings reported in the literature (Catani, Jacob, Schauer, Kohila, & Neuner, 2008; Hovens et al., 2010; Spinhoven et al., 2010; Thabet et al., 2008). However, in the multivariate analyses that followed, specific mental health problems and anxiety in children were significantly predicted only by the child's age, but not by either type of trauma or other sociodemographic variables such as gender or family standard of living.

Regarding depression, multivariate regression indicated that symptoms could be predicted by the child's increasing age, parental rearing style and parental

mental health problems. This finding may be explained by older children, given their cognitive capacity, being able to recognise that they are being viewed negatively by their parents, which in turn may result in exhibiting depressive manifestations (e.g. low self-esteem). In addition, parents with mental health problems are less likely to identify this impact or to change their parental strategies, are therefore more likely to maintain this adverse interaction.

The first hypothesis of this study, that exposure to trauma is significantly associated with emotional disorders, is thus supported by the findings. The second, that exposure to trauma is also significantly associated with social phobic disorders, is partially supported, as already discussed, in that exposure to trauma had some effect but there was no linear association with its severity. The third hypothesis, that the association between exposure to trauma and social phobic disorders is mediated by parental responses, specifically by parents' own anxiety levels, is partially supported, as parental stress and lack of emotional warmth, but not parental anxiety or other mental health problems, were found to contribute to this association.

7.3 Methodological implications

This section discusses in greater depth the essential methodological issues and implications of this study.

7.3.1 Sample

Sample size and representativeness are important issues in scientific research. The researcher considered several alternatives in recruiting the sample, one of

which was to select the participants from schools. This design would have had the advantages of recruiting a large sample size with varied demographic characteristics, and would have required fewer resources than the strategy of identifying clinical cases. Nevertheless, such a design would also have had drawbacks, the most notable one being that, in order to select participants with diagnosable conditions, it would have been necessary to start by screening quite a large population, whereas the choice of a clinical sample offered the relative clinical homogeneity of symptoms and diagnoses. The present study therefore opted for a clinical sample, as this was more closely matched to the aims and hypotheses of the research.

As explained in chapter three, the researcher estimated that approximately 30 children daily attended psychiatric clinics in the main Riyadh hospitals as out-patients. Three major Riyadh hospitals were approached to select nominated participants. Power calculation software was used to determine the sample size required (Fritz & MacKinnon, 2007; Naing, Winn, & Rusli, 2006). Based on the literature discussed in chapters one and two, it was estimated that the sample size should range between 30 and 132; thus the sample used, consisting of 89 children, was deemed sufficient. This final sample consisted of three subgroups with emotional disorders: PTSD, anxiety and social phobia.

A substantial proportion of families who fulfilled the selection criteria, as mentioned in chapter three, did not participate in the study ($n=70$, 32.26% of total sample). This attrition may have been due to a number of factors, of which the main one was living outside Riyadh city. One more reason may have been

the poor standards of literacy among these families. Another reason, which is culturally common, could be the passive way of declining to participate and/or returning the questionnaires, because of not wishing to refuse directly a request from someone of perceived higher status.

There is a possibility that some children suffered from phobic symptoms which prevented them from returning to the hospital. This could not be tested, because of the lack of information that would enable comparison with participating families, as those in the former group did not return the sociodemographic checklist. This was a limitation of the present study, which might be addressed in future research by administering all tools at the same time. However, drop-out from studies of this nature is a common constraint often encountered by researchers (Naing et al., 2006).

7.3.2 Measures

Saudi Arabia is a newly established state and going through a period of speedy development. Research is still relatively limited, with a lack of culturally appropriate instruments. A researcher must usually choose between developing a new instrument and using an existing one after considering its established psychometric properties. The second choice is often adopted, because it is more resource-effective and practical, and because it enables comparison with findings from different countries. Questionnaires are often translated based on assumptions of cultural transferability; it should not, however, be taken for granted that their items effectively represent the measured constructs in the concerned culture. This concern is of a psychometric nature, in light of the

indigenous measures in account (Allwood, 2011; Cheung & Leung, 1998). Psychological constructs vary between cultures, therefore measures translated from one language to another may not represent the targeted culture properly by missing important aspects. This does not necessarily invalidate the use of measures across different cultures. The current study used existing measures by following translation and back-translation guidelines to capture as many aspects that could be measured in the targeted culture, for the purpose of the research. Maintaining the original content of the measure was also important in enabling comparison with previous studies.

The present study used a semi-structured interview tool, the Kiddie Schedule of Affective Disorders and Schizophrenia for School-Age Children (6-18) years (K-SADS-IVR), which was updated by Ambrosini and Dixon (2000) to make it compatible with DSM-IV criteria. After the researcher had used the emotional disorders section of the K-SADS that had been translated into Arabic, many members of hospital staff expressed the wish to use it as a diagnostic interview in their clinical practice.

The remaining instruments were self-administrated. All of them had previously been widely used and translated into Arabic, except the Parenting Rearing Style (EMBU-C), which had not been previously used with an Arabic-speaking sample. Instruments which have been evaluated in developing countries, have been translated into various languages and are of low cost are particularly useful for the general population, as well as for clinical studies. Despite these advantages, such instruments need further psychometric investigation if they

are to be used for clinical purposes such as monitoring symptoms, rather than in research. Overall, measures used in this study were found to be of satisfactory psychometric suitability, as shown in chapter four.

As discussed in detail in chapter three, the researcher developed the social phobia and exposure to trauma instruments himself, both because of the lack of available tools with appropriate psychometric properties and because the constructs in existing instruments were not applicable to Saudi families. Preliminary evaluation of the new instruments was encouraging. For instance, they exhibited good reliability, as assessed by alpha values, and satisfactory internal validity. Nevertheless, more research is needed to revise them and to further establish their validity and reliability by re-testing them in larger clinical and non-clinical samples, in order to explore their factorial structure in more depth and to contrast their properties with those of established tools.

7.3.3 Cultural issues

The Saudi society is collectively characterized by a number of distinct features. Among these are close family relationships and a tendency to attribute events to external (i.e. not related to oneself) rather than internal causes, which is widely referred to as 'external attribution'. Another common characteristic is the wide use of directive parental rearing practices. These features may be attributed to the deeply collectivist nature of this culture as opposed to the more distant and individualist ones found elsewhere. It is suggested that the use of external attribution, for instance, is consistent with the features of collectivism, as it implies that one is not fully responsible for one's behaviour and that there are

'uncontrolled' causes which contribute to it (Barrett, 1997; Berry, Phinney, Sam, & Vedder, 2006; Triandis, 1980).

Perceptions of mental health problems may be different from those in western societies. In terms of their origins and causes, concepts like 'devil eye' or 'spirit possession' are usually considered to constitute valid explanations when trying to make sense of psychological disorders (Alanazi, 2001). Hence, religious and traditional healers are usually first approached to seek treatment, while evidence-based mental health services remain the last treatment option (M. A. Dwairy, 1998; Lin & Church, 2004).

This particular manifestation applies to almost all psychological disorders, including social phobia, which may also be subjected to cultural factors that impact upon its definition and treatment. In the context of strong ties with one's reference group through obedience and societal norms, behaviours associated with social phobia such as avoidance are likely to be found socially 'appropriate' in the Saudi society. In fact, shyness is encouraged, especially in young females, as a sign that a girl is 'good' (M. A. Dwairy, 1998; Nobles & Sciarra, 2000).

Results presented in the previous chapters may be understood in the light of these cultural characteristics. For instance, an association was found between social phobia and lack of emotional warmth from the parents. Parents represent the first and the most influential link with the wider community, so the child may perceive a dysfunctional relationship within the family such as a lack of

emotional warmth as an indicator of his/her own weakness, a perception which may be responsible for developing, exacerbating and maintaining the symptoms. However, while the results may be consistent with this explanation, the cross-sectional design used in this research does not enable this model to be tested. Therefore, longitudinal studies would be useful in understanding the reasons for these contacts.

In addition to social learning, the relationship between parental stress and social phobia may also have a genetic underpinning; in other words, it may provide support for the role of inheritance in the development of social phobia. It could also be viewed from a socio-cultural perspective: individuals from collectivist backgrounds often consider their parents as role models, so parents' mental health is likely to be reflected in the children through the socializing processes (Triandis & Suh, 2002). Socio-economic status can be understood as the position of individuals along a level of economic, political, or cultural attributes (e.g. income, educational achievement, occupational prestige). Several studies found that low socio-economic status was correlated with child psychopathology. In other words, a high-level of socio-economic status hypothesis predicted lower rates of mental disorders because of associated protective factors (Patel, Knapp, Henderson, & Baldwin, 2002; Wohlfarth, Winkel, Ybema, & van den Brink, 2001). In this study no differences were found according to the socioeconomic level of the family in relation to child psychopathology. Nevertheless, the literature on socio-economic factors and child mental health problems suggests that these mechanisms should be investigated in more depth for children with social phobia.

7.3.4 Ethics

Even with the increase of research demand in Saudi Arabia, incorporating research ethics into clinical and academic institutions is still growing. Each recruiting hospital had its own procedure in obtaining ethical approval. However, they all shared the same basic ethical principles, and also remarkable similarities in procedures. Participants were provided with information about the study and what this involved prior to taking part. If they expressed an interest, verbal and written consent were obtained from children and their parents. Due to lack of familiarity with this procedure, some parents preferred for the consent form to be read to them.

Based on observations made while collecting data for the present research, a number of recommendations to improve research ethics in Saudi Arabia in particular, and in other countries in general, can be put forward. First, it is important to establish a general research ethics council, which should aim to develop a background framework of ethical principles, to work as an advisory body for on-going and future research, and to monitor research ethics applications in the country. Second, it is suggested that research ethics be further incorporated into University courses, especially those related to research methods and those delivered to postgraduate students. Finally, it is also of importance that research funding panels consider ethical issues and obligations as an integral part of their decision-making process.

7.3.5 Statistical analysis

Two options were considered regarding the statistical analysis, depending on how exposures to trauma scores were dealt with when looking at their relationships with the five psychopathology outcomes. Both total scores and subscales of the psychopathology measures were initially considered. In the first option, exposure to trauma was studied as a continuous variable, at the levels of items, factors (subscales) and total scores. The second option, in contrast, involved the measurement of exposure to trauma as a dichotomous variable (with or without trauma).

Data was analysed following both these options. However, it was decided to adopt and report findings predominantly according to the second option, for several reasons. Results of the first option were complicated and difficult to explain, because of the large number of variables (i.e. individual items) involved. Second, it was observed from analysing the individual items that they tended to show similar relationships with psychopathology variables. Such a repetition of results would not have added to our knowledge. Finally, findings based on the second approach were very similar, if not identical, to those from the first option, but with a smaller number of variables, and were therefore preferable for reasons of parsimony.

7.4 Methodological strengths and limitations

A strength of this study was the selection of the sample from the main hospitals in Riyadh, which provide services for most psychiatric conditions and have

specialists in child mental health. The sample size was compatible with that of clinical samples in similar previous studies, as reviewed earlier in this thesis. Besides, this study managed to recruit a clinical sample of children with social phobia, although this disorder is not a prevalent one. It also collected data on three types of emotional disorders, in which psychiatric diagnoses were independently established using the K-SADS tool. Finally, families who took part returned all measures of an extensive instrument pack.

It is worth mentioning that most instruments were being used with a Saudi or Arab sample for the first time. While this element of novelty is a strength, introducing a new instrument to this culture could also be seen as a limitation, as no norms were available for these measures. Finally, to the researcher's knowledge, no studies have so far investigated the association between exposure to trauma and social phobia in Saudi Arabia.

Regarding the limitations, one was the attrition rate of participants. Patients with social phobia are not easy to recruit and it is difficult to encourage them to participate in a multi-stage study, even if they initially provide consent. Information was not collected on families who withdrew from the study; therefore, it was not possible to compare them with the participating group. In addition, it was not specified whether the instruments were completed by the mother or father. It would have been useful to have collected more in depth data on the characteristics of the sample, and to have explored their relationship with the outcome measures.

Another limitation concerned the representatives of the sample of Saudi patients. Although it is hard to conclude that the sample truly represented the target population, several indicators may help to evaluate the extent to which it did so. The three hospitals provide the main mental health services in Riyadh, as they receive most psychiatric referrals from general practitioners and state hospitals, as well as from other Saudi hospitals outside Riyadh (Al Zahrani, 2007). Riyadh, where these three hospitals are located, is the capital and largest city of Saudi Arabia, with residents originating from all parts of the country. The research sample recruited participants from different categories of the Saudi society, i.e. from rural, urban and Bedouin groups, and from different socio economic and educational strata. Data was collected over a six-month period, which captured the clinical population of these services.

The emotional disorders measured by the K-SADS consist of avoidance, generalized anxiety, overanxious disorder, separation anxiety, obsessive-compulsive disorder, simple phobia, social phobia, panic disorder and post-traumatic stress disorder. The current research focused on the main types of anxiety, social phobia and PTSD, because of symptomatic overlap between different anxiety and phobic disorders. Post-traumatic stress disorder was included because of its association with different types of trauma (human or nature induced), which has been strongly evidenced by previous research and was replicated by this study. The aim of selecting these three diagnostic groups was to establish whether there were differences in the impact of trauma on child psychopathology, rather than to examine diagnostic presentations in detail. The

study was based on children and their parents, whose reports were not corroborated with those of clinicians or teachers.

Finally, it should be mentioned that the process of devising two measures for the purpose of this research had some limitations, covered in more detail in the measures section above. Briefly, these included the lack of external criteria to validate the newly devised measures, and the sample size employed in checking their psychometric suitability.

7.5 Practice and service implications

The objectives of research are to identify problems and to initiate solutions. This applies to the findings of this study, which has potential clinical implications at three levels: prevention, treatment and clinical training.

In terms of prevention services that target high-risk populations, the study identified the origin of the hazard: children exposed to trauma are at particular risk of developing social phobia and other emotional disorders. The risk is compounded by lack of parental warmth and high parental stress levels. Recognition of these factors and identification of vulnerable children is thus important for parents, teachers, social workers, GPs and other frontline practitioners in contact with children.

In addition, primary prevention through the modification of parental rearing styles might decrease the likelihood of developing clinical symptoms. The influence of parental style begins early, so early intervention is essential

(Landry, Smith, & Swank, 2006; Landry, Smith, Swank, & Guttentag, 2008). Parenting programmes can provide modelling and education (Barlow & Start, 2007; Goodson, 2007). Such programmes can be complemented by school-based interventions to lessen the impact of abuse or aggressive behaviour and to increase self-esteem among schoolchildren at risk (Cunningham, Bremner, & Boyle, 1995; Weissberg, Kumpfer, & Seligman, 2003).

For children who have already developed a disorder (secondary prevention), those planning psychological interventions should consider addressing these factors if they are to be effective in cases of exposure to trauma. Providing affected children with cognitive-behavioural therapy skills within schools would reduce worries, fears of negative evaluation by others, and cognitive bias. The effectiveness of these skills has been indicated in treatment studies of social phobia, specifically for children and young people with these cognitive distortions (Spence et al., 2000). It is also worth mentioning that clinicians should pay more attention to the psycho-social factors that might be involved in developing or maintaining this condition. A treatment plan that takes into account both biological and psycho-social aspects of the disorder is more likely to be beneficial (Beidel, Turner, & Association, 2007; Geist, Grdisa, & Otley, 2003).

In order for both primary and secondary prevention approaches to be effective, it is important that all professionals interacting with children have adequate skills in understanding the developmental and psychological nature of this group. In particular, teachers should receive extensive training in detecting children at risk

of mental health problems, managing the less complex cases, and referring children with more severe needs to appropriate services. This should be incorporated into good-practice guidelines. Besides, well-designed workshops for parents might increase their awareness of mental health conditions in general and social phobia in particular, thus helping to reduce the number of children being referred to specialist mental health services.

It appears plausible to suggest that service protocols developed originally in individualist societies would also be useful in collectivist societies. Some adjustment would help improve knowledge, and take into account the specific aspects of the new cultures, such as by involving the external appraisal alongside internal processes and the use of self-report questionnaires to detect child at risk of developing the clinical threshold of the disorder. This would help to reduce the costs of health care in the context of limited financial resources in many countries. Health economic evaluation would be important in determining the cost-effectiveness of such protocols and service models.

7.6 Research implications

Investigating a condition like social phobia requires multi-stage recruitment, accumulation of data, development of expertise, and establishment of links with schools and specialist mental health services. As social phobia is often comorbid with other anxiety disorders, depression, or both, it is even more difficult to study (APA, 2000; Van Ameringen, Mancini, Styan, & Donison, 1991). Research into this disorder would thus be more feasible within an academic institution that has an established ongoing programme of research in this field.

In investigating this condition, a longitudinal research design would be more useful; tracking high-risk individuals over a long period would help to identify aetiological factors. It is highly recommended for future studies to attempt to approach social phobia in relation to other relevant factors longitudinally. Such a design would facilitate the better understanding of mechanisms that underpin the association between trauma, other risk factors and social phobia. The investigation of these complex and dynamic relationships would promote knowledge of their causal contribution, by exploring how they interact and co-vary over time.

Such a longitudinal investigation of the development of social phobia should approach the relationship between parenting style variables and social phobia, and should address all significant factors, including family processes. Other important factors are traumatic conditioning, social skills deficits and early attachment. Methods of direct observation, self- and parent-rated reports, including measurement of child rearing practice, would complement such a longitudinal design in providing different perspectives on trauma, other risk factors and symptoms. Considering additional types of trauma to those assessed in the current study would be helpful. It would be particularly valuable for future research to explore which traumatic events are most prevalent in the Saudi culture. This would clearly enhance the quality of the research, as well as inform clinical interventions.

As mentioned in the previous section, those designing clinical interventions for this group should consider incorporating aspects of parental rearing. This might be constructed as a psycho-education component and delivered directly to parents and other caregivers. Such an intervention might also address parental mental health problems, as these are often associated with poor mental health in children (Coren & Barlow, 2001).

The findings of this study provide several opportunities for future research. Exploring the cross-cultural differences and similarities in the context of the measures translated into Arabic in this study would be important before these can be routinely used by services and researchers. This could be achieved at both item and total score levels. Another important study would be to explore whether the tendency to exaggerate among Saudi and/or Arab individuals, might increase vulnerability to SP within these societies; .and to examine how common this tendency also features in collectivist societies by using samples from representative collectivist and individualist societies .

7.7 Conclusions

The relationship between children's exposure to trauma and social phobia was investigated in this study. Based on responses gathered in the context of Saudi culture, it found evidence for a partial effect of trauma, mediated by parental rearing style (lack of emotional warmth) and parental stress, on the development of social phobia, an association which became more apparent with the increasing age of the affected children. The study also confirmed previous findings that exposure to trauma is a significant predictor of post-traumatic

stress disorder and that this association is also mediated by parenting factors. Children's age was found to play an important role in all types of psychopathology, as it also contributed to the prediction of anxiety, depression and general mental health problems.

The relationship between exposure to trauma and social phobia in childhood and young life was explored for the first time in a non-western cultural sample. Equally, applicable variables were derived from predominantly western countries to be tested in the context of the Saudi culture. As social phobia may share universal constructs across cultures, it would be interesting to investigate diagnostic similarities and differences in further cross-cultural research, particularly towards the revision of the major classification systems, ICD-11 and DSM-V. The further understanding of the mechanisms implicated in the development and maintenance of symptoms will inform interventions for children, young people and their families who are at risk of social phobia, or who have already developed impairing mental health presentations.

References

References

- Abbott, M. J., & Rapee, R. M. (2004). Post-event rumination and negative self-appraisal in social phobia before and after treatment. *Journal of Abnormal Psychology, 113*(1), 136.
- Abdel-Fattah, M. M., Asal, A., Al-Asmary, S. M., Al-Helali, N. S., Al-Jabban, T. M., & Arafa, M. A. (2004). Emotional and Behavioral Problems among Male Saudi Schoolchildren and Adolescents Prevalence and Risk Factors. *Ger J Psychiatr, 1*, 1-9.
- Abidin, R. (1995). Parenting stress index: Professional manual . Lutz, FL: Psychological Assessment Resources: Inc.
- Abolfotouh, M. A. (1997). Behaviour disorders among urban schoolboys in south-western Saudi Arabia. *Eastern Mediterranean health journal, 3*, 274-283.
- Abou, N. M. W., Fahmy, S., Younis, I., Seif, D. A. G., Abdel, F. M., Mokhtar, S., & Ayoub, A. (1991). A study of depression among Alexandria preparatory school adolescents. *The Journal of the Egyptian Public Health Association, 66*(5-6), 649.
- Abramsky, T., Watts, C., Garcia-Moreno, C., Devries, K., Kiss, L., Ellsberg, M., . . . Heise, L. (2011). What factors are associated with recent intimate partner violence? findings from the WHO multi-country study on women's health and domestic violence. *BMC Public Health, 11*(1), 109.

- Achenbach, T. (1991). *Child behavior checklist/4–18*. Burlington: University of Vermont.
- Ahmed M, A.-K., & Alansari, B. M. (2004). GENDER DIFFERENCES IN ANXIETY AMONG UNDERGRADUATES FROM TEN ARAB COUNTRIES. *Social Behavior and Personality: an international journal*, 32(7), 649-655. doi: 10.2224/sbp.2004.32.7.649
- Al-Ahmadi, H. (2011). Challenges facing women leaders in Saudi Arabia. *Human Resource Development International*, 14(2), 149-166.
- Al-Fakeeh, A. (1994). Adult male psychiatric morbidity among PHC attendants in Al-Khobar [Dissertation]. *King Faisal Univirsity*.
- Al-Faris, E., Al-Subaie, A., Khoja, T., Al-Ansary, L., Abdul-Raheem, F., Al-Hamdan, N., . . . Khwsky, F. E. (1997). Training primary health care physicians in Saudi Arabia to recognize psychiatric illness. *Acta Psychiatrica Scandinavica*, 96(6), 439-444.
- Al-Farsy, F. (1986). *Saudi Arabia: A Country Study in Development*: London: Kegan Paul.
- Al-Gelban, K. S. (2007). Depression, anxiety and stress among Saudi adolescent school boys. *The Journal of the Royal Society for the Promotion of Health*, 127(1), 33.
- Al-Haidar, F. A. (2003). Survey of inpatients child and adolescent psychiatric referrals in a teaching hospital in Saudi Arabia. *Neurosciences*, 8(1), 43-45.

- Al-Hemaidi, W. K. (2001). The metamorphosis of the urban fabric in Arab-Muslim City: Riyadh, Saudi Arabia. *Journal of Housing and the Built Environment*, 16(2), 179-201.
- Al-Khateeb, S. A. H. (2008). Women, Family and the Discovery of Oil in Saudi Arabia. *Marriage & Family Review*, 27(1-2), 167-189. doi: 10.1300/J002v27n01_11
- Al-Khodair, I., & Freeman, C. (1997). Social phobia in two cultures: cross cultural study of social phobia in Saudi Arabia and Scotland. *Saudi medical journal*, 18(2), 130-136.
- Al-Krenawi, A., & Graham, J. R. (2000). Culturally sensitive social work practice with Arab clients in mental health settings. *Health and Social Work*, 25(1), 9-22.
- Al-Rasheed, M. (2002). *A history of Saudi Arabia*: Cambridge Univ Pr.
- Al-Sadlaan, S. i. G. (1996). *Marital Discord (al-nushooz): Its Definition, Cases, Causes, Means of Protection from It, and Its Remedy from the Quran and Sunnah*: Al-Basheer Co. for Publications and Translations.
- Al-Saggaf, Y. (2004). The effect of online community on offline community in Saudi Arabia. *The Electronic Journal of Information Systems in Developing Countries*, 16.
- Al-Saud, M., A. A. (2000). *Child Abuse in Riyadh: Causes, Forms & Characteristics of Victims*. Cairo, Egyptian.

- Al-Zahrani, A. (2005). *Child Abuse and Neglect Its causes and consequences: In the Kingdom of Saudi Arabia*. (PhD), Edinburgh University
- Al-Khenaizan, S., Almuneef, M., & Kentab, O. (2005). Lichen sclerosus mistaken for child sexual abuse. *International journal of dermatology*, 44(4), 317-320.
- Al Ayed, I. H., Irfan Qureshi, M., Al Jarallah, A., & Al Saad, S. (1998). The spectrum of child abuse presenting to a university hospital in Riyadh. *Annals of Saudi medicine*, 18, 125-131.
- Al Eissa, M., & Almuneef, M. (2010). Child abuse and neglect in Saudi Arabia: Journey of recognition to implementation of national prevention strategies. *Child abuse & neglect*, 34(1), 28.
- Al Gelban, K. S. (2009). Prevalence of psychological symptoms in Saudi secondary school girls in Abha, Saudi Arabia. *Annals of Saudi medicine*, 29(4), 275.
- Al Zahrani, A. (2007). *Testing an Aetiological Model of Social Phobia: A Study in the Kingdom of Saudi Arabia*. (PhD), Curtin University of Technology, Australia.
- Alanazi, F. M. (2001). The Revised Self-Consciousness Scale: An assessment of factor structure, reliability, and gender differences in Saudi Arabia. *Social Behavior and Personality: an international journal*, 29(8), 763-776.
- Albano, A. M., & Kendall, P. C. (2002). Cognitive behavioural therapy for children and adolescents with anxiety disorders: clinical research

advances. *International Review of Psychiatry*, 14(2), 129-134. doi:
doi:10.1080/09540260220132644

Alessandri, S. M., & Lewis, M. (1993). Parental evaluation and its relation to shame and pride in young children. *Sex Roles*, 29(5), 335-343.

AlJasser, M., & Al-Khenaizan, S. (2008). Cutaneous mimickers of child abuse: a primer for pediatricians. *European journal of pediatrics*, 167(11), 1221-1230.

Allwood, C. M. (2011). On the foundation of the indigenous psychologies. *Social Epistemology*, 25(1), 3-14.

Almalki, M., FitzGerald, G., & Clark, M. (2011). The nursing profession in Saudi Arabia: An overview. *International Nursing Review*, 58(3), 304-311.

Almaqami, M. H., & Shuwail, A. Y. (2004). Validity of the self-report version of the strengths and difficulties questionnaire in Yemen. *Saudi medical journal*, 25(5), 592-601.

Almuneef, M. A., & Al Buhairan, F. M. (2012). Child Maltreatment Prevention Readiness Assessment Country Report: Saudi Arabia January 2012. *Child Maltreatment*, 11, 12.

Alnaes, R., & Torgersen, S. (1988). The relationship between DSM-III symptom disorders (Axis I) and personality disorders (Axis II) in an outpatient population. *Acta Psychiatrica Scandinavica*, 78(4), 485-492.

- Alyahri, A., & Goodman, R. (2006). Validation of the Arabic strengths and difficulties questionnaire and the development and well-being assessment. *Eastern Mediterranean health journal, 12*(2), S139.
- Ambrosini. (2000). Historical development and present status of the schedule for affective disorders and schizophrenia for school-age children (K-SADS). *Journal of the American Academy of Child & Adolescent Psychiatry, 39*(1), 49-58.
- Ambrosini, & Dixon, J. (2000). Schedule for affective disorders & schizophrenia for school age children (6-18 years)–Kiddie-SADS (KSADS)(present state and lifetime version) K-SADS-IVR (Revision of K-SADS-IIIR). *Unpublished manuscript, Eastern Pennsylvania Psychiatric Institute, Philadelphia, PA.*
- Ambrosini, Metz, C., Prabucki, K., & Lee, J. (1989). Videotape reliability of the third revised edition of the K-SADS. *Journal of the American Academy of Child & Adolescent Psychiatry, 28*(5), 723-728.
- Amdur, R. L., & Liberzon, I. (2001). The structure of posttraumatic stress disorder symptoms in combat veterans: A confirmatory factor analysis of the impact of event scale. *Journal of Anxiety Disorders, 15*(4), 345-357. doi: 10.1016/s0887-6185(01)00068-8
- Amies, P. L., Gelder, M. G., & Shaw, P. M. (1983). Social phobia: a comparative clinical study. *The British Journal of Psychiatry, 142*(2), 174-179. doi: 10.1192/bjp.142.2.174

- Anastasi, A., & Urbina, S. (1997). *Psychological testing*: Prentice Hall Upper Saddle River, NJ.
- Andrews, L., Shevlin, M., Troop, N., & Joseph, S. (2004). Multidimensionality of intrusion and avoidance: alternative factor models of the Impact of Event Scale. *Personality and Individual Differences*, 36(2), 431-446. doi: 10.1016/s0191-8869(03)00107-7
- Angst, J. (1993). Comorbidity of anxiety, phobia, compulsion and depression. *International clinical psychopharmacology*.
- Anthony, J. L., Lonigan, C. J., Vernberg, E. M., Greca, A. M. L., Silverman, W. K., & Prinstein, M. J. (2005). Multisample cross-validation of a model of childhood posttraumatic stress disorder symptomatology. *Journal of Traumatic Stress*, 18(6), 667-676.
- APA, A. P. A. (1987). Diagnostic and statistical manual of mental disorders (3rd, revised ed.).
- APA, A. P. A. (1994). Statistical Manual of Mental Disorders. *American Psychiatric Association, Washington, DC*.
- APA, A. P. A. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR*: American Psychiatric Publishing, Inc.
- Arafa, M., Al-Klmi, M., Hamdi, E., Yousseyria, A., El-Defrawi, & Moussa, F. A. (1992). Social Phobia in an Arab Culture: The Impact of Sociocultural Factors. *Psychiat*, 15(1), 102-113.

- Arbelle, S., Benjamin, J., Golin, M., Kremer, I., Belmaker, R. H., & Ebstein, R. P. (2003). Relation of shyness in grade school children to the genotype for the long form of the serotonin transporter promoter region polymorphism. *American Journal of Psychiatry, 160*(4), 671-676.
- Arcelus, J., Gale, F., & Vostanis, P. (2001). Characteristics of children and parents attending a British primary mental health service. *European child and adolescent psychiatry, 10*(1), 91-95.
- Arcelus, J., & Vostanis, P. (2003). Child psychiatric disorders among primary mental health service attenders. *The British Journal of General Practice, 53*(488), 214.
- Aroian, K. J., Norris, A. E., González de Chávez Fernández, M. A., & García Averasturi, L. M. (2008). Gender differences in psychological distress among Latin American immigrants to the Canary Islands. *Sex Roles, 59*(1), 107-118.
- Arrindell, Emmelkamp, P. M., Monsma, A., & Brilman, E. (1983). The role of perceived parental rearing practices in the aetiology of phobic disorders: a controlled study. *The British Journal of Psychiatry, 143*(2), 183-187. doi: 10.1192/bjp.143.2.183
- Arrindell, Kwee, M., Methorst, G., Van der Ende, J., Pol, E., & Moritz, B. (1989). Perceived parental rearing styles of agoraphobic and socially phobic in-patients. *The British Journal of Psychiatry, 155*(4), 526-535.

- Azar, M., & Badr, L. K. (2006). The adaptation of mothers of children with intellectual disability in Lebanon. *Journal of Transcultural Nursing, 17*(4), 375-380.
- Azar, M., & Badr, L. K. (2010). Predictors of coping in parents of children with an intellectual disability: comparison between Lebanese mothers and fathers. *Journal of Pediatric Nursing, 25*(1), 46-56.
- Baddam, J. P., Russell, S., & Russell, P. S. S. (2007). The Prevalence of Posttraumatic Stress Disorder Among Children and Adolescents Affected by Tsunami Disaster in Tamil Nadu. *Disaster management & response, 5*(1), 3-7.
- Banyard, V. L., Rozelle, D., & Englund, D. W. (2001). Parenting the traumatized child: Attending to the needs of nonoffending caregivers of traumatized children. *Psychotherapy: Theory, Research, Practice, Training, 38*(1), 74.
- Barenbaum, J., Ruchkin, V., & Schwab-Stone, M. (2004). The psychosocial aspects of children exposed to war: practice and policy initiatives. *Journal of Child Psychology and Psychiatry, 45*(1), 41-62.
- Barlow, J., & Start, B. C. N. E. o. S. (2007). *Family and parenting support in Sure Start local programmes*: DfES Publications.
- Barrett, R. J. (1997). Cultural Formulation of Psychiatric Diagnosis. *Culture, Medicine and Psychiatry, 21*(4), 481-496. doi: 10.1023/a:1005391212195

- Basaffar, A. A. (2012). Understanding the entrepreneurial potential of female Saudi Arabian family and consumer sciences students and businesswomen.
- Bassiony, M. M. (2005). Social anxiety disorder and depression in Saudi Arabia. *Depression and anxiety, 21*(2), 90-94. doi: 10.1002/da.20056
- Becker, A., Steinhausen, H. C., Baldursson, G., Dalsgaard, S., Lorenzo, M. J., Ralston**, S. J., . . . Rothenberger, A. (2006). Psychopathological screening of children with ADHD: Strengths and Difficulties Questionnaire in a pan-European study. *European Child & Adolescent Psychiatry, 15*, 56-62.
- Beech, B., & Leather, P. (2006). Workplace violence in the health care sector: A review of staff training and integration of training evaluation models. *Aggression and Violent Behavior, 11*(1), 27-43.
- Beidel, D. C., Turner, S. M., & Association, A. P. (2007). *Shy children, phobic adults: Nature and treatment of social anxiety disorder*. American Psychological Association.
- Beidel, D. C., Turner, S. M., & Morris, T. L. (1995). A new inventory to assess childhood social anxiety and phobia: The Social Phobia and Anxiety Inventory for Children. *Psychological Assessment, 7*(1), 73.
- Beidel, D. C., Turner, S. M., & Morris, T. L. (2000). Behavioral treatment of childhood social phobia. *Journal of Consulting and Clinical Psychology, 68*(6), 1072.

- Benatar, S. R. (2002). Reflections and recommendations on research ethics in developing countries. *Social Science & Medicine*, *54*(7), 1131-1141.
- Bentovim, A. (1992). *Trauma-organized systems: Physical and sexual abuse in families*: Karnac Books.
- Berry, J. W., Phinney, J. S., Sam, D. L., & Vedder, P. (2006). Immigrant Youth: Acculturation, Identity, and Adaptation. *Applied Psychology*, *55*(3), 303-332. doi: 10.1111/j.1464-0597.2006.00256.x
- Birenbaum, M., & Nasser, F. (2006). Ethnic and gender differences in mathematics achievement and in dispositions towards the study of mathematics. *Learning and Instruction*, *16*(1), 26-40. doi: 10.1016/j.learninstruc.2005.12.004
- Blom, G. E. (1986). A school disaster--Intervention and research aspects. *Journal of the American Academy of Child Psychiatry*, *25*(3), 336-345.
- Bögels, & Siqueland, L. (2006). Family cognitive behavioral therapy for children and adolescents with clinical anxiety disorders. *Journal of the American Academy of Child & Adolescent Psychiatry*, *45*(2), 134-141.
- Bögels, & Tarrrier, N. (2004). Unexplored issues and future directions in social phobia research. *Clinical Psychology Review*, *24*(7), 731-736. doi: 10.1016/j.cpr.2004.07.003
- Borge, F. M., Hoffart, A., & Sexton, H. (2010). Predictors of outcome in residential cognitive and interpersonal treatment for social phobia: Do

cognitive and social dysfunction moderate treatment outcome? *Journal of behavior therapy and experimental psychiatry*, 41(3), 212-219.

Breslau, Peterson, E. L., Kessler, R. C., & Schultz, L. R. (1999). Short screening scale for DSM-IV posttraumatic stress disorder. *American Journal of Psychiatry*, 156(6), 908-911.

Breslau, N. (2009). The Epidemiology of Trauma, PTSD, and Other Posttrauma Disorders. *Trauma, Violence, & Abuse*, 10(3), 198-210. doi: 10.1177/1524838009334448

Briere. (1992). *Child abuse trauma: Theory and treatment of the lasting effects* (Vol. 2): Sage Publications, Inc.

Briere. (2005). Trauma Symptom Checklist for Young Children (TSCYC). *Odessa, FL: Psychological Assessment Resources.*

Briere. (2010). Trauma Symptom Checklist for Children–TSCC™. *Produktkatalog*, 45.

Briere, & Elliott, D. M. (2003). Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse & Neglect*, 27(10), 1205-1222.

Briere, Johnson, K., Bissada, A., Damon, L., Crouch, J., Gil, E., . . . Ernst, V. (2001). The Trauma Symptom Checklist for Young Children (TSCYC): Reliability and association with abuse exposure in a multi-site study. *Child abuse & neglect*, 25(8), 1001-1014.

- Briere, & Jordan, C. E. (2004). Violence against women. *Journal of Interpersonal Violence, 19*(11), 1252-1276.
- Briere, & Runtz, M. (1989). The trauma symptom checklist (TSC-33). *Journal of Interpersonal Violence, 4*(2), 151.
- Briggs, S. R., & Cheek, J. M. (1986). The role of factor analysis in the development and evaluation of personality scales. *Journal of personality, 54*(1), 106-148.
- Brooks, T. L., Harris, S. K., Thrall, J. S., & Woods, E. R. (2002). Association of adolescent risk behaviors with mental health symptoms in high school students. *Journal of Adolescent Health, 31*(3), 240-246.
- Brown. (2002). *Measurement and the epidemiology of childhood trauma*.
- Brown, Craig, T. K. J., Harris, T. O., Handley, R. V., & Harvey, A. L. (2007). Validity of retrospective measures of early maltreatment and depressive episodes using the Childhood Experience of Care and Abuse (CECA) instrument — A life-course study of adult chronic depression — 2. *Journal of affective disorders, 103*(1–3), 217-224. doi: 10.1016/j.jad.2007.06.003
- Brozovich, F., & Heimberg, R. G. (2011). The Relationship of Post-Event Processing to Self-Evaluation of Performance in Social Anxiety. *Behavior Therapy, 42*(2), 224-235. doi: 10.1016/j.beth.2010.08.005
- Bruce, S. E., Yonkers, K. A., Otto, M. W., Eisen, J. L., Weisberg, R. B., Pagano, M., . . . Keller, M. B. (2005). Influence of psychiatric comorbidity on

recovery and recurrence in generalized anxiety disorder, social phobia, and panic disorder: a 12-year prospective study. *The American journal of psychiatry*, 162(6), 1179.

Bruch, M. A., & Heimberg, R. G. (1994). Differences in perceptions of parental and personal characteristics between generalized and nongeneralized social phobics. *Journal of Anxiety Disorders*, 8(2), 155-168. doi: 10.1016/0887-6185(94)90013-2

Bryant, B., Mayou, R., Wiggs, L., Ehlers, A., & Stores, G. (2004). Psychological consequences of road traffic accidents for children and their mothers. *Psychological Medicine*, 34(2), 335-346.

Buka, S. L., Stichick, T. L., Birdthistle, I., & Earls, F. J. (2001). Youth exposure to violence: Prevalence, risks, and consequences. *American Journal of orthopsychiatry*, 71(3), 298-310.

Calhoun, L. G., & Tedeschi, R. G. (1999). *Facilitating posttraumatic growth: A clinician's guide*: Lawrence Erlbaum.

Calvert, J. R., & Al-Shetaiwi, A. S. (2002). Exploring the mismatch between skills and jobs for women in Saudi Arabia in technical and vocational areas: the views of Saudi Arabian private sector business managers. *International Journal of Training and Development*, 6(2), 112-124.

Carpenter, L. L., Tyrka, A. R., Ross, N. S., Khoury, L., Anderson, G. M., & Price, L. H. (2009). Effect of Childhood Emotional Abuse and Age on Cortisol Responsivity in Adulthood. *Biological Psychiatry*, 66(1), 69-75. doi: 10.1016/j.biopsych.2009.02.030

- Cartwright-Hatton, S., Tschernitz, N., & Gomersall, H. (2005). Social anxiety in children: social skills deficit, or cognitive distortion? *Behaviour Research and Therapy*, *43*(1), 131-141. doi: 10.1016/j.brat.2003.12.003
- Caspi, A., & Shiner, R. L. (2006). Personality development. *Handbook of child psychology*.
- Cassano, G. B., Pini, S., Sacttoni, M., & Dell'Oso, L. (1999). Multiple anxiety disorder comorbidity in patients with mood spectrum disorders with psychotic features. *American Journal of Psychiatry*, *156*(3), 474-476.
- Castaneda, A., McCandless, B. R., & Palermo, D. S. (1956). The children's form of the manifest anxiety scale. *Child development*, *27*(3), 317-326.
- Castro, J., Toro, J., Van der Ende, J., & Arrindell, W. (1993). Exploring the Feasibility of Assessing Perceived Parental Rearing Styles in Spanish Children With Theembu. *International Journal of Social Psychiatry*, *39*(1), 47.
- Catani, C., Jacob, N., Schauer, E., Kohila, M., & Neuner, F. (2008). Family violence, war, and natural disasters: A study of the effect of extreme stress on children's mental health in Sri Lanka. *BMC psychiatry*, *8*(1), 33.
- Celebi Oncu, E., & Metindogan Wise, A. (2010). The effects of the 1999 Turkish earthquake on young children: Analyzing traumatized children's completion of short stories. *Child development*, *81*(4), 1161-1175.
- Chaleby, K. (1987). Social phobia in Saudis. *Social psychiatry and psychiatric epidemiology*, *22*(3), 167-170.

- Chaleby, K., & Raslan, A. (1990). Delineation of social phobia in Saudia Arabians. *Social psychiatry and psychiatric epidemiology*, 25(6), 324-327.
- Chambers, J. A., Power, K. G., & Durham, R. C. (2004). The relationship between trait vulnerability and anxiety and depressive diagnoses at long-term follow-up of Generalized Anxiety Disorder. *Journal of Anxiety Disorders*, 18(5), 587-607.
- Chambers, W. J., Puig-Antich, J., Hirsch, M., Paez, P., Ambrosini, P. J., Tabrizi, M. A., & Davies, M. (1985). The assessment of affective disorders in children and adolescents by semistructured interview: test-retest reliability of the Schedule for Affective Disorders and Schizophrenia for School-Age Children, Present Episode Version. *Archives of general psychiatry*, 42(7), 696.
- Chambless, D. L., Tran, G. Q., & Glass, C. R. (1997). Predictors of response to cognitive-behavioral group therapy for social phobia. *Journal of Anxiety Disorders*, 11(3), 221-240.
- Chapman, T. F., Mannuzza, S., Fyer, A. J., Heimberg, R., Liebowitz, M., Hope, D., & Schneier, F. (1995). Epidemiology and family studies of social phobia. *Social phobia: Diagnosis, assessment, and treatment*, 21-40.
- Chartier, Walker, & Stein. (2003). Considering comorbidity in social phobia. *Social psychiatry and psychiatric epidemiology*, 38(12), 728-734. doi: 10.1007/s00127-003-0720-6

- Chartier, Walker, J., & Stein, M. (2001). Social phobia and potential childhood risk factors in a community sample. *Psychological Medicine, 31*(2), 307-315.
- Chartrand, M. M., Frank, D. A., White, L. F., & Shope, T. R. (2008). Effect of parents' wartime deployment on the behavior of young children in military families. *Archives of Pediatrics and Adolescent Medicine, 162*(11), 1009.
- Chemtob, C. M., Nakashima, J., & Carlson, J. G. (2002). Brief treatment for elementary school children with disaster-related posttraumatic stress disorder: A field study. *Journal of clinical psychology, 58*(1), 99-112.
- Cheung, F. M., & Leung, K. (1998). Indigenous Personality Measures Chinese Examples. *Journal of cross-cultural psychology, 29*(1), 233-248.
- Chorpita, B. F., Moffitt, C. E., & Gray, J. (2005). Psychometric properties of the Revised Child Anxiety and Depression Scale in a clinical sample. *Behaviour Research and Therapy, 43*(3), 309-322.
- Christensen, P., & Prout, A. (2002). Working with ethical symmetry in social research with children. *Childhood, 9*(4), 477-497.
- Clark, & McManus, F. (2002). Information processing in social phobia. *Biological Psychiatry, 51*(1), 92-100. doi: 10.1016/s0006-3223(01)01296-3
- Clark, & Wells, A. (1995). A cognitive model of social phobia. *Social phobia: Diagnosis, assessment, and treatment, 41*, 68.
- Clay-Warner, J., & McMahan-Howard, J. (2009). Rape Reporting: Classic Rape and the Behavior of Law. *Violence and victims, 24*(6), 723-743.

- Cole, D. A., & Martin, N. C. (2005). The longitudinal structure of the Children's Depression Inventory: testing a latent trait-state model. *Psychological Assessment, 17*(2), 144.
- Corby, B. C. (2003). Supporting Families and Protecting Children. *Journal of Social Work, 3*(2), 195-210. doi: 10.1177/14680173030032005
- Coren, E., & Barlow, J. (2001). Individual and group-based parenting programmes for improving psychosocial outcomes for teenage parents and their children. *Cochrane Database Syst Rev, 3*.
- Cox, B. J., Borger, S. C., & Enns, M. W. (1999). Anxiety sensitivity and emotional disorders: Psychometric studies and their theoretical implications. *Anxiety sensitivity: Theory, research, and treatment of the fear of anxiety, 115-148*.
- Cronbach, L. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika, 16*(3), 297-334. doi: 10.1007/bf02310555
- Cunningham, C. E., Bremner, R., & Boyle, M. (1995). Large Group Community-Based Parenting Programs for Families of Preschoolers at Risk for Disruptive Behaviour Disorders: Utilization, Cost Effectiveness, and Outcome. *Journal of Child Psychology and Psychiatry, 36*(7), 1141-1159.
- Davidson, Hughes, D., George, L. K., & Blazer, D. G. (1993). The epidemiology of social phobia: findings from the Duke Epidemiological Catchment Area Study. *PSYCHOLOGICAL MEDICINE-LONDON-, 23*, 709-709.

- Davidson, Marshall, J. R., Tomarken, A. J., & Henriques, J. B. (2000). While a phobic waits: Regional brain electrical and autonomic activity in social phobics during anticipation of public speaking. *Biological Psychiatry*, *47*(2), 85-95.
- Davidson, Miner, C., De Veauugh-Geiss, J., Tupler, L., Colket, J., & Potts, N. (1997). The brief social phobia scale: a psychometric evaluation. *Psychological Medicine*, *27*(1), 161-166.
- Davis, & Carter, A. S. (2008). Parenting stress in mothers and fathers of toddlers with autism spectrum disorders: Associations with child characteristics. *Journal of Autism and Developmental Disorders*, *38*(7), 1278-1291.
- Davis, C., Kennedy, S. H., Ralevski, E., Dionne, M., Brewer, H., Neitzert, C., & Ratusny, D. (1995). Obsessive compulsiveness and physical activity in anorexia nervosa and high-level exercising. *Journal of Psychosomatic Research*, *39*(8), 967-976.
- Degonda, M., Wyss, M., & Angst, J. (1993). The Zurich Study. *European Archives of Psychiatry and Clinical Neuroscience*, *243*(1), 16-22. doi: 10.1007/bf02191519
- Deighton, R. M. K., Gurriss, N., & Traue, H. (2007). Factors affecting burnout and compassion fatigue in psychotherapists treating torture survivors: Is the therapist's attitude to working through trauma relevant? *Journal of Traumatic Stress*, *20*(1), 63-75.

- Dell'Osso, L., Rucci, P., Ducci, F., Ciapparelli, A., Vivarelli, L., Carlini, M., . . . Cassano, G. B. (2003). Social anxiety spectrum. *European Archives of Psychiatry and Clinical Neuroscience*, 253(6), 286-291.
- Demir, T., Demir, D., Alkas, L., Copur, M., Dogangun, B., & Kayaalp, L. (2010). Some clinical characteristics of children who survived the Marmara earthquakes. *European Child & Adolescent Psychiatry*, 19(2), 125-133. doi: 10.1007/s00787-009-0048-1
- Department of Health, D. (2010). *Children, Education and Skills*. England: Department of Health (DOH) Retrieved from <http://www.education.gov.uk/rsgateway/DB/STR/d000970/osr28-2010.pdf>.
- DeWit, D. J., Chandler-Coutts, M., Offord, D. R., King, G., McDougall, J., Specht, J., & Stewart, S. (2005). Gender differences in the effects of family adversity on the risk of onset of DSM-III-R social phobia. *Journal of Anxiety Disorders*, 19(5), 479-502.
- Di Gallo, A., & Barton, J. Parry-Jones (1997), WL, Road traffic accidents: early psychological consequences in children and adolescents. *British Journal of Psychiatry*, 170(4), 358-362.
- Di Gallo, A., Barton, J., & Parry-Jones, W. L. (1997). Road traffic accidents: early psychological consequences in children and adolescents. *The British Journal of Psychiatry*, 170(4), 358-362.

- Dinnel, D. L., Kleinknecht, R. A., & Tanaka-Matsumi, J. (2002). A cross-cultural comparison of social phobia symptoms. *Journal of Psychopathology and Behavioral Assessment, 24*(2), 75-84.
- Dixon-Woods, M., Young, B., & Heney, D. (1999). Partnerships with children. *BMJ, 319*(7212), 778-780.
- Dobash, R. E., Dobash, R. P., Cavanagh, K., & Medina-Ariza, J. (2007). Lethal and Nonlethal Violence Against an Intimate Female Partner. *Violence Against Women, 13*(4), 329-353. doi: 10.1177/1077801207299204
- DOH, D. o. H. (2005) Mental health of children and young people in Great Britain, 2004. (pp. 284).
- Douki, S., Ben Zineb, S., Nacef, F., & Halbreich, U. (2007). Women's mental health in the Muslim world: Cultural, religious, and social issues. *Journal of affective disorders, 102*(1), 177-189.
- Doumas, D., Margolin, G., & John, R. S. (1994). The intergenerational transmission of aggression across three generations. *Journal of Family Violence, 9*(2), 157-175.
- Doumato, E. A. (2003). Education in Saudi Arabia: gender, jobs, and the price of religion. *Women and Globalization in the Arab Middle East, 239-258.*
- DSM-IV., A. P. A. T. F. o. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR*: American Psychiatric Publishing, Inc.
- Dubowitz, H., & Bennett, S. (2007). Physical abuse and neglect of children. *Lancet, 369*(9576), 1891-1899. doi: 10.1016/S0140-6736(07)60856-3

- Durrant, J. E. (2008). Physical punishment, culture, and rights: current issues for professionals. *Journal of Developmental & Behavioral Pediatrics, 29*(1), 55.
- Dwairy, M., Achoui, M., Abouserie, R., Farah, A., Sakhleh, A. A., Fayad, M., & Khan, H. K. (2006). Parenting Styles in Arab Societies A First Cross-Regional Research Study. *Journal of cross-cultural psychology, 37*(3), 230-247.
- Dwairy, M. A. (1998). *Cross-cultural counseling: the Arab-Palestinian case*: Routledge.
- Dyregrov, A., Kuterovac, G., & Barath, A. (1996). Factor analysis of the impact of event scale with children in war. *Scandinavian journal of Psychology, 37*(4), 339-350.
- Dyregrov, A., & Raundalen, M. (1992). *The impact of the Gulf war on the children of Iraq*.
- Eksi, A., & Braun, K. L. (2009). Over-time changes in PTSD and depression among children surviving the 1999 Istanbul earthquake. *European Child & Adolescent Psychiatry, 18*(6), 384-391.
- El-Islam, M. F. (1982). Arabic cultural psychiatry.
- El-Rufaie, O., & Daradkeh, T. (1996). Validation of the Arabic versions of the thirty-and twelve-item General Health Questionnaires in primary care patients. *The British Journal of Psychiatry, 169*(5), 662-664.

- El-Tantawy, A. M., Raya, Y. M., Al-Yahya, A. H., & Zaki, A. S. M. K. (2010). Social Phobia Among Patients Attending the Outpatient Clinics of Buraydah Mental Health Hospital, Al-Gassim, KSA. *Current Psychiatry*, 17(2), 35-43.
- Elhai, J. D., Gray, M. J., Kashdan, T. B., & Franklin, C. L. (2005). Which instruments are most commonly used to assess traumatic event exposure and posttraumatic effects?: A survey of traumatic stress professionals. *Journal of Traumatic Stress*, 18(5), 541-545.
- Epstein, T., Saltzman-Benaiah, J., O'Hare, A., Goll, J. C., & Tuck, S. (2008). Associated features of Asperger Syndrome and their relationship to parenting stress. *Child: Care, Health and Development*, 34(4), 503-511. doi: 10.1111/j.1365-2214.2008.00834.x
- Erwin, B. A., Heimberg, R. G., Marx, B. P., & Franklin, M. E. (2006). Traumatic and socially stressful life events among persons with social anxiety disorder. *Journal of Anxiety Disorders*, 20(7), 896-914. doi: 10.1016/j.janxdis.2005.05.006
- Escalona, R., Achilles, G., Waitzkin, H., & Yager, J. (2004). PTSD and Somatization in Women Treated at a VA Primary Care Clinic. *Psychosomatics*, 45(4), 291-296. doi: 10.1176/appi.psy.45.4.291
- Esmaeili, H. (2009). On a Slow Boat towards the Rule of Law: The Nature of Law in the Saudi Arabia Legal System. *Ariz. J. Int'l & Comp. L.*, 26, 1.

- Essau, C. A., Conradt, J., & Petermann, F. (1999). Frequency and comorbidity of social phobia and social fears in adolescents. *Behaviour Research and Therapy*, 37(9), 831-843. doi: 10.1016/s0005-7967(98)00179-x
- Essau, C. A., Conradt, J., & Petermann, F. (2000). Frequency, Comorbidity, and Psychosocial Impairment of Depressive Disorders in Adolescents. *Journal of Adolescent Research*, 15(4), 470-481. doi: 10.1177/0743558400154003
- Evans, J., Briere, J., Boggiano, A., & Barrett, M. (1994). *Reliability and validity of the Trauma Symptom Checklist for Children in a normal sample.*
- Famularo, R., Kinscherff, R., & Fenton, T. (1991). Posttraumatic stress disorder among children clinically diagnosed as borderline personality disorder. *Journal of Nervous and Mental Disease*.
- Fargues, P. (2003). La femme dans les pays arabes: vers une remise en cause du système patriarcal? *Population et Sociétés*, 387.
- Fedoroff, I. C., & Taylor, S. (2001). Psychological and pharmacological treatments of social phobia: a meta-analysis. *Journal of clinical psychopharmacology*, 21(3), 311.
- Fergusson, D. M., Horwood, L., & Lynskey, M. T. (1996). Childhood sexual abuse and psychiatric disorder in young adulthood: II. Psychiatric outcomes of childhood sexual abuse. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35(10), 1365-1374.

- Feske, U., Perry, K. J., Chambless, D. L., Renneberg, B., & Goldstein, A. J. (1996). Avoidant personality disorder as a predictor for treatment outcome among generalized social phobics. *Journal of Personality Disorders, 10*(2), 174-184.
- Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of orthopsychiatry, 55*(4), 530-541.
- Flannery, R. B. (2004). Characteristics of staff victims of psychiatric patient assaults: Updated review of findings, 1995-2001. *American Journal of Alzheimer's Disease and Other Dementias, 19*(1), 35.
- Ford, T., Goodman, R., & Meltzer, H. (2003). The British Child and Adolescent Mental Health Survey 1999: The Prevalence of DSM-IV Disorders. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(10), 1203-1211.
- Forsberg, R., & Saveman, B. I. (2011). Survivors' experiences from a train crash. *International Journal of Qualitative Studies on Health and Well-being, 6*(4).
- Freeman, M. P., Freeman, S. A., & McElroy, S. L. (2002). The comorbidity of bipolar and anxiety disorders: prevalence, psychobiology, and treatment issues. *Journal of affective disorders, 68*(1), 1-23.
- Fritz, M. S., & MacKinnon, D. P. (2007). Required Sample Size to Detect the Mediated Effect. *Psychological Science, 18*(3), 233-239. doi: 10.1111/j.1467-9280.2007.01882.x

- Fullerton, C. S., Ursano, R. J., Norwood, A. E., & Holloway, H. H. (2003). Trauma, terrorism, and disaster. *Terrorism and disaster: Individual and community mental health interventions*, 1-21.
- Furmark. (2002). Social phobia: overview of community surveys. *Acta Psychiatrica Scandinavica*, 105(2), 84-93. doi: 10.1034/j.1600-0447.2002.1r103.x
- Gallagher, H. M., Rabian, B. A., & McCloskey, M. S. (2004). A brief group cognitive-behavioral intervention for social phobia in childhood. *Journal of Anxiety Disorders*, 18(4), 459-479.
- Gao, F., Luo, N., Thumboo, J., Fones, C., Li, S. C., & Cheung, Y. B. (2004). Does the 12-item General Health Questionnaire contain multiple factors and do we need them? *Health and Quality of Life Outcomes*, 2(1), 63.
- Gauer, G., Picon, P., Vasconcellos, S., Turner, S., & Beidel, D. (2005). Validation of the Social Phobia and Anxiety Inventory for Children (SPAI-C) in a sample of Brazilian children. *Brazilian Journal of Medical and Biological Research*, 38(5), 795-800.
- Geeraert, L., Van den Noortgate, W., Grietens, H., & Onghena, P. (2004). The Effects of Early Prevention Programs for Families with Young Children at Risk for Physical Child Abuse and Neglect: A Meta-Analysis. *Child Maltreatment*, 9(3), 277-291. doi: 10.1177/1077559504264265
- Geist, R., Grdisa, V., & Otley, A. (2003). Psychosocial issues in the child with chronic conditions. *Best Practice & Research Clinical Gastroenterology*, 17(2), 141-152.

- Gerard, A. B., & Reynolds, C. R. (1999). Characteristics and applications of the Revised Children's Manifest Anxiety Scale (RCMAS). *The use of psychological testing for treatment planning and outcomes assessment*, 323-340.
- Ghareeb, G. A., & Beshai, J. (1989). Arabic version of the Children's Depression Inventory: Reliability and validity. *Journal of Clinical Child Psychology*, 18(4), 323-326.
- Gil-Rivas, V., Holman, E. A., & Silver, R. C. (2004). Adolescent vulnerability following the September 11th terrorist attacks: A study of parents and their children. *Applied Developmental Science*, 8(3), 130-142.
- Gillies, M. L., Barton, J., & Gallo, A. D. (2003). Follow-up of young road accident victims. *Journal of Traumatic Stress*, 16(5), 523-526.
- Gillott, A., Furniss, F., & Walter, A. (2001). Anxiety in high-functioning children with autism. *Autism*, 5(3), 277-286.
- Gladstone, G. L., Parker, G. B., Mitchell, P. B., Wilhelm, K. A., & Malhi, G. S. (2005). Relationship between self-reported childhood behavioral inhibition and lifetime anxiety disorders in a clinical sample. *Depression and anxiety*, 22(3), 103-113.
- Glaser, D. (2002). Emotional abuse and neglect (psychological maltreatment): a conceptual framework. *Child Abuse & Neglect*, 26(6-7), 697-714.
doi: 10.1016/s0145-2134(02)00342-3

- Glaser, J.-P., van Os, J., Portegijs, P. J. M., & Myin-Germeys, I. (2006). Childhood trauma and emotional reactivity to daily life stress in adult frequent attenders of general practitioners. *Journal of Psychosomatic Research, 61*(2), 229-236. doi: 10.1016/j.jpsychores.2006.04.014
- Gold, P. B., Engdahl, B. E., Eberly, R. E., Blake, R. J., Page, W. F., & Frueh, B. C. (2000). Trauma exposure, resilience, social support, and PTSD construct validity among former prisoners of war. *Social psychiatry and psychiatric epidemiology, 35*(1), 36-42.
- Goodman. (1997). The Strengths and Difficulties Questionnaire: a research note. *Journal of Child Psychology and Psychiatry, 38*(5), 581-586.
- Goodman. (1999). The extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric caseness and consequent burden. *Journal of Child Psychology and Psychiatry, 40*(5), 791-799.
- Goodman. (2001). Psychometric properties of the strengths and difficulties questionnaire. *Journal of the American Academy of Child & Adolescent Psychiatry, 40*(11), 1337-1345.
- Goodman, & Goodman, R. (2009). Strengths and difficulties questionnaire as a dimensional measure of child mental health. *Journal of the American Academy of Child & Adolescent Psychiatry, 48*(4), 400-403.
- Goodman, & Scott, S. (1999). Comparing the Strengths and Difficulties Questionnaire and the Child Behavior Checklist: is small beautiful? *Journal of Abnormal Child Psychology, 27*(1), 17-24.

- Goodson, B. D. (2007). Parent support programs and outcomes for children. *Parenting skills*.
- Gray, E. K., & Watson, D. (2007). Assessing positive and negative affect via self-report. *Handbook of emotion elicitation and assessment*, 171-183.
- Green, Goodman, L. A., Krupnick, J. L., Corcoran, C. B., Petty, R. M., Stockton, P., & Stern, N. M. (2000). Outcomes of single versus multiple trauma exposure in a screening sample. *J Trauma Stress*, 13(2), 271-286. doi: 10.1023/A:1007758711939
- Green, Grace, M. C., & Gleser, G. C. (1985). Identifying survivors at risk: Long-term impairment following the Beverly Hills Supper Club fire. *Journal of Consulting and Clinical Psychology*, 53(5), 672.
- Gregory, R. J. (2004). *Psychological testing: History, principles, and applications*: Allyn & Bacon.
- Groome, D., & Soureti, A. (2004). Post-traumatic stress disorder and anxiety symptoms in children exposed to the 1999 Greek earthquake. *British Journal of Psychology*, 95(3), 387-397.
- Gurwitch, R. H., Sullivan, M. A., & Long, P. J. (1998). The impact of trauma and disaster on young children. *Child and adolescent psychiatric clinics of North America*, 7(1), 19.
- Hadi, F., Llabre, M. M., & Spitzer, S. (2006). Gulf war-related trauma and psychological distress of Kuwaiti children and their mothers. *Journal of Traumatic Stress*, 19(5), 653-662.

- Hague, G., Thiara, R., & Mullender, A. (2011). Disabled Women and Domestic Violence: Making the Links, a National UK Study. *Psychiatry, Psychology and Law*, 18(1), 117-136.
- Haj-Yahia, M. M., & Tamish, S. (2001). The rates of child sexual abuse and its psychological consequences as revealed by a study among Palestinian university students. *Child Abuse & Neglect*, 25(10), 1303-1327. doi: 10.1016/s0145-2134(01)00277-0
- Haj-Yahia, M. M., & Tamish, S. (2001). The rates of child sexual abuse and its psychological consequences as revealed by a study among Palestinian university students. *Child abuse & neglect*, 25(10), 1303-1327.
- Hamarman, S., Pope, K. H., & Czaja, S. J. (2002). Emotional abuse in children: variations in legal definitions and rates across the United States. *Child Maltreatment*, 7(4), 303-311.
- Hamdan, A. (2005). Women and education in Saudi Arabia: Challenges and achievements. *International Education Journal*, 6(1), 42-64.
- Hanna, K. (2008). Debating war-trauma and post-traumatic stress disorder (PTSD) in an interdisciplinary arena. *Social Science & Medicine*, 67(2), 218-227. doi: 10.1016/j.socscimed.2008.03.030
- Hassall, R., Rose, J., & McDonald, J. (2005). Parenting stress in mothers of children with an intellectual disability: The effects of parental cognitions in relation to child characteristics and family support. *Journal of Intellectual Disability Research*, 49(6), 405-418.

- Hassan, S. (2010). *Parent and teacher based epidemiological survey of psychiatric morbidity amongst school children in Karachi, Pakistan*. University of Leicester.
- Hayward, Varady, S., Albano, A. M., Thienemann, M., Henderson, L., & Schatzberg, A. F. (2000). Cognitive-Behavioral Group Therapy for Social Phobia in Female Adolescents: Results of a Pilot Study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 39(6), 721-726. doi: 10.1097/00004583-200006000-00010
- Health, U. S. D. o., & Services, H. (2000). *Tracking healthy people 2010: US Department of Health and Human Services*.
- Helfer, R. E., Kempe, C. H., & Mondale, W. F. (1976). *Child abuse and neglect: The family and the community*. Ballinger Pub. Co.
- Hilsdon, A.-M., & Rozario, S. (2006). *Special issue on Islam, gender and human rights*. Paper presented at the Women's studies international forum.
- Hirsch, C. R., Clark, D. M., & Mathews, A. (2006). Imagery and Interpretations in Social Phobia: Support for the Combined Cognitive Biases Hypothesis. *Behavior Therapy*, 37(3), 223-236. doi: 10.1016/j.beth.2006.02.001
- Hobfoll, S. E. (2002). Social and psychological resources and adaptation. *Review of General Psychology*, 6(4), 307.
- Hollander, E., Kwon, J., Weiller, F., Cohen, L., Stein, D. J., DeCaria, C., . . . Simeon, D. (1998). Serotonergic function in social phobia: comparison to

normal control and obsessive–compulsive disorder subjects. *Psychiatry research*, 79(3), 213-217.

Honjo, S., Nishide, T., Niwa, S., Sasaki, Y., Kaneko, H., Inoko, K., & Nishide, Y. (2001). School refusal and depression with school inattendance in children and adolescents: Comparative assessment between the Children's Depression Inventory and somatic complaints. *Psychiatry and clinical neurosciences*, 55(6), 629-634.

Horowitz. (2001). *Stress response syndromes*: J. Aronson.

Horowitz, K., Weine, S., & Jekel, J. (1995). PTSD Symptoms in Urban Adolescent Girls: Compounded Community Trauma. *Journal of the American Academy of Child & Adolescent Psychiatry*, 34(10), 1353-1361. doi: 10.1097/00004583-199510000-00021

Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of Event Scale: a measure of subjective stress. *Psychosomatic Medicine*, 41(3), 209-218.

Horwitz, A. V., Widom, C. S., McLaughlin, J., & White, H. R. (2001). The impact of childhood abuse and neglect on adult mental health: A prospective study. *Journal of health and social behavior*, 184-201.

Hovens, J. G. F. M., Wiersma, J. E., Giltay, E. J., Van Oppen, P., Spinhoven, P., Penninx, B. W. J. H., & Zitman, F. G. (2010). Childhood life events and childhood trauma in adult patients with depressive, anxiety and comorbid disorders vs. controls. *Acta Psychiatrica Scandinavica*, 122(1), 66-74. doi: 10.1111/j.1600-0447.2009.01491.x

- Hu, Y., Stewart-Brown, S., Twigg, L., & Weich, S. (2007). Can the 12-item General Health Questionnaire be used to measure positive mental health? *Psychological Medicine*, 37(7), 1005-1014.
- Hudson, J. L., & Rapee, R. M. (2002). Parent-child interactions in clinically anxious children and their siblings. *Journal of Clinical Child and Adolescent Psychology*, 31(4), 548-555.
- Hussein, S. A., Hussein, P. S. A., & Vostanis, P. (2008). URDU TRANSLATION AND CULTURAL ADAPTATION OF SCHEDULE FOR AFFECTIVE DISORDERS & SCHIZOPHRENIA FOR SCHOOL AGE CHILDREN (6-18 YRS) K-SADS-IV R-SADS-IV R. *JPPS*, 5(2), 81-85.
- Hyder, A. A., Wali, S., Khan, A., Teoh, N., Kass, N., & Dawson, L. (2004). Ethical review of health research: a perspective from developing country researchers. *Journal of Medical Ethics*, 30(1), 68-72.
- International Strategy for Disaster Reduction (2004). International Day for Disaster Reduction.
- Ivarsson, T., Svalander, P., & Litalere, O. (2006). The Children's Depression Inventory (CDI) as measure of depression in Swedish adolescents. A normative study. *Nordic Journal of Psychiatry*, 60(3), 220-226.
- Jamjoom, M. I. (2010). Female Islamic studies teachers in Saudi Arabia: a phenomenological study. *Teaching and Teacher Education*, 26(3), 547-558.

- Janet, P. (1889). *L'Automatisme Psychologique* (Reprint: Société Pierre Janet, Paris, 1973). *Paris: Félix Alcan.*
- Jensen, P. S., Koretz, D., Locke, B. Z., Schneider, S., Radke-Yarrow, M., Richters, J. E., & Rumsey, J. M. (1993). Child and adolescent psychopathology research: Problems and prospects for the 1990s. *Journal of Abnormal Child Psychology, 21*(5), 551-580.
- Johnson, H., & Thompson, A. (2008). The development and maintenance of post-traumatic stress disorder (PTSD) in civilian adult survivors of war trauma and torture: A review. *Clinical Psychology Review, 28*(1), 36-47.
- Joiner, T. E., Sachs-Ericsson, N. J., Wingate, L. R. R., Brown, J. S., Anestis, M. D., & Selby, E. A. (2007). Childhood physical and sexual abuse and lifetime number of suicide attempts: A persistent and theoretically important relationship. *Behaviour Research and Therapy, 45*(3), 539-547.
- Jones, C., Harvey, A. G., & Brewin, C. R. (2007). The organisation and content of trauma memories in survivors of road traffic accidents. *Behaviour Research and Therapy, 45*(1), 151-162. doi: 10.1016/j.brat.2006.02.004
- Joseph, S., Williams, R., & Yule, W. (1997). *Understanding Post-Traumatic Stress: A Psychosocial Perspective on PTSD and Treatment*. Cambridge Univ Press.
- Kagan, J. (1989). Temperamental contributions to social behavior. *American Psychologist, 44*(4), 668.

- Kaplan, R. M., & Saccuzzo, D. P. (1993). *Psychological Testing: Principles, Applications and Issues, 3rd ed., Brooks Cole, Pacific Grove, CA.*
- Kaplan, R. M., & Saccuzzo, D. P. (2008). *Psychological testing: Principles, applications, and issues: Wadsworth Pub Co.*
- Kardiner, A. (1941). The traumatic neuroses of war.
- Kashani, J. H., & Orvaschel, H. (1990). A community study of anxiety in children and adolescents. *The American journal of psychiatry.*
- Kashdan, & Herbert, J. (2001). Social Anxiety Disorder in Childhood and Adolescence: Current Status and Future Directions. *Clinical Child and Family Psychology Review, 4(1)*, 37-61. doi: 10.1023/a:1009576610507
- Kashdan, & Steger, M. F. (2006). Expanding the Topography of Social Anxiety: An Experience-Sampling Assessment of Positive Emotions, Positive Events, and Emotion Suppression. *Psychological Science, 17(2)*, 120-128.
- Kattan, H., Sakati, N., Abduljabbar, J., Al-Eisa, A., & Nou-Nou, L. (1995). Subcutaneous fat necrosis as an unusual presentation of child abuse. *Annals of Saudi medicine, 15*, 162-162.
- Kaufman, J., Birmaher, B., Brent, D. A., Ryan, N. D., & Rao, U. (2000). K-SADS-PL.
- Keddie, A. (2000). Research with young children: Some ethical considerations. *Journal of educational enquiry, 1(2)*, 72-81.

- Keller, M. B., Herzog, D. B., Lavori, P. W., Bradburn, I. S., & Mahoney, E. S. (1992). The naturalistic history of bulimia nervosa: Extraordinarily high rates of chronicity, relapse, recurrence, and psychosocial morbidity. *International Journal of Eating Disorders*, *12*(1), 1-9.
- Kendall-Tackett, K., Lyon, T., Taliaferro, G., & Little, L. (2005). Why child maltreatment researchers should include children's disability status in their maltreatment studies. *Child Abuse and Neglect*, *29*(2), 147-151.
- Kendall, P. C., Safford, S., Flannery-Schroeder, E., & Webb, A. (2004). Child Anxiety Treatment: Outcomes in Adolescence and Impact on Substance Use and Depression at 7.4-Year Follow-Up. *Journal of Consulting and Clinical Psychology*, *72*(2), 276-287. doi: 10.1037/0022-006x.72.2.276
- Kendall, P. C., & Warman, M. J. (1996). Anxiety disorders in youth: Diagnostic consistency across DSM-III-R and DSM-IV. *Journal of Anxiety Disorders*, *10*(6), 453-463. doi: 10.1016/s0887-6185(96)00022-9
- Kendler, K. S., Bulik, C. M., Silberg, J., Hettema, J. M., Myers, J., & Prescott, C. A. (2000). Childhood sexual abuse and adult psychiatric and substance use disorders in women: an epidemiological and cotwin control analysis. *Archives of general psychiatry*, *57*(10), 953.
- Kendler, K. S., Neale, M. C., Kessler, R. C., Heath, A. C., & Eaves, L. J. (1992). The genetic epidemiology of phobias in women: The interrelationship of agoraphobia, social phobia, situational phobia, and simple phobia. *Archives of general psychiatry*, *49*(4), 273.

- Kessler, Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of dsm-iv disorders in the national comorbidity survey replication. *Archives of general psychiatry*, 62(6), 593-602. doi: 10.1001/archpsyc.62.6.593
- Kessler, McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., . . . Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. *Archives of general psychiatry*, 51(1), 8.
- Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of general psychiatry*, 52(12), 1048.
- Khamis, V. (2000). *Political violence and the Palestinian family: Implications for mental health and well-being*: Routledge.
- Khamis, V. (2005). Post-traumatic stress disorder among school age Palestinian children. *Child abuse & neglect*, 29(1), 81-95.
- Khamis, V. (2007). Psychological distress among parents of children with mental retardation in the United Arab Emirates. *Social Science & Medicine*, 64(4), 850-857.
- Kilpatrick, D. G., Ruggiero, K. J., Acierno, R., Saunders, B. E., Resnick, H. S., & Best, C. L. (2003). Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: Results from the National Survey of Adolescents. *Journal of Consulting and Clinical Psychology*, 71(4), 692.

- Kleinknecht, R. A., Dinnel, D. L., Kleinknecht, E. E., Hiruma, N., & Harada, N. (1997). Cultural factors in social anxiety: A comparison of social phobia symptoms and Taijin Kyofusho. *Journal of Anxiety Disorders, 11*(2), 157-177.
- Koplewicz, H. S., Vogel, J. M., Solanto, M. V., Morrissey, R. F., Alonso, C. M., Abikoff, H., . . . Novick, R. M. (2002). Child and parent response to the 1993 World Trade Center bombing. *Journal of Traumatic Stress, 15*(1), 77-85.
- Korbin, J. E. (2003). Neighborhood and community connectedness in child maltreatment research. *Child Abuse & Neglect: The International Journal, 27*(2), 137-140.
- Korol, M., Green, B. L., & Gleser, G. C. (1999). Children's responses to a nuclear waste disaster: PTSD symptoms and outcome prediction. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*(4), 368-375.
- Korol, M., Kramer, T. L., Grace, M. C., & Green, B. L. (2002). Dam break: Long-term follow-up of children exposed to the Buffalo Creek disaster.
- Kovacs, M. (1985). The Interview Schedule for Children (ISC). *Psychopharmacology Bulletin, 21*(4), 991.
- Kovacs, M. (1992). *Children's Depression Inventory:[manual]*: Multi-Health Systems.

- Kraidy, M. M. (2007). Saudi Arabia, Lebanon and the changing Arab information order.
- Kroenke, K., Spitzer, R. L., Williams, J. B. W., Monahan, P. O., & Löwe, B. (2007). Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. *Annals of Internal Medicine, 146*(5), 317-325.
- Krulik, T., Turner-Henson, A., Kanematsu, Y., & Al-Ma'aitah, R. (1999). Parenting stress and mothers of young children with chronic illness: A cross-cultural study¹. *Journal of Pediatric Nursing, 14*(2), 130-140.
- Krystal, H. (1978). Trauma and affects. *Psychoanalytic Study of the Child, 33*, 81-116.
- Lambert, M. C., Weisz, J. R., & Knight, F. (1989). Over-and undercontrolled clinic referral problems of Jamaican and American children and adolescents: The culture general and the culture specific. *Journal of Consulting and Clinical Psychology, 57*(4), 467.
- Landry, S. H., Smith, K. E., & Swank, P. R. (2006). Responsive parenting: establishing early foundations for social, communication, and independent problem-solving skills. *Developmental psychology, 42*(4), 627.
- Landry, S. H., Smith, K. E., Swank, P. R., & Guttentag, C. (2008). A responsive parenting intervention: The optimal timing across early childhood for impacting maternal behaviors and child outcomes. *Developmental Psychology; Developmental Psychology, 44*(5), 1335.

- Laor, N., & Wolmer, L. (2000). Image control and posttraumatic symptoms in children following SCUD missile attacks. *Perceptual and Motor Skills*, 90(3c), 1295-1298.
- Larsson, B., & Melin, L. (1992). Prevalence and short-term stability of depressive symptoms in schoolchildren. *Acta Psychiatrica Scandinavica*, 85(1), 17-22.
- Layne, C. M., Pynoos, R. S., Saltzman, W. R., Arslanagić, B., Black, M., Savjak, N., . . . Čampara, N. (2001). Trauma/grief-focused group psychotherapy: School-based postwar intervention with traumatized Bosnian adolescents. *Group Dynamics: Theory, Research, and Practice*, 5(4), 277.
- Lecavalier, L., Leone, S., & Wiltz, J. (2006). The impact of behaviour problems on caregiver stress in young people with autism spectrum disorders. *Journal of Intellectual Disability Research*, 50(3), 172-183.
- Levin, J. B., Hermesh, H., & Marom, S. (2001). Social phobia subtyping with the MMPI-2. *Journal of clinical psychology*, 57(12), 1489-1502.
- Levine, P. A., & Frederick, A. (1997). *Waking the tiger: Healing trauma: The innate capacity to transform overwhelming experiences*: North Atlantic Books.
- Lieb, R., Wittchen, H., Höfler, M., Fuetsch, M., Stein, M. B., & Merikangas, K. R. (2000). Parental psychopathology, parenting styles, and the risk of social phobia in offspring: A prospective-longitudinal community study. *Archives of general psychiatry*, 57(9), 859-866. doi: 10.1001/archpsyc.57.9.859

- Liebowitz, M. R., Gorman, J. M., Fyer, A. J., & Klein, D. F. (1985). Social phobia: Review of a neglected anxiety disorder. *Archives of general psychiatry*, 42(7), 729.
- Lin, E. J. L., & Church, A. T. (2004). Are Indigenous Chinese Personality Dimensions Culture-Specific? *Journal of cross-cultural psychology*, 35(5), 586-605.
- Lindhout, I., Markus, M., Hoogendijk, T., Borst, S., Maingay, R., Spinhoven, P., . . . Boer, F. (2006). Childrearing style of anxiety-disordered parents. *Child Psychiatry & Human Development*, 37(1), 89-102.
- Liu, M., Wang, L., Shi, Z., Zhang, Z., Zhang, K., & Shen, J. (2011). Mental health problems among children one-year after Sichuan earthquake in China: a follow-up study. *PloS one*, 6(2), e14706.
- Llabre, M. M., & Hadi, F. (1997). Social support and psychological distress in Kuwaiti boys and girls exposed to the Gulf crisis. *Journal of Clinical Child Psychology*, 26(3), 247-255.
- Lonigan, C. J., Phillips, B. M., & Richey, J. A. (2003). Posttraumatic stress disorder in children: diagnosis, assessment, and associated features. *Child and adolescent psychiatric clinics of North America*, 12(2), 171.
- Loyd, B. H., & Abidin, R. R. (1985). Revision of the parenting stress index. *Journal of Pediatric Psychology*, 10(2), 169.

- Luteijn, F., & Bouman, T. K. (1988). The concepts of depression, anxiety, and neuroticism in questionnaires. *European journal of personality, 2*(2), 113-120.
- Magee, Eaton, W. W., Wittchen, H., McGonagle, K. A., & Kessler, R. C. (1996). AGoraphobia, simple phobia, and social phobia in the national comorbidity survey. *Archives of general psychiatry, 53*(2), 159-168. doi: 10.1001/archpsyc.1996.01830020077009
- Mahfouz, A. A., Abdelmoneim, I., Al-Gelban, K. S., Daffalla, A. A., Amri, H. A., Shaban, H., . . . Mohammed, A. A. (2009). Adolescents' Mental Health in Abha City, Southwestern Saudi Arabia. *The International Journal of Psychiatry in Medicine, 39*(2), 169-177.
- Manassis, K., Mendlowitz, S. L., Scapillato, D., Avery, D., Fiksenbaum, L., Freire, M., . . . Owens, M. (2002). Group and Individual Cognitive-Behavioral Therapy for Childhood Anxiety Disorders: A Randomized Trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*(12), 1423-1430. doi: 10.1097/00004583-200212000-00013
- Manfro, G. G., Isolan, L., Blaya, C., Maltz, S., Heldt, E., & Pollack, M. H. (2003). Relationship between adult social phobia and childhood anxiety. *Revista Brasileira de Psiquiatria, 25*, 96-99.
- Mansour, K., Roshdy, E., Daoud, O. A., Langdon, P. E., El-Saadawy, M., Al-Zahrani, A., & Khashaba, A. (2010). Child abuse and its long-term

- consequences: An exploratory study on Egyptian university students. *The Arab Journal of Psychiatry*, 22, 137-163.
- Marks, & Dar, R. (2000). Fear reduction by psychotherapies. *The British Journal of Psychiatry*, 176(6), 507-511.
- Marks, & Gelder. (1966). Different ages of onset in varieties of phobia. *The American journal of psychiatry*.
- Markus, M. T., Lindhout, I. E., Boer, F., Hoogendijk, T. H. G., & Arrindell, W. A. (2003). Factors of perceived parental rearing styles: the EMBU-C examined in a sample of Dutch primary school children. *Personality and Individual Differences*, 34(3), 503-519.
- Matsuishi, T., Nagano, M., Araki, Y., Tanaka, Y., Iwasaki, M., Yamashita, Y., . . . Shibuya, K. (2008). Scale properties of the Japanese version of the Strengths and Difficulties Questionnaire (SDQ): A study of infant and school children in community samples. *Brain and Development*, 30(6), 410-415.
- Matsunaga, H., Kiriike, N., Matsui, T., Iwasaki, Y., & Stein, D. J. (2001). Taijin kyofusho: a form of social anxiety disorder that responds to serotonin reuptake inhibitors? *The International Journal of Neuropsychopharmacology*, 4(3), 231-237.
- McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3(1), 131-149. doi: 10.1007/bf00975140

- McCarroll, J. E., Ursano, R. J., Fullerton, C. S., Liu, X., & Lundy, A. (2002). Somatic Symptoms in Gulf War Mortuary Workers. *Psychosomatic Medicine*, 64(1), 29-33.
- McConville, B., Ambrosini, P., Somoza, G., Bianchi, M., & Minnery, K. (1995). Optimal cut-off points for depression rating scales in adolescent depression. *Proceedings of the American Academy of Child and Adolescent Psychiatry*, 126.
- McFarlane, A. C., & Yehuda, R. A. (1996). Resilience, vulnerability, and the course of posttraumatic reactions.
- McGee, C. (2000). Childhood experiences of domestic violence.
- McGee, R., Feehan, M., Williams, S., Partridge, F., Silva, P. A., & Kelly, J. (1990). DSM-III disorders in a large sample of adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 29(4), 611-619.
- McLaughlin, J., Ambrosini, P., Fallon, T., Bianchi, M., & Metz, C. (1997). Validity parameters of the Children's Depression Inventory in pre-adolescent outpatients. *Proceedings of the American Academy of Child and Adolescent Psychiatry*, 139.
- McNaughton, N., & Gray, J. A. (2000). Anxiolytic action on the behavioural inhibition system implies multiple types of arousal contribute to anxiety. *Journal of affective disorders*, 61(3), 161-176. doi: 10.1016/s0165-0327(00)00344-x

- Meiser-Stedman, R., Smith, P., Glucksman, E., Yule, W., & Dalgleish, T. (2007). Parent and Child Agreement for Acute Stress Disorder, Post-Traumatic Stress Disorder and other Psychopathology in a Prospective Study of Children and Adolescents Exposed to Single-Event Trauma. *Journal of Abnormal Child Psychology*, 35(2), 191-201. doi: 10.1007/s10802-006-9068-1
- Mellor, D. (2004). Furthering the Use of the Strengths and Difficulties Questionnaire: Reliability With Younger Child Respondents. *Psychological Assessment*, 16(4), 396-401. doi: 10.1037/1040-3590.16.4.396
- Mersch, P. P. A., Emmelkamp, P. M. G., & Lips, C. (1991). Social phobia: individual response patterns and the long-term effects of behavioral and cognitive interventions. A follow-up study. *Behaviour Research and Therapy*, 29(4), 357-362.
- Metcalfe, B. D. (2008). Women, management and globalization in the Middle East. *Journal of Business Ethics*, 83(1), 85-100.
- Ministry of Economy and Planning, M. P. (2010). Development Plan
- Mofrad, S., Abdollah, R., & Samah, B. A. (2009). Perceived Parental Overprotection and Separation Anxiety: Does Specific Parental Rearing Serve as Specific Risk Factor. *Asian Social Science*, 5(11), P109.
- Mohammadi, M. R., Ghanizadeh, A., Mohammadi, M., & Mesgarpour, B. (2006). Prevalence of social phobia and its comorbidity with psychiatric disorders in Iran. *Depression and anxiety*, 23(7), 405-411.

- Molina, J. A. (1983). Understanding the biopsychosocial model. *The International Journal of Psychiatry in Medicine*, 13(1), 29-36.
- Molnar, B. E., Buka, S. L., & Kessler, R. C. (2001). Child sexual abuse and subsequent psychopathology: Results from the National Comorbidity Survey. *American journal of public health*, 91(5), 753.
- Montazeri, A., Harirchi, A. M., Shariati, M., Garmaroudi, G., Ebadi, M., & Fateh, A. (2003). The 12-item General Health Questionnaire (GHQ-12): translation and validation study of the Iranian version. *Health and Quality of Life Outcomes*, 1(1), 66.
- Montazeri, A., Vahdaninia, M., Ebrahimi, M., & Jarvandi, S. (2003). The Hospital Anxiety and Depression Scale (HADS): translation and validation study of the Iranian version. *Health and Quality of Life Outcomes*, 1(1), 14.
- Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E., & Herbison, G. P. (1993). Childhood sexual abuse and mental health in adult life. *The British Journal of Psychiatry*, 163(6), 721-732. doi: 10.1192/bjp.163.6.721
- Muris, P., Merckelbach, H., Ollendick, T., King, N., & Bogie, N. (2002). Three traditional and three new childhood anxiety questionnaires: Their reliability and validity in a normal adolescent sample. *Behaviour Research and Therapy*, 40(7), 753-772.
- Musa, C., Lépine, J. P., Clark, D., Mansell, W., & Ehlers, A. (2003). Selective attention in social phobia and the moderating effect of a concurrent depressive disorder. *Behaviour Research and Therapy*, 41(9), 1043-1054.

- Naing, L., Winn, T., & Rusli, B. (2006). Practical issues in calculating the sample size for prevalence studies. *Archives of Orofacial Sciences*, 1, 9-14.
- Neal, J. A., & Edelmann, R. J. (2003). The etiology of social phobia: Toward a developmental profile. *Clinical Psychology Review*, 23(6), 761-786.
- Niblock, T. (2006). *Saudi Arabia: power, legitimacy and survival*. RoutledgeCurzon.
- Niblock, T., & Malik, M. (2007). *The political economy of Saudi Arabia*: Taylor & Francis.
- Nicholas, S., Povey, D., Walker, A., & Kershaw, C. (2005). Crime in England and Wales 2004/2005. *STATISTICAL BULLETIN-HOME OFFICE RESEARCH DEVELOPMENT AND STATISTICS DIRECTORATE*, 11.
- Nichols, K. A. (1974). Severe social anxiety. *British Journal of Medical Psychology*, 47(4), 301-306.
- Niditch, L. A., & Varela, R. E. (2011). *Perceptions of Parenting, Emotional Self-Efficacy, and Anxiety in Youth: Test of a Mediational Model*.
- Nobles, A. Y., & Sciarra, D. T. (2000). Cultural determinants in the treatment of Arab Americans: A primer for mainstream therapists. *American Journal of orthopsychiatry*, 70(2), 182-191.
- Omair, K. (2008). Women in management in the Arab context. *Education, Business and Society: Contemporary Middle Eastern Issues*, 1(2), 107-123.

- Oosterbaan, D. B., Balkom, A. J. L. M., Spinhoven, P., Oppen, P., & Dyck, R. (2001). Cognitive therapy versus moclobemide in social phobia: a controlled study. *Clinical Psychology & Psychotherapy, 8*(4), 263-273.
- Osman, A., Gutierrez, P. M., Barrios, F. X., Kopper, B. A., & Chiros, C. E. (1998). The social phobia and social interaction anxiety scales: Evaluation of psychometric properties. *Journal of Psychopathology and Behavioral Assessment, 20*(3), 249-264.
- Öst, L. G. (1987). Age of onset in different phobias. *Journal of Abnormal Psychology, 96*(3), 223.
- Otto, M. W., Pollack, M. H., Maki, K. M., Gould, R. A., Worthington III, J. J., Smoller, J. W., & Rosenbaum, J. F. (2001). Childhood history of anxiety disorders among adults with social phobia: rates, correlates, and comparisons with patients with panic disorder. *Depression and anxiety, 14*(4), 209-213.
- Ozer, E. J., Best, S. R., Lipsey, T. L., & Weiss, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. *Psychological bulletin, 129*(1), 52.
- Page, A. C., Jones, R., & Wilson, F. (2004). Survey of West Australian anxiety support group participants' views on treatment processes and outcomes. *Australian Psychologist, 39*(3), 208-211.
- Palmieri, P. A., & Smith, G. C. (2007). Examining the structural validity of the Strengths and Difficulties Questionnaire (SDQ) in a US sample of custodial grandmothers. *Psychological Assessment, 19*(2), 189.

- Patel, A., Knapp, M., Henderson, J., & Baldwin, D. (2002). The economic consequences of social phobia. *Journal of affective disorders*, 68(2-3), 221-233. doi: [http://dx.doi.org/10.1016/S0165-0327\(00\)00323-2](http://dx.doi.org/10.1016/S0165-0327(00)00323-2)
- Paton, D. (1990). Assessing the impact of disasters on helpers. *Counselling Psychology Quarterly*, 3(2), 149-152.
- Pereda, N., Guilera, G., Forns, M., & Gómez-Benito, J. (2009). The prevalence of child sexual abuse in community and student samples: A meta-analysis. *Clinical Psychology Review*, 29(4), 328-338.
- Perkonig, A., Kessler, R. C., Storz, S., & Wittchen, H. (2000). Traumatic events and post-traumatic stress disorder in the community: prevalence, risk factors and comorbidity. *Acta Psychiatrica Scandinavica*, 101(1), 46-59.
- Pfefferbaum, B. (1997). Posttraumatic stress disorder in children: A review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36(11), 1503-1511.
- Pillai, P., & Chaudhary, N. (2009). Culture in minds and societies: Foundations of cultural psychology. *Psychological Studies*, 54(3), 238-239. doi: 10.1007/s12646-009-0030-5
- Pina, A. A., Silverman, W. K., Saavedra, L. M., & Weems, C. F. (2001). An analysis of the RCMAS lie scale in a clinic sample of anxious children. *Journal of Anxiety Disorders*, 15(5), 443-457. doi: 10.1016/s0887-6185(01)00075-5

- Pine, D. S., & Cohen, J. A. (2002). Trauma in children and adolescents: Risk and treatment of psychiatric sequelae. *Biological Psychiatry*, 51(7), 519-531.
- Pine, D. S., Costello, J., & Masten, A. (2005). Trauma, Proximity, and Developmental Psychopathology: The Effects of War and Terrorism on Children. *Neuropsychopharmacology*, 30(10), 1781-1792.
- Pollock, R. A., Rosenbaum, J. F., Marris, A., Miller, B. S., & Biederman, J. (1995). Anxiety disorders of childhood: Implications for adult psychopathology. *The Psychiatric Clinics of North America*, 18(4).
- Prawira, Y., Tumbelaka, I., Alhadar, A., Hendrata, E., Hidayat, R., & Anderson, D. (2010). Detection of Developmental Disorder, Behavioral Disorder, and Depression in Post-Earthquake Children.
- Punamäki, R. L., Qouta, S., & El-Sarraj, E. (2001). Resiliency factors predicting psychological adjustment after political violence among Palestinian children. *International Journal of Behavioral Development*, 25(3), 256-267.
- Punch, S. (2002). Research with children. *Childhood*, 9(3), 321-341.
- Pynoos, R. S., Frederick, C., Nader, K., Arroyo, W., Steinberg, A., Eth, S., . . . Fairbanks, L. (1987). Life threat and posttraumatic stress in school-age children. *Archives of general psychiatry*, 44(12), 1057.
- Qur'an, T. H. Surat Al-Rum

- Ranta, K., Kaltiala-Heino, R., Koivisto, A. M., Tuomisto, M. T., Pelkonen, M., & Marttunen, M. (2007). Age and gender differences in social anxiety symptoms during adolescence: The Social Phobia Inventory (SPIN) as a measure. *Psychiatry research, 153*(3), 261-270.
- Ranta, K., Kaltiala-Heino, R., Rantanen, P., Tuomisto, M. T., & Marttunen, M. (2007). Screening social phobia in adolescents from general population: the validity of the Social Phobia Inventory (SPIN) against a clinical interview. *European psychiatry, 22*(4), 244-251.
- Rapee, & Heimberg, R. G. (1997). A cognitive-behavioral model of anxiety in social phobia. *Behaviour Research and Therapy, 35*(8), 741-756.
- Rapee, Schniering, C. A., & Hudson, J. L. (2009). Anxiety disorders during childhood and adolescence: origins and treatment. *Annual Review of Clinical Psychology, 5*, 311-341.
- Rapee, & Spence. (2004). The etiology of social phobia: empirical evidence and an initial model. *Clinical Psychology Review, 24*(7), 737-767. doi: 10.1016/j.cpr.2004.06.004
- Rawas, H. O., Yates, P., Windsor, C., & Clark, R. A. (2012). Cultural challenges to secondary prevention: Implications for Saudi women. *Collegian, 19*(1), 51-57.
- Reavis, R. (2005). Exploratory study of the relationship between social anxiety, depressogenic style and coping skills in children. *The Sciences and Engineering, 65*(7-B), 22-37.

- Reduction, I. S. f. D. (2004). *Living with risk: a global review of disaster reduction initiatives* (Vol. 1): United Nations Publications.
- Reed, R. V., Fazel, M., Jones, L., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in low-income and middle-income countries: risk and protective factors. *The Lancet*, 379(9812), 250-265.
- Reich, J., & Yates, W. (1988). Family history of psychiatric disorders in social phobia. *Comprehensive Psychiatry*, 29(1), 72-75. doi: 10.1016/0010-440x(88)90039-9
- Reynolds, C. R., & Richmond, B. O. (1978). What I think and feel: A revised measure of children's manifest anxiety. *Journal of Abnormal Child Psychology*, 6(2), 271-280.
- Reynolds, C. R., & Richmond, B. O. (1979). Factor structure and construct validity of 'What I Think and Feel': The Revised Children's Manifest Anxiety Scale. *Journal of Personality Assessment*, 43(3), 281-283.
- Rheingold, A. A., Herbert, J. D., & Franklin, M. E. (2003). Cognitive bias in adolescents with social anxiety disorder. *Cognitive Therapy and Research*, 27(6), 639-655.
- Rimm-Kaufman, S. E., & Kagan, J. (2005). Infant predictors of kindergarten behavior: The contribution of inhibited and uninhibited temperament types. *Behavioral Disorders*, 30(4), 331.

- Roberts, R., O'Connor, T., Dunn, J., & Golding, J. (2004). The effects of child sexual abuse in later family life; mental health, parenting and adjustment of offspring. *Child abuse & neglect*, 28(5), 525-545.
- Roggman, L. A., Moe, S. T., Hart, A. D., & Forthun, L. F. (1994). Family leisure and social support: Relations with parenting stress and psychological well-being in Head Start parents. *Early Childhood Research Quarterly*, 9(3-4), 463-480.
- Ross, G. (2003). *Beyond the trauma vortex: the media's role in healing fear, terror, and violence*: North Atlantic Books.
- Roth, M. (1969). Anxiety neuroses and phobic states. I. Clinical features. *British medical journal*, 1(5642), 489.
- Rowe, D. C., Stever, C., Gard, J. M. C., Cleveland, H. H., Sanders, M. L., Abramowitz, A., . . . Waldman, I. D. (1998). The Relation of the Dopamine Transporter Gene (DAT1) to Symptoms of Internalizing Disorders in Children. *Behavior Genetics*, 28(3), 215-225. doi: 10.1023/a:1021427314941
- Rozin, P. (2003). Five potential principles for understanding cultural differences in relation to individual differences. *Journal of Research in Personality*, 37(4), 273-283. doi: 10.1016/s0092-6566(02)00566-4
- Ruscio, A., Brown, T., Chiu, W., Sareen, J., Stein, M., & Kessler, R. (2008). Social fears and social phobia in the USA: results from the National Comorbidity Survey Replication. *Psychological Medicine*, 38(1), 15-28.

- Ryan, E. P., Aaron, J., Burnette, M. L., Warren, J., Burket, R., & Aaron, T. (2008). Emotional responses of staff to assault in a pediatric state hospital. *Journal of the American Academy of Psychiatry and the Law Online*, 36(3), 360-368.
- Saigh, P. A. (1991). The development of posttraumatic stress disorder following four different types of traumatization. *Behaviour Research and Therapy*, 29(3), 213-216.
- Samad, L., Hollis, C., Prince, M., & Goodman, R. (2005). Child and adolescent psychopathology in a developing country: testing the validity of the strengths and difficulties questionnaire (Urdu version). *International journal of methods in psychiatric research*, 14(3), 158-166.
- Sanchez-Lopez, M. D. E. L. P., & Dresch, V. THE 12-ITEM GENERAL HEALTH QUESTIONNAIRE (GHQ-12): RELIABILITY, EXTERNAL VALIDITY AND FACTOR STRUCTURE IN THE SPANISH POPULATION *Psicothema*, año/vol. 20, número 004 Universidad de Oviedo Oviedo, España.
- Sappington, A. (2000). Childhood abuse as a possible locus for early intervention into problems of violence and psychopathology. *Aggression and Violent Behavior*, 5(3), 255-266.
- Sar, V., Taycan, O., Bolat, N., Özmen, M., Duran, A., Öztürk, E., & Ertem-Vehid, H. (2010). Childhood trauma and dissociation in schizophrenia. *Psychopathology*, 43(1), 33-40.

- Saylor, C. F., Finch, A., Spirito, A., & Bennett, B. (1984). The Children's Depression Inventory: A systematic evaluation of psychometric properties. *Journal of Consulting and Clinical Psychology, 52*(6), 955.
- Scaer, R. C. (2001). *The body bears the burden: Trauma, dissociation, and disease*: Informa HealthCare.
- Scheeringa, M. S., & Zeanah, C. H. (2001). A relational perspective on PTSD in early childhood. *Journal of Traumatic Stress, 14*(4), 799-815.
- Schmitz, N., Kruse, J., Heckrath, C., Alberti, L., & Tress, W. (1999). Diagnosing mental disorders in primary care: the General Health Questionnaire (GHQ) and the Symptom Check List (SCL-90-R) as screening instruments. *Social psychiatry and psychiatric epidemiology, 34*(7), 360-366.
- Schneier, Johnson, Hornig, Liebowitz, & Weissman. (1992). Social phobia: Comorbidity and morbidity in an epidemiologic sample. *Archives of general psychiatry, 49*(4), 282-288. doi: 10.1001/archpsyc.1992.01820040034004
- Schnurr, P. P., & Green, B. L. (2004). *A context for understanding the physical health consequences of exposure to extreme stress*: American Psychological Association.
- Schwartz, C. E., Snidman, N., & Kagan, J. (1999). Adolescent social anxiety as an outcome of inhibited temperament in childhood. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*(8), 1008-1015.

- Sedlak, A. J., & Broadhurst, D. D. (1996). The national incidence study of child abuse and neglect. *Washington DC. US Department of Health and Human Services.*
- Seidman, L. J., Faraone, S. V., Goldstein, J. M., Kremen, W. S., Horton, N. J., Makris, N., . . . Tsuang, M. T. (2002). Left hippocampal volume as a vulnerability indicator for schizophrenia: a magnetic resonance imaging morphometric study of nonpsychotic first-degree relatives. *Archives of general psychiatry, 59(9)*, 839.
- Shaw, D. S., Schonberg, M., Sherrill, J., Huffman, D., Lukon, J., Obrosky, D., & Kovacs, M. (2006). Responsivity to offspring's expression of emotion among childhood-onset depressed mothers. *Journal of Clinical Child and Adolescent Psychology, 35(4)*, 490-503.
- Silove, D., Sinnerbrink, I., Field, A., Manicavasagar, V., & Steel, Z. (1997). Anxiety, depression and PTSD in asylum-seekers: associations with pre-migration trauma and post-migration stressors. *The British Journal of Psychiatry, 170(4)*, 351-357.
- Silverman, A. B., Reinherz, H. Z., & Giaconia, R. M. (1996). The long-term sequelae of child and adolescent abuse: A longitudinal community study. *Child Abuse & Neglect, 20(8)*, 709-723. doi: 10.1016/0145-2134(96)00059-2
- Smith, Perrin, S., Yule, W., & Rabe-Hesketh, S. (2001). War exposure and maternal reactions in the psychological adjustment of children from

Bosnia-Herzegovina. *Journal of Child Psychology and Psychiatry*, 42(03), 395-404.

Smith, C., Hancock, H., Blake-Mortimer, J., & Eckert, K. (2007). A randomised comparative trial of yoga and relaxation to reduce stress and anxiety. *Complementary Therapies in Medicine*, 15(2), 77-83.

Smith, P., Perrin, S., Yule, W., Hacam, B., & Stuvland, R. (2002). War exposure among children from Bosnia-Herzegovina: Psychological adjustment in a community sample. *Journal of Traumatic Stress*, 15(2), 147-156.

Spataro, J., Mullen, P. E., Burgess, P. M., Wells, D. L., & Moss, S. A. (2004). Impact of child sexual abuse on mental health. *The British Journal of Psychiatry*, 184(5), 416-421.

Spatz Widom, C., DuMont, K., & Czaja, S. J. (2007). A prospective investigation of major depressive disorder and comorbidity in abused and neglected children grown up. *Archives of general psychiatry*, 64(1), 49.

Spector, I. P., Pecknold, J. C., & Libman, E. (2003). Selective attentional bias related to the noticeability aspect of anxiety symptoms in generalized social phobia. *Journal of Anxiety Disorders*, 17(5), 517-531.

Spence. (2003). Social skills training with children and young people: Theory, evidence and practice. *Child and Adolescent Mental Health*, 8(2), 84-96.

Spence, Donovan, C., & Brechman-Toussaint, M. (2000). The Treatment of Childhood Social Phobia: The Effectiveness of a Social Skills Training-based, Cognitive-behavioural Intervention, with and without Parental

Involvement. *Journal of Child Psychology and Psychiatry*, 41(6), 713-726.
doi: 10.1111/1469-7610.00659

Spinhoven, P., Elzinga, B. M., Hovens, J. G. F. M., Roelofs, K., Zitman, F. G., van Oppen, P., & Penninx, B. W. J. H. (2010). The specificity of childhood adversities and negative life events across the life span to anxiety and depressive disorders. *Journal of affective disorders*, 126(1), 103-112.

Stallard, P., Salter, E., & Velleman, R. (2004). Posttraumatic stress disorder following road traffic accidents. *European Child & Adolescent Psychiatry*, 13(3), 172-178.

Stanko, E. A. (2006). Theorizing About Violence. *Violence Against Women*, 12(6), 543-555. doi: 10.1177/1077801206289137

Stark, K. D., & Laurent, J. (2001). Joint factor analysis of the children's depression inventory and the revised children's manifest anxiety scale. *Journal of Clinical Child Psychology*, 30(4), 552-567.

Stein. (1993). Cross-cultural psychiatry and the DSM-IV. *Comprehensive Psychiatry*, 34(5), 322-329.

Stein, Fuetsch, M., Muller, N., Hofler, M., Lieb, R., & Wittchen, H. U. (2001). Social anxiety disorder and the risk of depression: a prospective community study of adolescents and young adults. *Archives of general psychiatry*, 58(3), 251.

Stein, Tancer, M. E., Gelernter, C. S., & Vittone, B. J. (1990). Major depression in patients with social phobia. *The American journal of psychiatry*.

- Stein, M. B., Torgrud, L. J., & Walker, J. R. (2000). Social phobia symptoms, subtypes, and severity: findings from a community survey. *Archives of general psychiatry*, 57(11), 1046.
- Steinberg, A. M., Brymer, M. J., Decker, K. B., & Pynoos, R. S. (2004). The University of California at Los Angeles post-traumatic stress disorder reaction index. *Current psychiatry reports*, 6(2), 96-100.
- Stemberger, R. T., Turner, S. M., Beidel, D. C., & Calhoun, K. S. (1995). Social phobia: An analysis of possible developmental factors. *Journal of Abnormal Psychology*, 104(3), 526.
- Stopa, L., & Clark, D. M. (2000). Social phobia and interpretation of social events. *Behaviour Research and Therapy*, 38(3), 273-283. doi: 10.1016/s0005-7967(99)00043-1
- Stopa, L., & Clark, D. M. (2001). Social Phobia: Comments on the Viability & Validity of an Analogue Research Strategy & British Norms for the Fear of Negative Evaluation Questionnaire. *Behavioural and Cognitive Psychotherapy*, 29(4), 423-430.
- Strauss, C. C., & Last, C. G. (1993). Social and simple phobias in children. *Journal of Anxiety Disorders*, 7(2), 141-152. doi: 10.1016/0887-6185(93)90012-a
- Susser, M. (2001). Glossary: causality in public health science. *Journal of Epidemiology and Community Health*, 55(6), 376-378.

- Swahn, M. H., Whitaker, D. J., Phippen, C. B., Leeb, R. T., Teplin, L. A., Abram, K. M., & McClelland, G. M. (2006). Concordance between self-reported maltreatment and court records of abuse or neglect among high-risk youths. *American journal of public health, 96*(10), 1849.
- Swartz, D. (1997). *Culture and power: The sociology of Pierre Bourdieu*. University of Chicago Press.
- Tabachnick, B., & Fidell, L. (2007). *Using multivariate statistics* Boston: Pearson Education: Inc.
- Tedeschi, R. G., Calhoun, L. G., Linley, P., & Joseph, S. (2004). A clinical approach to posttraumatic growth. *Positive psychology in practice, 405-419*.
- Terr, L. C. (1995). Childhood traumas. *Psychotraumatology: Key papers and core concepts in post-traumatic stress, 301*.
- Thabet, Abed, Y., & Vostanis, P. (2001). Effect of trauma on the mental health of Palestinian children and mothers in the Gaza Strip. *Eastern Mediterranean health journal= La revue de santé de la Méditerranée orientale= al-Majallah al-ṣiḥḥiyah li-sharq al-mutawassiṭ, 7*(3), 413.
- Thabet, Abed, Y., & Vostanis, P. (2002). Emotional problems in Palestinian children living in a war zone: a cross-sectional study. *The Lancet, 359*(9320), 1801-1804.

- Thabet, Abed, Y., & Vostanis, P. (2004). Comorbidity of PTSD and depression among refugee children during war conflict. *Journal of Child Psychology and Psychiatry, 45*(3), 533-542. doi: 10.1111/j.1469-7610.2004.00243.x
- Thabet, Ibraheem, A., Shivram, R., Winter, E., & Vostanis, P. (2009). Parenting support and PTSD in children of a war zone. *International Journal of Social Psychiatry, 55*(3), 226-237.
- Thabet, Karim, K., & Vostanis, P. (2006). Trauma exposure in pre-school children in a war zone. *The British Journal of Psychiatry, 188*(2), 154-158. doi: 10.1192/bjp.188.2.154
- Thabet, Tawahina, El Sarraj, & Vostanis. (2008). Exposure to war trauma and PTSD among parents and children in the Gaza strip. *European Child & Adolescent Psychiatry, 17*(4), 191-199. doi: 10.1007/s00787-007-0653-9
- Thabet, & Vostanis, P. (2000). Post traumatic stress disorder reactions in children of war: a longitudinal study. *Child abuse & neglect, 24*(2), 291-298.
- Thabet, Vostanis, P., & Karim, K. (2005). Group crisis intervention for children during ongoing war conflict. *European Child & Adolescent Psychiatry, 14*(5), 262-269.
- Thabet, A. A., Tawahina, A. A., El Sarraj, E., & Vostanis, P. (2008). Exposure to war trauma and PTSD among parents and children in the Gaza strip. *European Child & Adolescent Psychiatry, 17*(4), 191-199.

- The Department of Health, D. (2000). *guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.*
- Theall-Honey, L. A., & Schmidt, L. A. (2006). Do temperamentally shy children process emotion differently than nonshy children? Behavioral, psychophysiological, and gender differences in reticent preschoolers. *Developmental psychobiology*, *48*(3), 187-196.
- Thienkrua, W., Cardozo, B. L., Chakkraband, M. L. S., Guadamuz, T. E., Pengjuntr, W., Tantipiwatanaskul, P., . . . Group, f. t. T. P.-T. M. H. S. (2006). Symptoms of Posttraumatic Stress Disorder and Depression Among Children in Tsunami-Affected Areas in Southern Thailand. *JAMA: The Journal of the American Medical Association*, *296*(5), 549-559. doi: 10.1001/jama.296.5.549
- Thomas, S. E., Randall, C. L., & Carrigan, M. H. (2003). Drinking to cope in socially anxious individuals: A controlled study. *Alcoholism: Clinical and Experimental Research*, *27*(12), 1937-1943.
- Toyabe, S., Shioiri, T., Kobayashi, K., Kuwabara, H., Koizumi, M., Endo, T., . . . Someya, T. (2007). Factor structure of the General Health Questionnaire (GHQ-12) in subjects who had suffered from the 2004 Niigata-Chuetsu Earthquake in Japan: a community-based study. *BMC Public Health*, *7*(1), 175.
- Triandis, H. C. (1980). Reflections on trends in cross-cultural research. *Journal of cross-cultural psychology*, *11*(1), 35-58.

- Triandis, H. C., & Suh, E. M. (2002). Cultural influences on personality. *Annual review of psychology, 53*(1), 133-160.
- Tsao, J. C. I., Mystkowski, J. L., Zucker, B. G., & Craske, M. G. (2005). Impact of cognitive-behavioral therapy for panic disorder on comorbidity: a controlled investigation. *Behaviour Research and Therapy, 43*(7), 959-970.
- Tsui, E. (1990). The “Jupiter” sinking disaster: Effects on teenagers’ school performance. *Unpublished MSc dissertation, University of London.*
- Tucker, P., Pfefferbaum, B., Nixon, S. J., & Dickson, W. (2000). Predictors of post-traumatic stress symptoms in Oklahoma City: exposure, social support, peri-traumatic responses. *The Journal of Behavioral Health Services and Research, 27*(4), 406-416.
- Turgeon, L., & Chartrand, É. (2003). Reliability and Validity of the Revised Children's Manifest Anxiety Scale in a French-Canadian Sample. *Psychological Assessment, 15*(3), 378.
- Turk, C. L., Heimberg, R. G., Orsillo, S. M., Holt, C. S., Gitow, A., Street, L. L., . . . Liebowitz, M. R. (1998). An investigation of gender differences in social phobia. *Journal of Anxiety Disorders, 12*(3), 209-223.
- U.S. Department of Health & Human Services. (2004). *Child Maltreatment In A. f. C. a. Family* (Ed.). Washington D.C.
- U.S. Department of Health & Human Services. (2006). *Child Maltreatment (A. f. C. a. Family, Trans.)*. Washington D. C. .

- Udwin, O., Boyle, S., Yule, W., Bolton, D., & O'Ryan, D. (2000). Risk Factors for Long-term Psychological Effects of a Disaster Experienced in Adolescence: Predictors of Post Traumatic Stress Disorder. *Journal of Child Psychology and Psychiatry*, 41(8), 969-979.
- Van Ameringen, M., Allgulander, C., Bandelow, B., Greist, J. H., Hollander, E., Montgomery, S. A., . . . Stein, D. J. (2003). WCA recommendations for the long-term treatment of social phobia. *CNS spectrums*.
- Van Ameringen, M., Mancini, C., & Oakman, J. M. (1998). The relationship of behavioral inhibition and shyness to anxiety disorder. *The Journal of nervous and mental disease*, 186(7), 425.
- Van Ameringen, M., Mancini, C., Styan, G., & Donison, D. (1991). Relationship of social phobia with other psychiatric illness. *Journal of affective disorders*, 21(2), 93-99.
- Van Ameringen, M., Oakman, J., Mancini, C., Pipe, B., & Chung, H. (2004). Predictors of response in generalized social phobia: effect of age of onset. *Journal of clinical psychopharmacology*, 24(1), 42.
- Van de Ven, P., Rawstorne, P., Treloar, C., Epidemiology, N. C. i. H., Research, C., Research, N. C. i. H. S., . . . Society. (2002). *HIV/AIDS, hepatitis C & related diseases in Australia: Annual report of behaviour 2002*: National Centre in HIV Social Research.
- Van der Kolk, B. A., McFarlane, A. C., & Van Der Hart, O. (1996). A general approach to treatment of posttraumatic stress disorder.

- Van Gastel, W., Legerstee, J., & Ferdinand, R. (2009). The role of perceived parenting in familial aggregation of anxiety disorders in children. *Journal of Anxiety Disorders, 23*(1), 46-53.
- Van Hooff, M., McFarlane, A. C., Baur, J., Abraham, M., & Barnes, D. J. (2009). The stressor Criterion-A1 and PTSD: A matter of opinion? *Journal of Anxiety Disorders, 23*(1), 77-86.
- Van Velzen, C. J. M., Emmelkamp, P. M. G., & Scholing, A. (2000). Generalized social phobia versus avoidant personality disorder: Differences in psychopathology, personality traits, and social and occupational functioning. *Journal of Anxiety Disorders, 14*(4), 395-411.
- Velting, O. N., & Albano, A. M. (2001). Current Trends in the Understanding and Treatment of Social Phobia in Youth. *Journal of Child Psychology and Psychiatry, 42*(1), 127-140. doi: 10.1111/1469-7610.00705
- Vogel, F. E. (2000). *Islamic law and legal system: studies of Saudi Arabia* (Vol. 8): Brill Academic Pub.
- Voncken, Alden, L. E., & Bögels, S. M. (2006). Hiding anxiety versus acknowledgment of anxiety in social interaction: Relationship with social anxiety. *Behaviour Research and Therapy, 44*(11), 1673-1679. doi: 10.1016/j.brat.2005.11.005
- Voncken, Bögels, S., & Peeters, F. (2007). Specificity of interpretation and judgemental biases in social phobia versus depression. *Psychology and Psychotherapy: Theory, Research and Practice, 80*(3), 443-453.

- Vranceanu, A.-M., Hobfoll, S. E., & Johnson, R. J. (2007). Child multi-type maltreatment and associated depression and PTSD symptoms: The role of social support and stress. *Child Abuse & Neglect, 31*(1), 71-84. doi: 10.1016/j.chiabu.2006.04.010
- Vriends, N., Becker, E. S., Meyer, A., Williams, S. L., Lutz, R., & Margraf, J. (2007). Recovery from social phobia in the community and its predictors: Data from a longitudinal epidemiological study. *Journal of Anxiety Disorders, 21*(3), 320-337.
- Walker, J. L., Carey, P. D., Mohr, N., Stein, D. J., & Seedat, S. (2004). Gender differences in the prevalence of childhood sexual abuse and in the development of pediatric PTSD. *Archives of women's mental health, 7*(2), 111-121. doi: 10.1007/s00737-003-0039-z
- Wallace, J. M., & Muroff, J. R. (2002). Preventing Substance Abuse Among African American Children and Youth: Race Differences in Risk Factor Exposure and Vulnerability. *The Journal of Primary Prevention, 22*(3), 235-261. doi: 10.1023/a:1013617721016
- Wallace, S. T., & Alden, L. E. (1997). Social phobia and positive social events: The price of success. *Journal of Abnormal Psychology, 106*(3), 416.
- Watson, M., James-Roberts, I. S., Ashley, S., Tilney, C., Brougham, B., Edwards, L., . . . Romer, G. (2005). Factors associated with emotional and behavioural problems among school age children of breast cancer patients. *British journal of cancer, 94*(1), 43-50.

- Weissberg, R. P., Kumpfer, K. L., & Seligman, M. E. P. (2003). Prevention that works for children and youth: An introduction. *American Psychologist; American Psychologist*, *58*(6-7), 425.
- Weissman, Bland, R., Canino, G., Greenwald, S., Lee, C., Newman, S., . . . Wickramaratne, P. (1996). The cross-national epidemiology of social phobia: a preliminary report. *International clinical psychopharmacology*, *11*, 9.
- Weissman, Bland, R. C., Canino, G. J., Faravelli, C., Greenwald, S., Hwu, H. G., . . . Lellouch, J. (1996). Cross-national epidemiology of major depression and bipolar disorder. *JAMA: The Journal of the American Medical Association*, *276*(4), 293-299. doi: 10.1001/jama.1996.03540040037030
- Weisz, J. R., Sigman, M., Weiss, B., & Mosk, J. (1993). Parent reports of behavioral and emotional problems among children in Kenya, Thailand, and the United States. *Child development*, *64*(1), 98-109.
- Weisz, J. R., Suwanlert, S., Chaiyasit, W., & Walter, B. R. (1987). Over-and undercontrolled referral problems among children and adolescents from Thailand and the United States: The< em> wat and< em> wai of cultural differences. *Journal of Consulting and Clinical Psychology*, *55*(5), 719.
- Wells, A., White, J., & Carter, K. (1997). Attention training: effects on anxiety and beliefs in panic and social phobia. *Clinical Psychology & Psychotherapy*, *4*(4), 226-232.

- WHO, W. H. O. (1993). *The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research*: World Health Organization.
- WHO, W. H. O. (2002). *The World Health Report, 2001: Mental Health: New Understanding, New Hope*: Bookwell.
- Wickrama, K. A. S., & Kaspar, V. (2007). Family context of mental health risk in Tsunami-exposed adolescents: Findings from a pilot study in Sri Lanka. *Social Science & Medicine*, 64(3), 713-723. doi: 10.1016/j.socscimed.2006.09.031
- Wiguna, T., Guerrero, A. P. S., Kaligis, F., & Khamelia, M. (2010). Psychiatric morbidity among children in North Aceh district (Indonesia) exposed to the 26 December 2004 tsunami. *Asia-Pacific Psychiatry*, 2(3), 151-155.
- Williams, J., Steel, C., Sharp, G. B., DelosReyes, E., Phillips, T., Bates, S., . . . Griebel, M. L. (2003). Parental anxiety and quality of life in children with epilepsy. *Epilepsy & Behavior*, 4(5), 483-486.
- Wilson, C., Budd, B., Chernin, R., King, H., Leddy, A., Maclennan, F., & Mallandain, I. (2011). The role of meta-cognition and parenting in adolescent worry. *Journal of Anxiety Disorders*, 25(1), 71-79. doi: 10.1016/j.janxdis.2010.08.005
- Wilson, S. L., Kuebli, J. E., & Hughes, H. M. (2005). Patterns of maternal behavior among neglectful families: implications for research and intervention. *Child abuse & neglect*, 29(9), 985-1001.

- Wisniewski, J. J., James, A. M., Genshaft, J. L., & Daniel, L. C. (1987). Test-retest reliability of the Revised Children's Manifest Anxiety Scale. *Perceptual and Motor Skills, 65*(1), 67-70.
- Wittchen, H., Stein, M., & Kessler, R. (1999). Social fears and social phobia in a community sample of adolescents and young adults: prevalence, risk factors and co-morbidity. *Psychological Medicine, 29*(2), 309-323.
- Woerner, W., Fleitlich-Bilyk, B., Martinussen, R., Fletcher, J., Cucchiaro, G., Dalgalarrrondo, P., . . . Tannock, R. (2004). The Strengths and Difficulties Questionnaire overseas: Evaluations and applications of the SDQ beyond Europe. *European Child & Adolescent Psychiatry, 13*.
- Wohlfarth, T., Winkel, F. W., Ybema, J. F., & van den Brink, W. (2001). The relationship between socio-economic inequality and criminal victimisation: a prospective study. *Social psychiatry and psychiatric epidemiology, 36*(7), 361-370. doi: 10.1007/s001270170042
- Wolfe, D. A., Crooks, C. V., Lee, V., McIntyre-Smith, A., & Jaffe, P. G. (2003). The effects of children's exposure to domestic violence: A meta-analysis and critique. *Clinical Child and Family Psychology Review, 6*(3), 171-187.
- Wozencraft, T., Wagner, W., & Pellegrin, A. (1991). Depression and suicidal ideation in sexually abused children. *Child abuse & neglect, 15*(4), 505-511.
- Wu, S. S., Ma, C. X., Carter, R. L., Ariet, M., Feaver, E. A., Resnick, M. B., & Roth, J. (2004). Risk factors for infant maltreatment: a population-based study. *Child abuse & neglect, 28*(12), 1253-1264.

- Wykes, T., & Whittington, R. (1998). Prevalence and predictors of early traumatic stress reactions in assaulted psychiatric nurses. *The Journal of Forensic Psychiatry, 9*(3), 643-658.
- Yamani, M. (2000). *Changed identities: The challenge of the new generation in Saudi Arabia*: Royal Institute of International Affairs, Middle East Programme.
- Ye, S. (2009). Factor structure of the General Health Questionnaire (GHQ-12): the role of wording effects. *Personality and Individual Differences, 46*(2), 197-201.
- Yeh, M., & Weisz, J. R. (2001). Why are we here at the clinic? Parent–child (dis) agreement on referral problems at outpatient treatment entry. *Journal of Consulting and Clinical Psychology, 69*(6), 1018.
- Yonkers, K. A., Bruce, S. E., Dyck, I. R., & Keller, M. B. (2003). Chronicity, relapse, and illness—course of panic disorder, social phobia, and generalized anxiety disorder: Findings in men and women from 8 years of follow-up. *Depression and anxiety, 17*(3), 173-179.
- Yule, W., Bolton, D., Udwin, O., Boyle, S., O’Ryan, D., & Nurrish, J. (2000). The long-term psychological effects of a disaster experienced in adolescence: I: The incidence and course of PTSD. *Journal of Child Psychology and Psychiatry, 41*(4), 503-511.
- Yule, W., Bruggencate, S. T., & Joseph, S. (1994). Principal components analysis of the Impact of Events Scale in adolescents who survived a shipping disaster. *Personality and Individual Differences, 16*(5), 685-691.

- Yule, W., & Williams, R. M. (1990). Post-traumatic stress reactions in children. *Journal of Traumatic Stress, 3*(2), 279-295.
- Zahr, L. K. (1996). Effects of war on the behavior of Lebanese preschool children: Influence of home environment and family functioning. *American Journal of orthopsychiatry, 66*(3), 401-408.
- Zatzick, D. F., Marmar, C. R., Weiss, D. S., Browner, W. S., Metzler, T. J., Golding, J. M., . . . Wells, K. B. (1997). Posttraumatic stress disorder and functioning and quality of life outcomes in a nationally representative sample of male Vietnam veterans. *American Journal of Psychiatry, 154*(12), 1690-1695.
- Zimmermann, G., Pin, M. A., Krenz, S., Bouchat, A., Favrat, B., Besson, J., & Zullino, D. F. (2004). Prevalence of social phobia in a clinical sample of drug dependent patients. *Journal of affective disorders, 83*(1), 83-87. doi: 10.1016/j.jad.2004.05.003
- Zlomke, K., & Young, J. (2009). A Retrospective Examination of the Role of Parental Anxious Rearing Behaviors in Contributing to Intolerance of Uncertainty. *Journal of Child and Family Studies, 18*(6), 670-679. doi: 10.1007/s10826-009-9269-7

Appendices

Appendices 3.1: Socio-demographic checklist

البيانات الأولية

أسم المريض: الجنس: ذكر/أنثى العمر: سنة / / هـ تاريخ التطبيق: / / هـ
المرافق مع المريض: والده/ والدته المرحلة الدراسية للمريض: عدد الأخوة () عدد الأخوات ()
ترتيب المريض بين أشقائه ()
عنوان المريض وطريقة الاتصال:

المستوى التعليمي لوالده: أقل من جامعي / جامعي / عالي المستوى التعليمي لوالدته: أقل من جامعي / جامعي / عالي
المستوى المعيشي للمريض: أقل من المتوسط/ متوسط / عالي
الحالة الاجتماعية للوالدين: متزوجين / مطلقين / أرملة / أكثر من زوجة

إقرار موافقة

المشارك بالبحث:

إن البحث والإجراء للدراسة المعنونة " بالتعرض للصدمة النفسية والخوف الاجتماعي لدى الأطفال " قد شرح لي بواسطة الباحث زياد السيد مبعث وزارة الصحة . وقد وضع لي بأنه يمكنني أن أسأل أي سؤال أو استفسر عن أي موضوع في أي وقت من مراحل البحث ولي حق الانسحاب من إكمال البحث عندما أشاء دون التأثير على حقنا في الرعاية الصحية . كما سيتم تسليمي نسخة من هذا الإقرار.
أوافق على المشاركة في هذه الدراسة طوعا ولست مجبرنا على توقيع إقرار المشاركة في هذا البحث دون رغبتي.

المشارك:
أسم وتوقيع ولي الأمر التاريخ ١ ١429 هـ الوقت: .../.../...

إقرار الباحث

أقر بأنني قد شرحت إجراءات وأهداف البحث والالتزامات المطلوبة من المشارك في هذا البحث. وقد أجبته على كافة الاستفسارات والتساؤلات في ذلك قدر استطاعتي . وسأقوم بتزويد المشارك بنسخة موقعة من هذا الإقرار.

أسم وتوقيع الباحث: التاريخ ١ ١429 هـ الوقت: .../.../...

توقيع الباحث الرئيسي

زياد السيد التاريخ ١ ١429 هـ الوقت: .../.../...

Appendices 3.2: Professor Ambrosini e-mails

Alsayed, Zeiad

From: Alsayed, Z.
Sent: 28 January 2008 20:44
To: Ambrosini, Paul J
Subject: RE: K-SADS

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Professor Ambrosini

I appreciate your acceptance, I will be glad to send you the final Arabic version.

Regards,

Zeiad Alsayed

From: Ambrosini, Paul J [mailto:Paul.Ambrosini@DrexelMed.edu]
Sent: Mon 28/01/2008 18:31
To: Alsayed, Z.
Subject: RE: K-SADS

Zeiad,

I would be more than happy to help you with your project to translate the K-SADS IVR for use in Saudi children. I assume you would be planning to translate it into Arabic. This should be a nice fit with Sajida's Urdu translation.

I only request that I get a copy of the final version for my records.

Best of luck,
Paul Ambrosini

Alsayed, Zeiad

From: Alsayed, Z.
Sent: 28 January 2008 02:26
To: Paul.Ambrosini@DrexelMed.edu
Subject: K-SADS

Dear Professor Ambrosini

I have been given your contact by Sajida Abdul Hussein my colleague at institute.

I am from Riyadh - Saudi Arabia. Presently I am doing my PhD at the institute of child health, university of Leicester under supervision of Professor Vostanis.

I plan to investigation the relationship between trauma and anxiety disorders among children in Saudi Arabia. I will be using the K-SADS IVR for assessment of prevalence of psychiatric disorders would like to know whether I need an authorization from the author as I am planning to translate and modify the instrument for use in Saudi Arabia.

I would be grateful if you could assist me through my study with your valuable suggestions and expert opinion.
Hope to hear from you soon.

Best regards,

Zeiad Alsayed

(PhD Student),
University of Leicester,
Green Wood Institute of Child Health,
za38@le.ac.uk

Appendices 3.3

Measures of emotional symptoms

Appendices 3.3.1: Impact of Event Scale

تأثير الحدث- الأطفال

The Impact of Events Scale (IES)

عزيزي: هذه قائمه ببعض الأعراض التي تلي الخبرات الصادمة التي تعرضت لها خلال الستة أشهر الماضية مثل القصف، والتجريف، و الاجتياح. الرجاء قراءتها وذكر تكرارها خلال الأيام القليلة الماضية، ضع علامة (صح) أمام الإجابة المناسبة.					
غالبا	احيانا	نادرا	أبدا		
5	3	1	0	Do you think about it even when you don't mean to? هل تفكر بالأحداث الصادمة دون قصد؟	١.
5	3	1	0	Do you try to remove it from your memory هل تفكر في إزالة الأحداث الصادمة من ذاكرتك؟	٢.
5	3	1	0	Do you have difficulties paying attention or concentrating? هل لديك صعوبات في التركيز و الانتباه؟	٣.
5	3	1	0	Do you have waves of strong feelings about it هل تتناوب موجات من المشاعر الشديدة الخاصة بالأحداث الصادمة؟	٤.
5	3	1	0	Do you startle more easily or feel more nervous than you did before it happened? . هل تستنثار بسهولة أو تشعر بأنك متوتر أكثر بعد الأحداث الصادمة؟	٥.
5	3	1	0	Do you stay away from reminders of it (e.g. places or situations) هل تحاول تجنب الأماكن و الأشخاص الذين يذكرونك بالأحداث الصادمة؟	٦.
5	3	1	0	Do you try not talk about it هل تحاول تجنب الحديث عن الأحداث الصادمة؟	٧.
5	3	1	0	Do pictures about it pop into your mind? هل تفاجئ عقلك صور خاصة بالأحداث الصادمة؟	٨.
5	3	1	0	Do other things keep making you think about it? هل هناك أشياء أخرى تذكرك بالأحداث الصادمة؟	٩.
5	3	1	0	Do you try not to think about it? هل تحاول عدم التفكير بالأحداث الصادمة؟	١٠.
5	3	1	0	Do you get easily irritable هل تستنثار بسهولة؟	١١.
5	3	1	0	Are you alert and watchful even when there is no obvious need to be? هل تشعر بأنك متحفز و مترقب لشيء غير متوقع	١٢.
5	3	1	0	Do you have sleep problems? هل لديك مشاكل في النوم (بسبب صور أو أفكار متعلقة بالأحداث الصادمة)	١٣.

Appendices 3.3.2: Revised Children's Manifest Anxiety Scale

مقياس القلق (RCMAS)

أمامك مجموعة من الأسئلة نرجو الإجابة عليها بنعم أو لا مع الشكر

الرقم	نعم	لا
1		أشعر بأنني غير قادر على اتخاذ قرار
2		أشعر بالقلق عندما لا تسير الأمور كما أريد
3		الآخرين يعملون الأشياء بسهولة أكثر مني
4		أنا أحب كل واحد أعرفه
5		بعض الأحيان أعاني من ضيق في التنفس
6		أنا قلقان معظم الوقت
7		أنا أخاف من حاجات كثيرة
8		أنا دائماً لطيف مع الناس
9		من السهولة إغضابي
10		أشعر بالقلق لما سيقوله لي والدي
11		أحس بأن الآخرين لا يحبون الطريقة التي أفعل بها الأشياء اليومية.
12		أنا دائماً أتصرف بشكل جيد
13		أنا أجد صعوبة في الذهاب للنوم في الليل
14		أنا قلق حيال ما يعتقد الناس عني
15		أنا دائماً أشعر بأنني وحيد عندما أكون مع الناس
16		أنا دائماً جيد
17		أشعر عادة بوجع في المعدة
18		من السهل جرح مشاعري و إيلامي
19		اشعر بتعرق يدي
20		أنا لطيف مع الجميع
21		أنا دائماً تعبان
22		أنا قلقان علي ما سيحصل في المستقبل
23		الأطفال الآخرين مبسوطين أكثر مني
24		أنا دائماً أقول الصدق
25		أنا أحلم أحلام سيئة
26		من السهولة جرح مشاعري عندما أكون قلقان
27		أنا اشعر بأن هناك من سيقول لي بأنني أعمل الأشياء بطريقة خاطئة

		أنا لا ازعل أبدا	28
		أقوم من النوم مرعوب بعض الأحيان	29
		أنا أقلق عندما أذهب إلى فراشي للنوم	30
		يصعب علي أن أركز على الواجبات المدرسية	31
		لا أقول أشياء لا ينبغي علي قولها	32
		انزعج وأمل من الجلوس لمدة طويلة	33
		أنا قلقان وعصبي	34
		أحس بأن ناس كثير ضدي	35
		أنا لا أكذب أبدا	36
		أنا دائما قلق على أشياء سيئة ممكن تحدث لي	37

The Revised Children's Manifest Anxiety Scale

Read each question carefully. Put a circle around the word YES if you think it is true about you. Put a circle around the word NO if you think it is not true about you

No.	Items
1	I have trouble making up my mind.
2	I get nervous when things do not go the right way for me.
3	Others seem to do things easier than I can.
4	I like everyone I know.
5	Often I have trouble getting my breath.
6	I worry a lot of the time.
7	I am afraid of a lot of things.
8	I am always kind.
9	I get mad easily.
10	I worry about what my parents will say to me.
11	I feel that others do not like the way I do things.
12	I always have good manners.
13	It is hard for me to get to sleep at night.
14	I worry about what other people think about me.
15	I feel alone even when there are people with me.
16	I am always good.
17	Often I feel sick in the stomach.
18	My feelings get hurt easily.
19	My hands feel sweaty.
20	I am always nice to everyone.
21	I am tired a lot.
22	I worry about what is going to happen.
23	Other children are happier than I am.
24	I tell the truth every single time.
25	I have bad dreams.
26	My feelings get hurt easily when I am fussed at.
27	I feel someone will tell me I do things the wrong way.
28	I never get angry.
29	I wake up scared some of the time.
30	I worry when I go to bed at night.
31	It is hard for me to keep my mind on my schoolwork.
32	I never say things that I shouldn't.
33	I wriggle in my seat a lot.
34	I am nervous.
35	A lot of people are against me.
36	I never lie.
37	I often worry about something bad happening to me.

The Physiological (10): 1+5+9+13+17+19+21+25+29+33.

The Worry / oversensitivity (11): 2+6+7+10+14+18+22+26+30+34+37.

The Concentration Anxiety (7): 3+11+15+23+27+31+35.

Appendices 3.3.3: Children's Depression Inventory

The Children's Depression Inventory (CDI)

" الصورة الفصحى" (CDI) مقياس (د) للصغار

أحياناً ما يشعر الصغار والشباب ببعض المشاعر و يفكرون في بعض الأفكار، و في هذه الكراسة بعض المشاعر و الأفكار مكتوبة في صورة مجموعات، تتكون كل مجموعة من ثلاث عبارات، عليك أن تختار واحدة من كل مجموعة من العبارات (في المربع المجاور للعبارة التي لا ترى أنت أن هذه العبارة تصفك خلال الأسبوعين الأخيرين ثم قم بوضع علامة) اخترتها، وبعد ذلك انتقل إلى مجموعة العبارات التالية لها، و هكذا حتى تنتهي كل المجموعات.

يجب أن تلاحظ أنه لا توجد إجابة صحيحة وإجابة خاطئة، ولكن المطلوب منك أن تختار عبارة واحدة من كل مجموعة، و تكون هذه العبارة هي التي ترى أنها تصف حالتك خلال الأسبوعين الأخيرين بما في ذلك اليوم. و على سبيل المثال التالي

أنا أقرأ الكتب طوال الوقت

أنا أقرأ الكتب أحياناً

أنا لم أقرأ كتب في حياتي

(في المربع إذا كانت العبارة الأولى تنطبق عليك و تصفك في الأسبوعين الأخيرين بما في ذلك اليوم، ضع علامة) المجاور لها تماماً كما رأيت في المثال السابق. تذكر أنك تختار العبارة التي تصف مشاعرك و أفكارك في الأسبوعين الأخيرين.

No.	Items	Arabic
1	I am sad some time.	أنا أشعر بالحزن أحيانا
	I feel sad a lot of times	إننا أشعر بالحزن في أوقات كثيرة.
	I feel sad all the times	إنني أشعر بالحزن طوال الوقت.
2	Nothing will ever work out for me	كل ما يخصني لا يسير سيرا حسناً
	I am not sure everything will work very well for me.	أنا لست متأكد من أن الأشياء و الظروف تسير سيرا حسناً.
	The everything will be good for me	الأشياء والظروف سوف تسير سيرا حسناً بالنسبة لي.
3	I do most of things correctly	أنا أعمل أغلب الأشياء بطريقة جيدة
	I do many things wrong	أنا أعمل أشياء كثيرة بطريقة خطأ.
	I do everything wrong	أنا أعمل كل شيء بطريقة خطأ.
4	There are many things are enjoyable	توجد أشياء كثيرة تسليني
	Some of things are fun	بعض الأشياء والحاجات تسليني.
	Nothing is fun at all.	لا يوجد شيء يسليني.
5	I am bad all the time.	في كل الأوقات أنا سيئ
	I am bad most of the times	في أوقات كثيرة أكون سيئ.
	I am sometimes bad	أحيانا أكون سيئ.
6	I think sometimes terrible things will happen to me	أحيانا أفكر في أشياء سيئة (غير مستحبة) تحدث لي
	I am worry from some terrible things maybe are happen to me	أنا قلق و مشغول من بعض الأشياء السيئة أو غير المستحبة تحدث لي
	I am sure that terrible things will happen to me.	أنا متأكد من أشياء سيئة أو غير مستحبة سوف تحدث لي
7	I hate myself	أنا أكره نفسي
	I do not love myself	أنا لا أحب نفسي
	I love myself	أنا أحب نفسي
8	All bad things are my fault	كل الأشياء السيئة أو غير المستحبة تحدث بسببي أنا
	Most of bad things are my fault	كثير من الأشياء السيئة أو غير المستحبة تحدث بسببي أنا
	The bad things not always my fault	لا تحدث الأشياء السيئة أو غير المستحبة دائماً بسببي أنا
9	I do not think of killing myself	أنا لا أفكر في أن أقتل نفسي
	I am thinking of killing myself, but I will not do so	أفكر في قتل نفسي و لكن لن أفعل ذلك
	I want to kill myself	أنا أريد أن أقتل نفسي
10	I feel like crying every day.	يوميأ أشعر بأنني أريد أن أبكي
	I feel like crying most of times	في أوقات كثيرة أشعر أنني أريد أن أبكي
	I feel like crying sometimes	أحيانا أشعر أنني أريد أن أبكي.
11	Things bother me all the time	توجد أشياء تضايقتني دائماً
	Things bother me most of times	توجد أشياء تضايقتني أوقات كثيرة
	Things bother me sometimes	توجد أشياء تضايقتني أحيانا

12	I like to be with people	أنا أحب أن أكون مع الناس
	I do not want to be with people most of times.	لا أحب أن أكون مع الناس في أوقات كثيرة
	I do not want to be with people ever	أنا لا أريد أن أكون مع الناس أبداً
13	I cannot make up my mind about things	أنا لا أستطيع أن أقرر أو أحدد رأيي في الأشياء
	I feel difficult to make up my mind about things	من الصعب علي أن أقرر أو أحدد رأيي في الأشياء
	I decide about things easily	أنا أقرر أو أحدد رأيي في الأشياء بسهولة
14	I look good.	أنا شكلي حسن
	There are some things in my look are not good.	يوجد بعض الأشياء في شكلي غير حسنة.
	I look ugly	أنا شكلي غير حسن
15	I have to push myself all the time to do my homework	يجب علي أن أدفع نفسي طوال الوقت حتى أكمل واجبات المدرسة
	I have bush myself more than one time to do my homework	يجب علي أن أدفع نفسي أكثر من مرة حتى أكمل واجبات المدرسة
	Homework does not make problem for me	واجبات المدرسة ليست مشكلة كبيرة بالنسبة لي.
16	I have trouble sleeping every night.	كل ليلة يصعب علي النوم
	I have trouble sleeping most of nights	في ليالي كثيرة يصعب علي النوم
	I sleep very well	أنا أنام جيداً.
17	I feel tired some time	أشعر أحياناً أنني مجهد أو متعب
	Most of time I feel tired	أشعر في أوقات كثيرة أنني مجهد أو متعب
	I am tired all the time.	أشعر طوال الوقت بالإجهاد أو التعب
18	Most days I do not feel like eating	في أغلب الأيام لا تكون لدي شهية للطعام
	Some days I do not feel like eating	في أيام كثيرة لا تكون لدي شهية للطعام
	I eat very well	أنا أكل بطريقة جيدة
19	I do not worry about aches and pains	أنا غير قلق من أي آلام أو أوجاع
	Sometime I worry about aches and pains	في مرات كثيرة أكون قلقاً من بعض الآلام و الأوجاع.
	I worry about aches and pains all the time	طوال الوقت أكون قلقاً من الآلام و الأوجاع
20	I do not feel lonely	أنا لا أشعر بالوحدة
	Sometime I feel lonely	في أوقات كثيرة أشعر بالوحدة
	I feel lonely all time	طوال الوقت أشعر بالوحدة
21	I never have fun at school	لم أشعر بالمتعة في المدرسة أبداً
	I feel fun at school some times	أحياناً أشعر بالمتعة في المدرسة
	I feel fun at school most of times	في أوقات كثيرة أشعر بالمتعة في المدرسة.
22	I have many friends.	لدي أصدقاء كثيرون
	I have some friends, but I hope that I have more friends	لدي بعض الأصدقاء و لكن أتمنى أن يكون لدي أصدقاء أكثر

	I do not have any friend	أنا ليس لدي صديق واحد
23	My school work is very good.	عملي- شغلي- المدرسي جيد
	My school work does not be good as I used to be before	عملي المدرسي ليس جيداً كما كان من قبل
	I do very badly in subjects I used to be good in.	عملي المدرسي سيئ جداً في مواد كنت دائماً جيد فيها.
24	I can never be as good as other kids	أنا لا يمكن أن أكون جيداً مثل باقي زملائي
	I can be as good as the other kids.	لو أردت فإني أستطيع أن أكون جيداً مثل باقي زملائي
	I am good as other kids	أنا جيد مثل باقي زملائي.
25	Nobody really loves me.	في الحقيقة لا أحد يحبني
	I not sure if there any one loves me	أنا لست متأكد من أن أحد يحبني
	I am sure that some people love me	أنا متأكد من أن بعض الأشخاص يحبونني
26	Usually I do what I am asked to do	أنا عادة أعمل ما يطلب مني
	Most of times I do what I am asked to do	في أغلبية الأوقات أنا لا أعمل ما يطلب مني
	I never do what I am told	طوال عمري لم أعمل ما يطلب مني
27	I get on with people	أنا أنسجم مع الناس
	I get into fights sometime.	في أوقات كثيرة أجد نفسي متورطاً في مشاجرات
	I get into fights all the time.	طوال الوقت أنا أتورط في مشاجرات

Appendices 3.3.4: Measures of social phobia symptoms

Social Phobia Checklist

قائمة الرهاب الاجتماعي

(SPC)

هذه قائمة ببعض الأعراض التي تشعر بها في المواقف الاجتماعية التي تتعرض لها. الرجاء قراءتها ووضع علامة (صح) أمام الإجابة المناسبة.

الرقم	العبارة	أبداً	أحياناً	دائماً
1	(خلال الأربعة أسابيع الماضية) أخاف عندما انضم لمجموعة كبيرة في حفلة على سبيل المثال			
2	أخاف عندما أكون محور الاهتمام			
3	(في الأربعة أسابيع الماضية) أخاف عندما يتوجب على القيام بعمل ما مثل الكتابة بينما يشاهدني الآخرون			
4	(خلال أربعة أسابيع الماضية) أخاف عندما أتحدث أو أقرأ بصوت عالي أمام مجموعة			
5	أخاف عندما أجاب سؤال في الفصل أو في اجتماع للمجموعة			
6	أخاف في الحفلات، العزائم، المدرسة وأذهب للمنزل مبكراً			
7	(خلال الأربعة أسابيع الماضية) أخاف أن التقى أصدقاء جدد			
8	أخاف كثيراً من طرح الأسئلة في الصف			
9	(خلال الأربعة أسابيع الماضية) أخاف من الأكل أمام مجموعة من الناس			
10	أخاف إذا بدأ أحد الجدال			
11	أخاف عندما يطلب مني أحدهم القيام بأشياء لا أريد القيام بها			
12	أخاف في المواقف المحرجة			
13	أخاف إذا أحدهم قال شيء خطأ أو سيء			
14	أخاف عندما أبدأ الحديث مع أحدهم			
15	أخاف عندما يتوجب علي الحديث لفترة أكثر من دقائق قليلة			
16	(خلال أربعة أسابيع الماضية) أخاف عندما أتكلم مع شباب حولي أو في الفصل			
17	أخاف عندما ألعب بالمدرسة، أو أشارك بالنشاطات المدرسية			
18	أخاف عندما يتجاهلني أو يسخر مني الآخرون			
19	أتجنب المناسبات الاجتماعية (الحفلات - المدرسة - اللعب مع الآخرين)			
20	أعادر المناسبات الاجتماعية			
21	قبل الذهاب إلى الحفلة، أفكر في الأشياء السيئة التي يمكن أن تحدث			
22	يخذلني صوتي أو يبدووا مضحكاً عندما أتحدث إلى الآخرين			
23	عندما أكون برفقة الآخرين، أفكر في أشياء مخيفة			
24	قبل الذهاب لبعض الأماكن، أشعر بإعراض جسدية			
25	عندما أكون في مناسبات اجتماعية، أشعر بأعراض جسدية			

Social Phobia

No.	Items
1	Afraid when joining a large group such as at a party
2	Afraid when becoming the centre of attention
3	Afraid when I have to do something such as writing while others watch me
4	Afraid when speaking or reading out loud in front of a group
5	Afraid when answering questions in class or at group meetings
6	Afraid at parties, dances, school... And go home early
7	Afraid to meet new kids
8	Too afraid to ask questions in class
9	Afraid eating in front of others
10	afraid if someone starts arguing
11	afraid if someone asks me to do something that I don't want to do
12	afraid in an embarrassing situation
13	afraid if someone says something that is wrong or bad
14	afraid when I start to talk to someone
15	afraid if I have to talk for longer than a few minutes
16	Afraid when speaking with other young people around, or in class
17	Afraid when in a school play, choir, music, or dance recital
18	afraid when ignored or made fun of by others
19	I avoid social situations (parties, school, playing with others)
20	I leave social situations
21	Before going to a party, I think about what might go wrong
22	My voice leaves me or sounds funny when I am talking to others
23	When I am with other people, I think "scary" thoughts
24	Before going someplace, I feel (somatic symptoms)
25	When I am in a social situation, I feel (somatic symptoms)

Appendices 3.3.5: Strengths and Difficulties Questionnaire

Strengths and Difficulties Questionnaire (SDQ)

استبيان مواطن القوة والصعوبة

يرجى الإجابة على كل فقرة بـ: غير صحيح - صحيح نوعا ما - صحيح بالتأكيد بوضع علامة تحت الإجابة المناسبة، حاول أن تكون دقيقاً في إجابتك، قد يساعدنا كثيرا إذا أجبت على كل فقرة حتى وإن كنت غير متأكد أو ترى إنها غير مناسبة. يرجى أن تكون إجابتك على أساس كيف كانت الأمور بالنسبة لك خلال الستة شهور الأخيرة.

الرقم	العبارة	صحيح بالتأكيد	صحيح نوعا ما	غير صحيح
1	أتعاطف مع مشاعر الناس الآخرين.			
2	لا أستطيع أن أبقى ساكنا لفترة طويلة في مكان واحد - غير مستقر - وكثير الحركة			
3	كثير ما تصيبني ألآم في البطن ألآم في الرأس أو شعور بالغثيان			
4	أشارك الآخرين فيما يخصني من أشياء (أكل- ألعاب - أفلام.. إلخ)			
5	ينتابني غضب شديد وكثيرا ما أفقد أعصابي			
6	في العادة أحب العزلة . أعب وحدي . أبقى بمفري معظم الوقت			
7	في عادة أفعل ما يطلبه مني الكبار			
8	أقلق كثيرا، وغالبا أبدو قلقا			
9	أساعد الآخرين إذا حدث لأحدهم مكروها			
10	أتململ وأتلوى (أثقلل وجسدي يتحرك) باستمرار أثناء جلوسي			
11	لدي صديق عزيز واحد أو أكثر			
12	أتشاجر كثيرا مع الآخرين وأتسلط عليهم وأجعلهم ينفذون ما أريد			
13	كثيرا ما أكون غير سعيد - حزين أو سريع البكاء			
14	بشكل عام يحبني من هم في سني			
15	يتشتت انتباهي بسرعة . أجد صعوبة في التركيز			
16	أنا عصبي في المواقف الجديدة . (غير المعتادة) بسهولة أفقد تقتي			
17	أنا لطيف مع من هم أصغر سنا مني			
18	كثيرا ما يتهمني الآخرون بالكذب والخداع			
19	الأطفال الآخرون يسخرون مني ويتمردون علي			
20	كثيرا ما أتطوع في مساعدة الآخرين. (الوالدين- المدرسين- الأطفال الآخرين)			
21	أفكر بالنتائج قبل ما أتصرف			
22	أخذ أشياء ليست ملكي من البيت أو المدرسة أو أي من أماكن أخرى			
23	أنسجم بشكل أفضل مع الكبار أكثر من انسجامي مع الصغار			
24	لدي مخاوف كثيرة . ومن السهل تخويفي			
25	أكمل العمل الذي أقوم به حتى النهاية . ولدي انتباه جيد			

هل لديك إضافة أخرى ؟ -----

من فضلك أقلب الصفحة هناك أسئلة قليلة أخرى على الوجه الأخر

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months or this school year.

No.	Items
1	Considerate of other people's feelings
2	Restless, overactive, cannot stay still for long
3	Often complains of headaches, stomach-aches or sickness
4	Shares readily with other children (treats, toys, pencils etc.)
5	Often has temper tantrums or hot tempers
6	Rather solitary, tends to play alone
7	Generally obedient, usually does what adults request
8	Many worries, often seems worried
9	Helpful if someone is hurt, upset or feeling ill
10	Constantly fidgeting or squirming
11	Has at least one good friend
12	Often fights with other children or bullies them
13	Often unhappy, down-hearted or tearful
14	Generally liked by other children
15	Easily distracted, concentration wanders
16	Nervous or clingy in new situations, easily loses confidence
17	Kind to younger children
18	Often lies or cheats
19	Picked on or bullied by other children
20	Often volunteers to help others (parents, teachers, other children)
21	Thinks things out before acting
22	Steals from home, school or elsewhere
23	Gets on better with adults than with other children
24	Many fears, easily scared
25	Sees tasks through to the end, good attention span

Do you have any other comments or concerns?

Emotional Symptoms : 3 – 8 – 13 – 16 – 24.

Conduct Problems: 5 – 7 – 12 – 18 – 22.

Hyperactivity: 2 – 10 – 15 – 21 – 25.

Peer Problems: 6 – 11 – 14 – 19 – 23.

Prosocial Behaviour: 1 – 4 – 9 – 17 – 20.

Appendices 3.4: Exposure to Trauma

قائمة التعرض للصدمات Exposure to trauma Checklist

هذه قائمة ببعض الأحداث والمشاكل التي قد يكون سبق وأن حدثت للطفل أو ارتبطت بأحد أفراد العائلة أو أترت عليها تجارب الآخرين. فضلاً حدد التجارب التي مر بها الطفل خلال هذه السنة الماضية وذلك بالإجابة على البنود التالية:

I would now like to ask about things that have happened or problems that your (NAME CHILD) may have directly faced or involved with family member or affected by others experiences.

Since NAME CHILD was born...

No	Yes	العبارة	م
0	1	هل سبق وان تعرض لانفصال لعلاقة زوجية أو لعلاقة دائمة Have had a separation due to marital difficulties or broken off a steady relationship?	1
0	1	هل شهد عنف أسري عنيف مثل أن يري والدته تضرب بالمنزل Have witnessed severe domestic violence, e.g. saw mother badly beaten up at home?	2
0	1	هل تعرض أو أحد المقربين له لازمه مالية قوية مثل خسارة نخل ثلاث شهور Have someone close to you had a major financial crisis, such as losing the equivalent of three-months income?	3
0	1	هل تعرض أو أحد المقربين له لمشكلة مع الشرطة تطلبت التحويل للمحكمة Have you (or someone close to you) had a problem with the police involving a court appearance?	4
0	1	هل تعرض أو أحد المقربين له لهجوم أو تهديد شديد، من قبل سارق أو عصابة على سبيل المثال Have experienced a severe attack or threat, e.g. by a mugger or gang?	5
0	1	هل تعرض أو أحد المقربين له لمرض عضوي مثل السرطان أو أزمة قلبية قوية Have you (or someone close to you) had a serious physical illness such as cancer or heart attack?	6
0	1	هل تعرض أو أحد المقربين له لمرض عقلي شديد مثل انفصام الشخصية أو اكتئاب شديد Have you (or someone close to you) had a serious mental illness such as schizophrenia or major depression?	7
0	1	خلال مراحل حياته هل سبق وان توفي أحد والديه أو أشقائه أو أحد العزيرين عليه Now turning to things have happened to her/him. At any stage in his/her life, has a parent, brother or sister of his/hers died?	8
0	1	هل حدث، وأن أصيب بمرض شديد تطلب التنويم بالمستشفى Has s/he ever had a serious illness which required a stay in hospital?	9
0	1	هل سبق وأن تعرض لحادث شديد أو تعرض لأذى في حادث Has s/he ever been in a serious accident or badly hurt in an accident?	10

0	1	هل تعرض لشيء مخيف أو خطر مثل دهس بالسيارة أو لحادث سيارة أو قطار ... الع.ج. Have you exposure to something frightening or dangerous, e.g. being in a ferry or a train crash... etc?	11
0	1	هل تعرض أو أحد المقربين له لحريق أو كفت هناك خيرة قاسية وسيئة كمن تحتجز في حادث حريق Have you (or someone close to you) experienced a serious fire, e.g. trapped in a burning house or car?	12
0	1	هل تعرضت أنت أو أحد المقربين لك لأحد هذه الكوارث مثل الخطف أو الزلازل أو الفيضانات أو أحد الانفجارات أو الحرب Have you (or someone close to you) experienced other disasters, e.g. kidnapping, earthquake, explosions, or war.	13
0	1	في السنة الماضية هل قطع علاقتك مع زميل أو قريب له مثلاً كمن قطع علاقتك بأفضل صديق له In the past year, has s/he ended close friendship, for example, permanently falling out with a best friend?	14
0	1	هل تعرض أو أحد المقربين له لإساءة بدنية شديدة ما زال يتذكرها Has s/he experienced (or someone close to here/him) severe physical abuse?	15
0	1	هل تعرض أو أحد المقربين له لإساءة أو تحرش جنسي Have you (or someone close to you) experienced sexual abuse?	16
0	1	هل تعرض أو أحد المقربين له للاغتصاب Have you (or someone close to you) experienced rape?	17
0	1	هل سبق وإن فقدت شيء عزيز عليك مثل لعبة أو دمية؟ Have you ever lost something that was dear to yourself, like a dolly or toy?	18
0	1	هل سبق وإن تعرض لموقف صعب وشديد من قبل عائلته أو زملاءه أو مدرسية ما زال يتذكره Has s/he experienced an embarrassing situation (for example, insults and humiliation) by his/her family, colleagues that he/she still remembers?	19

Appendices 3.5: Parental factors

Appendices 3.5.1: Parental Rearing Style

Parental Rearing Style (EMBU-C)

(Egna Minnen Beträffande Uppfostran)

م	العبارة	أبدا		أحيانا		في الغالب		دائما	
		أم	أب	أم	أب	أم	أب	أم	أب
1	هل يشعر بأن والداه يبينان له أنهما يحبانها؟ Do your parents show that they love you?	1	1	2	2	3	3	4	4
2	هل والداه يدللانه أكثر من إخوانه أو خواته Do your parents spoil you more than they do your brothers and sisters? (By brothers and sisters, we mean all the children who live at your house.)	1	1	2	2	3	3	4	4
3	هل يعتقد أن والداه يحبانها Do you think your parents love you?	1	1	2	2	3	3	4	4
4	هل يعاقبه والداه على الأشياء البسيطة؟ Do your parents punish you for minor things?	1	1	2	2	3	3	4	4
5	هل يشعر بعض الأحيان بخيبة الأمل في والديه لأنهما لم يعطيانها ما أراد؟ Are you sometimes disappointed in your parents because they won't give you what you want?	1	1	2	2	3	3	4	4
6	هل يعطيه والداه الأشياء التي يريد، بينما لا يفعلان ذلك مع إخوانه Do your parents give you things you want, but not your brothers and sisters? (By brothers and sisters, we mean all the children who live at your house.)	1	1	2	2	3	3	4	4
7	هل يعدل والداه دائما إذا عاقبه؟ If your parents punish you, are they always fair?	1	1	2	2	3	3	4	4
8	هل يعتقد ان والداه حازمين جدا معه Do you think that your parents are too firm with you?	1	1	2	2	3	3	4	4
9	إذا ارتكب حماقة معينة هل يستطيع تصليح الأمور مع والديه If you have done something stupid, can you then make it up to your parents?	1	1	2	2	3	3	4	4
10	هل يدللانه والداه بين الحين والآخر Do you get a cuddle from your parents every now and then?	1	1	2	2	3	3	4	4
11	هل والديه يمنعانه من عمل أشياء زملائه بالفصل يقومون بها لأنهم يخافون من أن يحدث له أي مكروه؟ Do your parents forbid you to do things that your classmates are allowed to do because they are afraid of something happening to you?	1	1	2	2	3	3	4	4
12	هل والديه بعض الأحيان يوبخونه أو يضربونه في وجود آخرين حولهم؟	1	1	2	2	3	3	4	4

								Do your parents sometimes tell you off or hit you when there are others around?	
4	4	3	3	2	2	1	1	هل يهتم والداه بما يقوم به بعد انتهاء المدرسة؟ Are your parents concerned about what you do after school hours?	13
4	4	3	3	2	2	1	1	هل يقوم والداه بمساعدته ومواساته إذا لم تسير الأمور على ما يرام؟ If things aren't going right for you, do your parents try to comfort or help you?	14
4	4	3	3	2	2	1	1	هل والداه شديدي الاهتمام بصحته البدنية Are your parents very concerned about your physical health?	15
4	4	3	3	2	2	1	1	هل والديه يعقبانه أكثر مما يستحق Do your parents hit you more than you deserve?	16
4	4	3	3	2	2	1	1	إذ طلب منه والداه المساعدة في الأعمال اليومية ولم يقم بذلك، هل يغضبان؟ If your parents ask you to help with the daily chores and you don't do this, do they get angry?	17
4	4	3	3	2	2	1	1	إذا عمل شيء لم يكن عليه عمله، هل هذا الشيء يجعل والداه غير سعيدين مما يجعله تشعر بالسوء والذنب If you have done something that you should not have, does this make your parents so unhappy that you start feeling bad/guilty?	18
4	4	3	3	2	2	1	1	هل لديه الانطباع بأن والديه يحبانه أكثر من إخوانه وخواته؟ Do you have the impression that your parents love you more than they do your brothers and sisters? (By brothers and sisters, we mean all the children who live at your house.)	19
4	4	3	3	2	2	1	1	هل يهتم والداه بدرجاته المدرسية؟ Are your parents interested in your school mark?	20
4	4	3	3	2	2	1	1	هل تعتقد بأن والداه سيساعدانه إذا كان لديه شيء يصعب عليه القيام به؟ Do you think that your parents would help you if you had something really difficult to do?	21
4	4	3	3	2	2	1	1	هل والداه يلومانه على كل شيء Do your parents blame you for everything?	22
4	4	3	3	2	2	1	1	هل سبق وان قال له والداه شيء مثل "أنت كبرت على فعل هذه الأشياء" Do your parents ever say things like you are too big to be still doing things like that?	23
4	4	3	3	2	2	1	1	إذا كان والداه حزينين، هل يعتقد أحيانا أنه غلظه If your parents are sad, do you sometimes think it's your fault?	24
4	4	3	3	2	2	1	1	هل والداه يوضحان أنهما يحبانه Do your parents make it obvious that they love	25

								you?	
4	4	3	3	2	2	1	1	هل يشعر أن والديه يقيمان وزننا لرأييه؟ Do you feel that your parents take account of your opinions?	26
4	4	3	3	2	2	1	1	عندما يكون لديه سر، هل يرغب والداه بمعرفته أيضا When you have a secret, do your parents want to know it too?	27
4	4	3	3	2	2	1	1	هل يشعر بأن والداه يحبون البقاء معه؟ Do you have the feeling that your parents like being with you?	28
4	4	3	3	2	2	1	1	هل يقول له والديه أحيانا أشياء مثل " سأكون حزينا جدا إذا فعلت هذا" Do your parents sometimes say things like "it would make me really unhappy if you did that"?	29
4	4	3	3	2	2	1	1	هل يعتقد أن والديه يحاولان جعل مرحلة النمو مرحلة سعيدة بالنسبة له، يتعلم فيها الكثير من الأشياء (مثل إعطائه كتب جيدة، والسماح له بالمشاركة في الرحلات وغيرها) Do you think that parents are trying to make growing up a happy time for you and one in which you learn lots of things (by, for example, give you good books, going on outings you to camps and so on?)	30
4	4	3	3	2	2	1	1	هل يقول له والداه في بعض الأحيان أنه قمت بعمل جيد؟ Do your parents sometimes tell you that you've done well?	31
4	4	3	3	2	2	1	1	هل يعتقد أحيانا انه سيء لأنه تعمل أشياء والداه لا يرغبان بأن تعملها؟ Do you sometimes think you are bad because you've done things your parents didn't want you to do?	32
4	4	3	3	2	2	1	1	هل يعتقد بأن والديه لديهما طموحات كبيرة فيما يتعلق بنتائج المدرسة وإنجازاته الرياضية وغيرها؟ Do you think your parents have high expectations as far as your school results; sports achievements and so on are concerned?	33
4	4	3	3	2	2	1	1	هل يعمل والداه ضجة أحيانا بسبب الفوضى التي قام بها أو بسبب إهماله في عمل بعض الأشياء؟ Do your parents sometimes make a fuss about the mess you make or that you're sloppy about the way you do things?	34
4	4	3	3	2	2	1	1	هل يحاول والداه مساعدته أو فهمه عندما يشعر بالتعاسة؟ Do your parents try to help you and to be understanding when you feel unhappy?	35
4	4	3	3	2	2	1	1	هل والداه أحيانا يعقبانته حتى لو لم يعمل شيء خاطئ؟ Do your parents sometimes punish you even	36

								though you haven't done anything wrong?	
4	4	3	3	2	2	1	1	هل من المهم لولداه معرفة أي نوع من الأصدقاء لديه؟ Is it important for your parents what sort of friends you've got?	37
4	4	3	3	2	2	1	1	إذا حدث خطأ ما في المنزل، هل يلقي عادة باللوم عليه؟ If something goes wrong at home, are you the one who usually gets blamed for it?	38
4	4	3	3	2	2	1	1	هل والداه يحبانكما كما هو؟ Do your parents like you the way you are?	39
4	4	3	3	2	2	1	1	هل يقسو عليه والداه في بعض الأحيان؟ Are your parents sometimes harsh and unkind to you?	40
4	4	3	3	2	2	1	1	هل يعاقبه والداه أحياناً على بعض الأشياء البسيطة؟ Do your parents sometimes punish you for minor things?	41
4	4	3	3	2	2	1	1	هل والداه أحياناً يصفعانك حينما لا يتوقع منهم ذلك؟ Do your parents sometimes give you a slap when you don't expect it?	42
4	4	3	3	2	2	1	1	هل يهتم والداه بهواياتهم والأشياء التي يحبونها؟ (على سبيل المثال، هل يقوموا بعمل بعض الأشياء مع بعض، هل يحضر والداه لمشاهدته وهو يمارس الرياضة، هل يستمتعان بالاستماع لما يود قوله) Are your parents interested in your hobbies and the things you like? (For example, do you sometimes do things together, do your parents come along when you're playing sport, do they enjoy listening to what you have to say?)	43
4	4	3	3	2	2	1	1	هل والداه يضربانك أحياناً؟ Do your parents sometimes hit you?	44
4	4	3	3	2	2	1	1	هل والداه أحياناً يجعلانك تحس بأنك تافه؟ Do your parents sometimes make you feel really little?	45
4	4	3	3	2	2	1	1	هل والداه أحياناً يعطون أخوانهم وخواتهم أشياء ولا يعطونهم مثلها؟ Do your parents sometimes give your brothers and sisters things that you don't get? (By brothers and sisters, we mean all the children who live at your house.)	46
4	4	3	3	2	2	1	1	هل تعتقد بأن والديك قلقان جداً من الأشياء التي تحدث لك؟ Do you think that your parents are too worried about things happening to you?	47
4	4	3	3	2	2	1	1	هل يشعر أنه ووالداه يحبان بعض بعض؟ Do you have the feeling that you and your parents really like each other?	48
4	4	3	3	2	2	1	1	هل يغضب والديك منه في بعض الأحيان دون أن يخبرانه السبب؟ Are your parents sometimes angry or unhappy	49

								about you without telling you why?	
4	4	3	3	2	2	1	1	إذا عمل عملاً بابتقان، هل يبدو والديه فخوران به؟ If you do something really well, do your parents seem to be very proud of you?	50
4	4	3	3	2	2	1	1	هل يسمح له بان يقوم بأشياء أكثر من أن يسمح به لإخوانه وحواته؟ Are you allowed to do more than your brothers and sisters are allowed to do? (By brothers and sisters, we mean all the children who live at your house.)	51
4	4	3	3	2	2	1	1	هل والداه يظهران حبهم له بأن يعانقانه أو يدللانه؟ Do your parents show you that they love you by hugging you or giving you a cuddle?	52

Subscale 1: Emotional Warmth

1-3-7-9-10-14-20-21-25-26-28-30-31-35-39-43-48-50-52.

Subscale 2: Rejection

4-5-8-12-16-17-22-23-36-38-40-41-42-44-45-46-49.

Subscale 3: Overprotection

11-13-15-18-24-27-29-32-33-34-37-47.

Subscale 4: Favouring Subject

2-6-19-51.

Appendices 3.5.2: Parenting Stress Index / Short Form

PARENTING STRESS INDEX, 3RD ED. (PSI) -P

Instructions:

This questionnaire contains 36 statements. Read each statement carefully. For each statement, please focus on the child you are most concerned about, and circle the response that best represents your opinion.

Circle the SA if you strongly agree with the statement.

Circle the A if you agree with the statement.

Circle the NS if you are not sure.

Circle the SA if you disagree with the statement.

Circle the SA if you strongly disagree with the statement.

For example, if you sometime enjoy to movies, you would circle A in response to the following statement:

I enjoy going to the movies. SA A NS D SD

While you may not find a response that exactly states your feeling, please circle the response that comes closest to describing how you feel. YOUR FIRST REACTION TO EACH QUESTION SHOULD BE YOUR ANSWER.

Circle only one response for each statement, and respond to all statements. DO NOT ERASE! If you need to change an answer, make an "X" through the incorrect answer and circle the correct response. For example:

I enjoy going to the movies. SA A NS D SD

Before responding to the statements, write your name, gender, date of birth, ethnic group, marital status, child's name, child's gender, child's date of birth, and today's date in the spaces at the top of the questionnaire.

SD	D	NS	A	SA	العبارة	م
1	2	3	4	5	كثيرا ما أشعر بعدم قدرتي على التعامل مع الأشياء بشكل جيد I often have the feeling that I cannot handle things very well.	1
1	2	3	4	5	وجدت نفسي أتخلى عن كثير من الأشياء في حياتي لأفي باحتياجات أطفالي بشكل أكثر مما توقعت I find myself giving up more of my life to meet my children's needs than I ever expected.	2
1	2	3	4	5	أبدو محصورا بمسؤولياتي كوالدا والدة I feel trapped by my responsibilities as a parent	3
1	2	3	4	5	منذ ولادة هذا الطفل أصبحت غير قادر على عمل أشياء جديدة ومختلفة Since having this child, I have been unable to do new and different things.	4
1	2	3	4	5	منذ ولادة هذا الطفل أشعر بأنني أصبحت تقريبا غير قادرا على عمل الأشياء التي أحب عملها Since having a child, I feel that I am almost never able to do things that I like to do	5
1	2	3	4	5	ألست سعيداً بما اشتريته من ملابس في المرة الأخيرة I am unhappy with the last purchase of clothing I made for myself.	6
1	2	3	4	5	هناك بعض الأشياء تزعجني بشأن حياتي There are quite a few things that bother me about my life	7
1	2	3	4	5	وجود طفل سبب مشاكل أكثر مما توقعت مع شريك حياتي (زوجي) Having a child has caused more problems than I expected in my relationship with my spouse (male/female friend).	8
1	2	3	4	5	أشعر بالوحدة وبدون أصدقاء I feel alone and without friends	9
1	2	3	4	5	عندما أذهب إلى حفلة، أتوقع عادة ألا أستمتع بها When I go to a party, I usually expect not enjoy myself	10
1	2	3	4	5	لم أعد أهتم بالناس كما كنت في السابق I am not as interested in people as I used to be	11
1	2	3	4	5	لم أعد استمتع بالأشياء كما كنت بالسابق I don't enjoy things as I used to	12
1	2	3	4	5	نادرا ما يقوم طفلي بعمل أشياء تشعرني بالراحة My child rarely dose thing for me that make me feel good	13
1	2	3	4	5	اشعر أغلب الأوقات بأن طفلي لا يحبني ولا يريد أن يكون بقربي Most times I feel that my child dose not like me and dose not want to be close to me	14
1	2	3	4	5	يبتسم طفلي لي أقل بكثير مما توقعت	15

					My child smiles at me much less than I expected.	
1	2	3	4	5	عندما أعمل الأشياء لطفي أشعر بأن مجهودي لم يقدر كثيرا When I do things for child I get the feeling that my efforts are not appreciated very much	16
1	2	3	4	5	طفلي غالبا لا يضحك أو يقهقه، أثناء اللعب When playing, my child doesn't often giggle or laugh.	17
1	2	3	4	5	يبدو طفلي لا يتعلم بسرعة كما يتعلم معظم الأطفال الآخرين My child doesn't seem to learn as quickly as most children	18
1	2	3	4	5	يبدو طفلي لا يبتسم بقدر ما يبتسم معظم الأطفال My child doesn't seem to smile as much as most children.	19
1	2	3	4	5	لا يستطيع طفلي القيام بكثير من الأشياء التي كنت أتوقعها منه My child is not able to do as much as I expected.	20
1	2	3	4	5	يستغرق طفلي الكثير من الوقت والجهد ليعتاد على الأشياء الجديدة It takes a long time and it is very hard for my child to get used to new things	21
5	4	3	2	1	للعبارة القادمة بالأسفل اختر إجابتك من الخيارات التالية ١ إلى ٥ أشعر بأني: - لست جيد كوالدا والدة. - شخص لدية بعض الصعوبات لان يكون والدا والدة. - والدا والدة بشكل عادي. - والدا والدة بشكل أفضل من عادي - والد جيد جدا. For the next statement, choose your response from the choices "1" to "5" below. I feel that I am : - Not very good at being a parent. - A person who has some trouble being a parent. - An average parent. - A better than average parent. - A very good parent.	22
1	2	3	4	5	توقعت أن يكون لدي مشاعر أكثر دفئا لطفي وأن أكون أقرب له أكثر مما أنا عليه الآن وهذا الشيء يزعجني I expected to have closer and warmer feeling for my child than I do and this bothers me.	23
1	2	3	4	5	أحيانا طفلي يعمل أشياء تزعجني فقط ليكون مزعجا Sometimes my child does thing that bother me just to be mean	24
1	2	3	4	5	يبدو طفلي أكثر بكاء واختلافا للضجة من بقية الأطفال My child seems to cry or fuss more often than most children	25

1	2	3	4	5	بشكل عام يستيقظ طفلي من الفراش بمزاج سيء My child generally wakes up in bad mood.	26
1	2	3	4	5	أشعر أن طفلي متقلب المزاج كثيرا ويغضب بسهولة I feel that my child is very moody and easily upset	27
1	2	3	4	5	يقوم طفلي بعمل بعض الأشياء التي تقلقني بشدة My child does a few things which bother me a great deal	28
1	2	3	4	5	طفلي لديه ردة فعل قوية للأشياء التي لا يحبها My child reacts very strongly when something happens that my child doesn't like	29
1	2	3	4	5	يغضب طفلي بسهولة على أقله الأشياء My child gets upset easily over the smallest thing.	30
1	2	3	4	5	تعبت أكثر مما توقعت في تنسيق أوقات الأكل والنوم لطفلي My child's sleeping or eating schedule was much harder to establish than I expected	31
5	4	3	2	1	<p>للعبارة القادمة بالأسفل اختر إجابتك من الخيارات التالية ١ إلى ٥ وجدت حتى يقوم طفلي بعمل بعض الأشياء أو التوقف عن عمل بعض الأشياء يكون:</p> <ul style="list-style-type: none"> - أصعب بكثير مما توقعت. - أصعب بقليل مما توقعت - صعب مثل ما توقعت - أسهل بقليل مما توقعت - أسهل بكثير مما توقعت <p>For the next statement, choose your response from the choice "1" to "5" below.</p> <p>I have found that getting my child to do something or stop doing something is:</p> <ol style="list-style-type: none"> 1- Much harder than I expected. 2- Somewhat harder than I expected. 3- About as hard as I expected. 4- Somewhat easier than I expected. 5- Much easier than I expected. 	32
1-3	4-5	6-7	8-9	10+	<p>للعبارة القادمة بالأسفل اختر إجابتك من الخيارات التالية +١٠ إلى "٣-١" فكر بعناية وعدد الأشياء التي يعملها طفل وتزعجك . مثلا: إضاعة الوقت، رفض كثرة النشاط، البكاء، المقاطعة، الشجار، الأئين الخ</p> <p>For the next statement, choose your response from the choice "10+" to "1-3".</p> <p>Think carefully and count the number of things which your child does that bother you. For example: dawdles, refuses to overactive, cries,</p>	33

					interrupts, fights, whines, etc.	
1	2	3	4	5	هناك بعض الأشياء يعملها طفلي تزعجني كثيرا There are some things my child does that really bother me a lot.	34
1	2	3	4	5	تحول ولدي إلى مشكلة بشكل أكثر مما كنت أتوقعه My child turned out to be more of a problem than I had expected	35
1	2	3	4	5	يطلب طفلي مني طلبات أكثر مما يطلبه بقية الأطفال My child makes more demands on me than most children	36

Parental Distress PD: 1+2+3+4+5+6+7+8+9+10+11+12

Parent-Child Dysfunctional Interaction P-CDI: 13+14+15+16+17+18+19+20+21+22+23+24

Difficult Child DC: 25+26+27+28+29+30+31+32+33+34+35+36

Appendices 3.5.3: General Health Questionnaire

استبيان الصحة العامة

General Health Questionnaire (GHQ)

Have you recently....

نرغب في معرفة كيف هي صحتك بشكل عام خلال الأسابيع القليلة الماضية، أرجو قراءة الأسئلة التالية ولكل سؤال هناك يوجد أربع إجابات محتملة أشر على أفضل إجابة تنطبق عليك. فضلاً أجب على جميع الأسئلة مع الشكر.

م	العبارة	ليس على الإطلاق	أقل من المعتاد	بحدود المعتاد	أكثر من المعتاد
1	هل أصبحت مؤخراً قادراً على التركيز بالإعمال التي تقوم بها Been able to concentrate on what you're doing	3	2	1	0
2	هل أصبحت مؤخراً تفقد الكثير من النوم بسبب القلق Lost much sleep over worry	3	2	1	0
3	هل تشعر مؤخراً بأنك تبلي دور حسن بأمورك Felt you were playing a useful part in things	3	2	1	0
4	هل شعرت مؤخراً بأنك مؤهل على اتخاذ قرارات بشأن أمورك Felt capable of making decisions about things	3	2	1	0
5	هل شعرت مؤخراً بأنك مجهد بشكل مستمر Felt constantly under strain	3	2	1	0
6	هل شعرت مؤخراً بعدم قدرتك على التغلب على مصاعبك Felt you couldn't overcome your difficulties	3	2	1	0
7	هل تستطيع مؤخراً القيام بأعمالك اليومية بشكل طبيعي Been able to enjoy your normal day-to-day activities	3	2	1	0
8	هل شعرت مؤخراً بأنك قادراً على أن تواجه مشاكلك Been able to face up to your problems	3	2	1	0
9	هل شعرت مؤخراً بأنك غير سعيد ومحبط Been feeling unhappy and depressed	3	2	1	0
10	هل شعرت مؤخراً بفقدان الثقة في نفسك Been losing confidence in yourself	3	2	1	0
11	هل فكرت مؤخراً بنفسك كشخص عديم الفائدة Been thinking of yourself as a worthless person.	3	2	1	0
12	هل شعرت مؤخراً بأنك سعيد لحد معقول ومهتم بكل الأشياء Been feeling reasonably happy, all things considered	3	2	1	0

Appendices 3.6: Official approval from the Ministry of Health

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ



المحترم

سعادة مدير عام التدريب والابتعاث

وزارة الصحة

السلام عليكم ورحمة الله وبركاته:-

أشير إلى خطابكم رقم [٧٧٧٩] وتاريخ ١٤٢٩/٠١/٢٦ هـ بشأن الموافقة على قيام/زيد هاشم ابراهيم السيد برحلة علمية نرفق لكم قرار لجنة تدريب وابتعاث موظفي الخدمة المدنية رقم [٩١] وتاريخ ١٤٢٩/٠٢/٠٢ هـ بالموافقة على القيام برحلة علمية كما هو موضح بالقرار .

والتأكيد على تزويد مركز المعلومات بالوزارة بصورة من القرار خلال (٣) أيام من صدوره وفق ما نص عليه دليل نماذج واجراءات شئون الموظفين المبلغ للأجهزة الحكومية بتعميم الوزارة رقم (٥٤٤٤) في ١٤٢١/٠٢/٠٥ هـ .

وتقبلوا خالص التحية والتقدير،،،

أمين عام لجنة تدريب وابتعاث موظفي الخدمة المدنية


صالح بن عبدالرحمن الشيب



نموذج (١٤٢١/١/١١٩٥)

التاريخ : ١٤٢٩/٠٢/٠٦ المرفقات : ١

الرقم : ٤٩٤٥



هاتف (٠٢٦٦٦٦٤) فاكس (٤٠٥٩٢٥٨) تليكس (٤٠٢٤٦٥ CIVSER SJ) ص.ب (١٨٣٦٧) الرياض (١١١١٤) - المملكة العربية السعودية

بسم الله الرحمن الرحيم



لجنة تدريب وابتعاث
موظفي الخدمة المدنية

رقم الطلب	٧٧٧٩
تاريخ الطلب	١٤٢٩/٠١/٢٦ هـ

قرار القيام برحلة علمية

الاسم	زيد هاشم ابراهيم السيد	الجهة	وزارة الصحة
التخصص	علم النفس السريري	الدرجة العلمية	الدكتوراه
الجهة التعليمية	جامعة أدنبره	مكاتها	بريطانيا-أدنبره
مدة البعثة	ثلاث سنوات	تاريخ بدء البعثة	١٤٢٦/٠٢/٢٩ هـ
مدة الرحلة المطلوبة	من ١٤٢٩/٠٢/٠٢ هـ حتى ١٤٢٩/٠٨/٠١ هـ		

قرار لجنة تدريب وابتعاث موظفي الخدمة المدنية

رقم القرار	٩١	التاريخ	١٤٢٩/٠٢/٠٢ هـ	قرار اللجنة
<p>بناءً على طلب وزارة الصحة رقم [٧٧٧٩] وتاريخ ١٤٢٩/٠١/٢٦ هـ وبناءً على المادة الخامسة من القرار الوزاري رقم (١٣٥١) وتاريخ ١٣٩٣/٤/١٣ هـ المتضمن السماح للمبتعثين بالقيام برحلات علمية داخل المملكة لإعداد رسائلهم الجامعية وفقاً للشروط المحددة بقرار مجلس الوزراء رقم (١١١٢) وتاريخ ١٣٩٠/١١/١٩ هـ تقرر ما يلي: الموافقة على قيام / زيد هاشم ابراهيم السيد برحلة علمية إلى المملكة العربية السعودية لمدة ثلاثة أشهر اعتباراً من ١٤٢٩/٠٢/٠٢ هـ حتى ١٤٢٩/٠٥/٠١ هـ لجمع المعلومات المتعلقة بالبحث على ان يكمل ما تبقى من مدة الرحلة المطلوبة بما يستحق من اجازات نظامية.</p>				
وزير الخدمة المدنية				
رئيس لجنة تدريب وابتعاث موظفي الخدمة المدنية				
محمد بن علي الفايز				



الجمهورية العربية السورية
وزارة الدفاع والطيران والمفتشية العامة
رئاسة هيئة الأركان العامة
الإدارة العامة للخدمات الطبية للقوات المسلحة
إدارة الامن/٤

الرقم: ٩٨٧/خ/٤/١١٩
التاريخ: ٢٤٢٩/٧/١١
المرققات: ٢٢٢
الموضوع: بشأن إجازة إستيبان سري

مدير إدارة التدريب بالإدارة العامة للخدمات الطبية للقوات المسلحة

السلام عليكم ورحمة الله وبركاته .

الإشارة:

لخطابكم رقم ٧٩٦٧/خ/١/٤/٩ وتاريخ ١٤٢٩/٧/٥ هـ المتضمن طلب إجازة الإستيبان الخاص بالمبتعث من قبل وزارة الصحة /زياد هاشم السيد / أخصائي نفسي بعنوان (التعرض للصدمة النفسية والخوف الإجتماعي لدى الأطفال) .

الإفاده:

١. إلتزام الباحث بإيداع نسخه من البحث في مكتب المساعد لشؤون التدريب والأبحاث.
٢. يجب المحافظه على توزيع نسخ الإستهانه وتكون بشكل مقنن بعيداً عن العشوائية في التوزيع على أن يتم ترقيم كل نسخه من نموذج الإستهانه .
٣. يجب عدم تصوير الإستهانه بعد التعبئة وعدم تسليمها لغير المعنيين .
٤. يجب على الباحث أن يتعهد بعدم إستخدام الإستهانه ونتائجها لغير أغراض البحث وعدم نشرها بأي وسيله إلا بإذن مكتوب من إدارة الأمن بالخدمات الطبية .
٥. يجب على معد الإستهانه أن يقوم بإتلاف الإستهانه في حال الإنتهاء من الدراسة وفقاً لإجراءات إتلاف الوثائق الرسمية .

المطلوب:

آمل الإطلاع والإحاطه .
والسلام عليكم .

صاحب العلم الداعي

رسمال للاثم

٧١١٦

العقيد
صقر بن سعدون السعدون

مدير إدارة الامن بالخدمات الطبية للقوات المسلحة

استه (داعي) كصبي
سعدون السعدون (٥٥) في الامن
١٦٦

نسخه / لملف المتابعه ق٤
==== / لصادر الامن السري

بسم الله الرحمن الرحيم
مستشفى القوات المسلحة بالرياض



مذكرة داخلية

Date ٢٠٠٨/٠٨/١١

التاريخ : ١٤٢٩/٠٨/١٠ هـ

من : د. إبراهيم الخضير رئيس قسم الطب النفسي
إلى : إلى جميع العاملين في قسم الطب النفسي

الموضوع : مساعدة الباحث / زياد هاشم السيد

الأستاذ / زياد هاشم السيد يقوم حالياً بدراسة ميدانية لعمل البحث العملي عن مرضى الاضطرابات
الانفعالية (Emotional Disorders) .

أمل من الجميع التكرم بمساعدته على مقابلة المرضى الذين يعانون من (الرهاب الاجتماعي،
اضطرابات ما بعد الصدمة و اضطرابات القلق) .

شاكرين تعاونكم ..

د. إبراهيم الخضير

مدير قسم الطب النفسي

الرقم : ٤٤١/١٤٩٦
التاريخ : ١٧ / ٩ / ١٤٩٦ هـ
المشروعات : ٣



المملكة العربية السعودية
وزارة الصحة
المديرية العامة للشئون الصحية بمنطقة الرياض

المحترم

سعادة،
عام البحوث الطبية
السلام عليكم ورحمة الله وبركاته

إشارة إلى خطابكم رقم ٣٧/٢٥٧٩٣ وتاريخ ١٤٣٩/٣/٣١ بشأن طلبكم تسميل مهمة طالب الدكتوراه / زياد بن هاشم السيد، بعمل دراسة بعنوان (التعرض للصدمة النفسية والخوف الاجتماعي) على إن يتم الالتزام بالضوابط الأخلاقية الصادرة عن اللجنة الوطنية لاختبارات البحوث الطبية الجيوية •
عنه نفيديكم بأنه وردنا خطاب المشرف العام على مجمع الأمل للصحة النفسية والمرفق يفيد بان المذكور قد انهى دراسته داخل المجمع في الفترة من تاريخ ١٤٣٩/٥/٣٩ إلى ١٣/٩/١٤٣٩ وذلك بعد الالتزام بالضوابط الأخلاقية للبحوث الطبية •
لاطلاع سعادتكم •

مع تحياتي

م/ المدير العام للطب العلاجي

٩١١٧

د/ محمد بن عبد الله الفايز

ص/ إدارة المستشفيات / إدارة الصحة النفسية والاجتماعية

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

الرقم : ٢٤٧٦٤٢٠
التاريخ : ١٤٣٧/٩/٢١ م
المشروعات : ٢٠٢٢



المملكة العربية السعودية
وزارة الصحة
الإدارة العامة للتدريب والإبتعاث

الموضوع : إنهاء رحلة علمية

الاسم	الوظيفة	الجنسية	رقم الملف
زياد هاشم إبراهيم السيد	أخصائي نفسي	سعودي	A 301

المحترم

سعادة المحقق الثقافي السعودي ببريطانيا

السلام عليكم ورحمة الله وبركاته

إشارة إلى خطاب أمين عام لجنة تدريب وإبتعاث موظفي الخدمة المدنية رقم ٤٩٤٥ وتاريخ ١٤٢٩/٢/٦هـ المتضمن موافقة لجنة تدريب وإبتعاث موظفي الخدمة المدنية رقم (٩١) وتاريخ ١٤٢٩/٢/٢هـ على قيام الموظف المذكور اسمه أعلاه برحلة علمية إلى المملكة العربية السعودية لجمع المعلومات . أفيدكم أن المبتعث المذكور قد أنهى الرحلة العلمية وجمع البيانات المطلوبة لإطلاع سعادتكم وإكمال اللازم .

وتقبلاً أطيب تحياتي ،،،

مدير عام التدريب والإبتعاث بالنيابة

أ / منصور بن صالح اليامي

٢٠٠٨/٠٩/٢٠

خ ١٢٧ ط ٢٩٩، إدارة الإبتعاث الخارجي

